

Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine

Vincenza Snow, MD¹
Dennis Beck, MD²
Tina Budnitz, MPH³
Doriane C. Miller, MD⁴
Jane Potter, MD⁵
Robert L. Wears, MD⁶
Kevin B. Weiss, MD, MPH⁷
Mark V. Williams, MD⁸

¹American College of Physicians, Philadelphia, Pennsylvania.

²Beacon Medical Services, Aurora, Colorado.

³Society of Hospital Medicine, Philadelphia, Pennsylvania.

⁴University of Chicago Medical Center, Chicago, Illinois.

⁵University of Nebraska, Lincoln, Nebraska.

⁶University of Florida, Gainesville, Florida.

⁷American Board of Medical Specialties, Chicago, Illinois.

⁸Northwestern University, Chicago, Illinois.

The Transitions of Care Consensus Conference was funded by an unrestricted educational grant from Novo Nordisk as part of the American College of Physicians Diabetes Initiative and by the Agency for Healthcare Research and Quality. The funders had no input into the planning, structure, content, participants, or outcomes of the conference. This article is also being published by the Journal of General Internal Medicine [Vincenza Snow, Dennis Beck, Tina Budnitz, Doriane C. Miller, Jane Potter, Robert L. Wears, Kevin B. Weiss, Mark V. Williams. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine]. *J Gen Intern Med* 2009 (online in advance of print).

The Transitions of Care Consensus Conference is described in Appendix A, and conflicts of interest are listed in Appendix B.

The American College of Physicians, Society of Hospital Medicine, and Society of General Internal Medicine convened a multi-stakeholder consensus conference in July 2007 to address the quality gaps in the transitions between inpatient and outpatient settings and to develop consensus standards for these transitions. Over 30 organizations sent representatives to the Transitions of Care Consensus Conference. Participating organizations included medical specialty societies from internal medicine as well as family medicine and pediatrics, governmental agencies such as the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services, performance measure developers such as the National Committee for Quality Assurance and the American Medical Association Physician Consortium on Performance Improvement, nurse associations such as the Visiting Nurse Associations of America and Home Care and Hospice, pharmacist groups, and patient groups such as the Institute for Family-Centered Care. The Transitions of Care Consensus Conference made recommendations for standards concerning the transitions between inpatient and outpatient settings for future implementation. The American College of Physicians, Society of Hospital Medicine, Society of General Internal Medicine, American Geriatric Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine all endorsed this document. *Journal of Hospital Medicine* 2009;4:364–370. © 2009 Society of Hospital Medicine.

KEYWORDS: care standardization, continuity of care transition and discharge planning, patient safety.

Studies of the transition of care between inpatient and outpatient settings have shown that there are significant patient safety and quality deficiencies in our current system. The transition from the hospital setting to the outpatient setting has been more extensively studied than the transition from the outpatient setting to the inpatient setting. One prospective cohort study of 400 patients found that 1 in 5 patients

discharged from the hospital to home experienced an adverse event, which was defined as an injury resulting from medical management rather than the underlying disease, within 3 weeks of discharge.¹ This study also concluded that 66% of these were drug-related adverse events, many of which could have been avoided or mitigated. Another prospective cross-sectional study of 2644 patient

discharges found that approximately 40% of the patients had pending test results at the time of discharge and that 10% of these required some action, yet the outpatient physicians and patients were unaware of these results.² Medication discrepancies have also been shown to be prevalent, with 1 prospective observational study of 375 patients showing that 14% of elderly patients had 1 or more medication discrepancies and 14% of those patients with medication discrepancies were rehospitalized within 30 days versus 6% of the patients who did not experience a medication discrepancy.³ A recent review of the literature cited improving transitional care as a key area of opportunity for improving postdischarge care⁴

Lack of communication has clearly been shown to adversely affect postdischarge care transitions.⁵ A recent summary of the literature by a Society of Hospital Medicine (SHM)/Society of General Internal Medicine (SGIM) task force found that direct communication between hospital physicians and primary care physicians occurs infrequently (in 3%-20% of cases studied), and the availability of a discharge summary at the first postdischarge visit is low (12%-34%) and does not improve greatly even after 4 weeks (51%-77%); this affects the quality of care in approximately 25% of follow-up visits.⁵ This systematic review of the literature also found that discharge summaries often lack important information such as diagnostic test results, the treatment or hospital course, discharge medications, test results pending at discharge, patient or family counseling, and follow-up plans.

However, the lack of studies of the communication between ambulatory physicians and hospital physicians prior to admission or during emergency department (ED) visits does not imply that this communication is not equally important and essential to high-quality care. According to the Centers for Disease Control, the greatest source of hospital admissions in many institutions is the ED. Over 115,000,000 visits were made to the nation's approximately 4828 EDs in 2005, and about 85.2% of ED visits end in discharge.⁶ The ED is also the point of re-entry into the system for individuals who may have had an adverse outcome linked to a prior hospitalization.⁶ Communication between hospital physicians and primary care physicians must be established to create a loop of continuous care and diminish morbidity and mortality at this critical transition point.

While transitions can be a risky period for patient safety, observational studies suggest there are benefits to transitions. A new physician may notice something overlooked by the current caregivers.⁷⁻¹² Another factor contributing to the challenges of care transitions is the lack of a single clinician or clinical entity taking responsibility for coordination across the continuum of the patient's overall healthcare, regardless of setting.¹³ Studies indicate that a relationship with a medical home is associated with better health on both the individual and population levels, with lower overall costs of care and with reductions in disparities in health between socially disadvantaged subpopulations and more

socially advantaged populations.¹⁴ Several medical societies have addressed this issue, including the American College of Physicians (ACP), SGIM, American Academy of Family Physicians, and American Academy of Pediatrics, and they have proposed the concept of the medical home or patient-centered medical home, which calls for clinicians to assume this responsibility for coordinating their patients' care across settings and for the healthcare system to value and reimburse clinicians for this patient-centered and comprehensive method of practice.¹⁵⁻¹⁷

Finally, patients and their families or caregivers have an important role to play in transitions of care. Several observational and cross-sectional studies have shown that patients and their caregivers and families express significant feelings of anxiety during care transitions. This anxiety can be caused by a lack of understanding and preparation for their self-care role in the next care setting, confusion due to conflicting advice from different practitioners, and a sense of abandonment attributable to the inability to contact an appropriate healthcare practitioner for guidance, and they report an overall disregard for their preferences and input into the design of the care plan.¹⁸⁻²⁰ Clearly, there is room for improvement in all these areas of the inpatient and outpatient care transition, and the Transitions of Care Consensus Conference (TOCCC) attempted to address these areas by developing standards for the transition of care that also harmonize with the work of the Stepping up to the Plate (SUTTP) Alliance of the American Board of Internal Medicine (ABIM) Foundation.²¹ In addition, other important stakeholders are addressing this topic and actively working to improve communication and continuity in care, including the Centers for Medicare and Medicaid Services (CMS) and the National Quality Forum (NQF). CMS recently developed the Continuity Assessment Record & Evaluation (CARE) tool, a data collection instrument designed to be a standardized, interoperable, common assessment tool to capture key patient characteristics that will provide information related to resource utilization, clinical outcomes, and postdischarge disposition. NQF held a national forum on care coordination in the spring of 2008.

In summary, it is clear that there are qualitative and quantitative deficiencies in transitions of care between the inpatient and outpatient setting that are affecting patient safety and experience with care. The transition from the inpatient setting to the outpatient setting has been more extensively studied, and this body of literature has underscored for the TOCCC several important areas in need of guidance and improvement. Because of this, the scope of application of this document should initially emphasize inpatient-to-outpatient transitions as a first step in learning how to improve these processes. However, the transition from the outpatient setting to the inpatient setting also is a clear priority. Because the needs for transfer of information, authority, and responsibility may be different in these situations, a second phase of additional work to develop principles to guide these transitions should be undertaken as

quickly as possible. Experience gained in applying these principles to inpatient-to-outpatient transitions might usefully inform such work.

Communication among providers and with the patients and their families arose as a clear priority. Medication discrepancies, pending tests, and unknown diagnostic or treatment plans have an immediate impact on patients' health and outcomes. The TOCCC discussed what elements should be among the standard pieces of information exchanged among providers during these transition points. The dire need for coordination of care or a coordinating clinician/medical home became a clear theme in the deliberations of the TOCCC. Most importantly, the role of the patients and their families/caregivers in their continuing care is apparent, and the TOCCC felt this must be an integral part of any principles or standards for transitions of care.

Methods

In the fall/winter of 2006, the executive committees of ACP, SGIM, and SHM agreed to jointly develop a policy statement on transitions of care. Transitions of care specifically between the inpatient and outpatient settings were selected as an ideal topic for collaboration for the 3 societies as they represent the continuum of care for internal medicine within these settings. To accomplish this, the 3 organizations decided to convene a consensus conference to develop consensus guidelines and standards concerning transitions between inpatient and outpatient settings through a multi-stakeholder process. A steering committee was convened with representatives from ACP, SGIM, SHM, the Agency for Healthcare Research and Quality (AHRQ), ABIM, and the American Geriatric Society (AGS). The steering committee developed the agenda and invitee list for the consensus conference. After the conference was held, the steering committee was expanded to include representation from the American College of Emergency Physicians (ACEP) and the Society for Academic Emergency Medicine (SAEM).

During the planning stages of the TOCCC, the steering committee became aware of the SUTTP Alliance of the ABIM Foundation. The SUTTP Alliance has representation from medical specialties such as internal medicine and its subspecialties, family medicine, and surgery. The alliance was formed in 2006 and has been working on care coordination across multiple settings and specialties. The SUTTP Alliance had developed a set of principles and standards for care transitions and agreed to provide the draft document to the TOCCC for review, input, and further development and refinement.

Recommendations on Principles and Standards for Managing Transitions in Care Between the Inpatient and Outpatient Settings from ACP, SGIM, SHM, AGS, ACEP, and SAEM

The SUTTP Alliance presented a draft document entitled "Principles and Standards for Managing Transitions in

Care." In this document, the SUTTP Alliance proposes 5 principles and 8 standards for effective care transitions. A key element of the conference was a presentation by NQF on how to move from principles to standards and eventually to measures. This presentation provided the TOCCC with the theoretical underpinnings for the discussion of these principles and standards and how the TOCCC would provide input on them. The presentation provided an outline for the flow from principles to measures. First, there needs to be a framework that provides guiding principles for what we would like to measure and eventually report. From those principles, a set of preferred practices or standards are developed; the standards are more granular and allow for more specificity in describing the desired practice or outcome and its elements. Standards then provide a roadmap for identification and development of performance measures. With this framework in mind, the TOCCC then discussed in detail the SUTTP principles and standards.

The 5 principles for effective care transitions developed by the SUTTP Alliance are as follows:

- Accountability.
- Communication: clear and direct communication of treatment plans and follow-up expectations.
- Timely feedback and feed-forward of information.
- Involvement of the patient and family member, unless inappropriate, in all steps.
- Respect of the hub of coordination of care.

The TOCCC re-affirmed these principles and added 4 additional principles to this list. Three of the "new" principles were statements within the 8 standards developed by the SUTTP, but when taking into consideration the framework for the development of principles into standards, the TOCCC felt that the statements were better represented as principles. They are as follows:

- All patients and their families/caregivers should have and should be able to identify their medical home or coordinating clinician (ie, practice or practitioner). (This was originally part of the coordinating clinicians standard, and the TOCCC voted to elevate this to a principle).
- At every point along the transition, the patients and/or their families/caregivers need to know who is responsible for care at that point and who to contact and how.
- National standards should be established for transitions in care and should be adopted and implemented at the national and community level through public health institutions, national accreditation bodies, medical societies, medical institutions, and so forth in order to improve patient outcomes and patient safety. (This was originally part of the SUTTP community standards standard, and the TOCCC moved to elevate this to a principle).
- For monitoring and improving transitions, standardized metrics related to these standards should be used in order to lead to continuous quality improvement and accountability. (This was originally part of the measurement

standard, and the TOCCC voted to elevate this to a principle).

The SUTTP Alliance proposed the following 8 standards for care transitions:

- Coordinating clinicians.
- Care plans.
- Communication infrastructure.
- Standard communication formats.
- Transition responsibility.
- Timeliness.
- Community standards.
- Measurement.

The TOCCC affirmed these standards and through a consensus process added more specificity to most of them and elevated components of some of them to principles, as discussed previously. The TOCCC proposes that the following be merged with the SUTTP standards:

- Coordinating clinicians. Communication and information exchange between the medical home and the receiving provider should occur in an amount of time that will allow the receiving provider to effectively treat the patient. This communication and information exchange should ideally occur whenever patients are at a transition of care (eg, at discharge from the inpatient setting). The timeliness of this communication should be consistent with the patient's clinical presentation and, in the case of a patient being discharged, the urgency of the follow-up required. Guidelines will need to be developed that address both the timeliness and means of communication between the discharging physician and the medical home. Communication and information exchange between the medical home and other physicians may be in the form of a call, voice mail, fax, or other secure, private, and accessible means including mutual access to an electronic health record. The ED represents a unique subset of transitions of care. The potential transition can generally be described as outpatient to outpatient or outpatient to inpatient, depending on whether or not the patient is admitted to the hospital. The outpatient-to-outpatient transition can also encompass a number of potential variations. Patients with a medical home may be referred to the ED by the medical home, or they may self-refer. A significant number of patients do not have a physician and self-refer to the ED. The disposition from the ED, either outpatient to outpatient or outpatient to inpatient, is similarly represented by a number of variables. Discharged patients may or may not have a medical home, may or may not need a specialist, and may or may not require urgent (<24 hours) follow-up. Admitted patients may or may not have a medical home and may or may not require specialty care. This variety of variables precludes a single approach to ED transition of care coordination. The determination of which scenarios will be appropriate for the development

of standards (coordinating clinicians and transition responsibility) will require further contributions from ACEP and SAEM and review by the steering committee.

- Care plans/transition record. The TOCCC also agreed that there is a minimal set of data elements that should always be part of the transition record. The TOCCC suggested that this minimal data set be part of an initial implementation of this standard. That list includes the following:
 - Principle diagnosis and problem list.
 - Medication list (reconciliation) including over-the-counter medications/herbals, allergies, and drug interactions.
 - Clear identification of the medical home/transferring coordinating physician/institution and the contact information.
 - Patient's cognitive status.
 - Test results/pending results.

The TOCCC discussed what components should be included in an ideal transition record and agreed on the following elements:

- Principle diagnosis and problem list.
- Medication list (reconciliation) including over-the-counter medications/herbals, allergies, and drug interactions.
- Emergency plan and contact number and person.
- Treatment and diagnostic plan.
- Prognosis and goals of care.
- Test results/pending results.
- Clear identification of the medical home and/or transferring coordinating physician/institution.
- Patient's cognitive status.
- Advance directives, power of attorney, and consent.
- Planned interventions, durable medical equipment, wound care, and so forth.
- Assessment of caregiver status.

The TOCCC also added a new standard under this heading: Patients and/or their families/caregivers must receive, understand, and be encouraged to participate in the development of the transition record, which should take into consideration patients' health literacy and insurance status and be culturally sensitive.

- Communication infrastructure. All communications between providers and between providers and patients and families/caregivers need to be secure, private, Health Insurance Portability and Accountability Act-compliant, and accessible to patients and those practitioners who care for them. Communication needs to be 2-way with an opportunity for clarification and feedback. Each sending provider needs to provide a contact name and the number of an individual who can respond to questions or concerns. The content of transferred information needs to include a core standardized data set. This information needs to be transferred as a living database; that is, it is created only once, and then each subsequent provider only needs to update,

validate, or modify the information. Patient information should be available to the provider prior to the patient's arrival. Information transfer needs to adhere to national data standards. Patients should be provided with a medication list that is accessible (paper or electronic), clear, and dated.

- Standard communication formats. Communities need to develop standard data transfer forms (templates and transmission protocols). Access to a patient's medical history needs to be on a current and ongoing basis with the ability to modify information as a patient's condition changes. Patients, families, and caregivers should have access to their information ("nothing about me without me"). A section on the transfer record should be devoted to communicating a patient's preferences, priorities, goals, and values (eg, the patient does not want intubation).
- Transition responsibility. The sending provider/institution/team at the clinical organization maintains responsibility for the care of the patient until the receiving clinician/location confirms that the transfer and assumption of responsibility is complete (within a reasonable timeframe for the receiving clinician to receive the information; ie, transfers that occur in the middle of the night can be communicated during standard working hours). The sending provider should be available for clarification with issues of care within a reasonable timeframe after the transfer has been completed, and this timeframe should be based on the conditions of the transfer settings. The patient should be able to identify the responsible provider. In the case of patients who do not have an ongoing ambulatory care provider or whose ambulatory care provider has not assumed responsibility, the hospital-based clinicians will not be required to assume responsibility for the care of these patients once they are discharged.
- Timeliness. Timeliness of feedback and feed-forward of information from a sending provider to a receiving provider should be contingent on 4 factors:
 - Transition settings.
 - Patient circumstances.
 - Level of acuity.
 - Clear transition responsibility.

This information should be available at the time of the patient encounter.

- Community standards. Medical communities/institutions must demonstrate accountability for transitions of care by adopting national standards, and processes should be established to promote effective transitions of care.
- Measurement. For monitoring and improving transitions, standardized metrics related to these standards should be used. These metrics/measures should be evidence-based, address documented gaps, and have a demonstrated impact on improving care (complying with performance measure standards) whenever feasible. Results from measurements using standardized metrics must lead to continuous improvement of the transition process. The validity, reliability, cost, and impact, including unintended conse-

quences, of these measures should be assessed and re-evaluated.

All these standards should be applied with special attention to the various transition settings and should be appropriate to each transition setting. Measure developers will need to take this into account when developing measures based on these proposed standards.

The TOCCC also went through a consensus prioritization exercise to rank-order the consensus standards. All meeting participants were asked to rank their top 3 priorities of the 7 standards, giving a numeric score of 1 for their highest priority, a score of 2 for their second highest priority, and a score of 3 for their third highest priority. Summary scores were calculated, and the standards were rank-ordered from the lowest summary score to the highest. The TOCCC recognizes that full implementation of all of these standards may not be feasible and that these standards may be implemented on a stepped or incremental basis. This prioritization can assist in deciding which of these to implement. The results of the prioritization exercise are as follows:

1. All transitions must include a transition record
2. Transition responsibility
3. Coordinating clinicians
4. Patient and family involvement and ownership of the transition record
5. Communication infrastructure
6. Timeliness
7. Community standards

Future Challenges

In addition to the work on the principles and standards, the TOCCC uncovered six further challenges which are described below.

Electronic Health Record

There was disagreement in the group concerning the extent to which electronic health records would resolve the existing issues involved in poor transfers of care. However, the group did concur that: established transition standards should not be contingent upon the existence of an electronic health record and some universally, nationally-defined set of core transfer information should be the short-term target of efforts to establish electronic transfers of information

Use of a Transition Record

There should be a core data set (much smaller than a complete health record or discharge summary) that goes to the patient and the receiving provider, and this data set should include items in the core record described previously.

Medical Home

There was a lot of discussion about the benefits and challenges of establishing a medical home and inculcating the concept into delivery and payment structures. The group

was favorable to the concept; however, since the medical home is not yet a nationally defined standard, care transition standards should not be contingent upon the existence of a medical home. Wording of future standards should use a general term for the clinician coordinating care across sites in addition to the term medical home. Using both terms will acknowledge the movement toward the medical home without requiring adoption of medical home practices to refine and implement quality measures for care transitions.

Pay for Performance

The group strongly agreed that behaviors and clinical practices are influenced by payment structures. Therefore, they agreed that a new principle should be established to advocate for changes in reimbursement practices to reward safe, complete transfers of information and care. However, the development of standards and measures should move forward on the basis of the current reimbursement practices and without assumptions of future changes.

Underserved/Disadvantaged Populations

Care transition standards and measures should be the same for all economic groups with careful attention that lower socioeconomic groups are not forgotten or unintentionally disadvantaged, including the potential for “cherry-picking”. It should be noted that underserved populations may not always have a medical home because of their disadvantaged access to the health system and providers. Moreover, clinicians who care for underserved/disadvantaged populations should not be penalized by standards that assume continuous clinical care and ongoing relationships with patients who may access the health system only sporadically.

Need for Patient-Centered Approaches

The group agreed that across all principles and standards previously established by the SUTTP coalition, greater emphasis is needed on patient-centered approaches to care including, but not limited to, the inclusion of patient and families in care and transition planning, greater access to medical records, and the need for education at the time of discharge regarding self-care and core transfer information.

Next Steps for the TOCCC

The TOCCC focuses only on the transitions between the inpatient and outpatient settings and does not address the equally important transitions between many other different care settings, such as the transition from a hospital to a nursing home or rehabilitation facility. The intent of the TOCCC is to provide this document to national measure developers such as the Physician Consortium for Performance Improvement and others in order to guide measure development and ultimately lead to improvements in quality and safety in care transitions.

Appendix A: Conference Description

The TOCCC was held over 2 days on July 11 to 12, 2007 at ACP headquarters in Philadelphia, PA. There were 51 participants representing over 30 organizations. Participating organizations included medical specialty societies from internal medicine as well as family medicine and pediatrics, governmental agencies such as AHRQ and CMS, performance measure developers such as the National Committee for Quality Assurance and the American Medical Association Physician Consortium on Performance Improvement, nurse associations such as the Visiting Nurse Associations of America and Home Care and Hospice, pharmacist groups, and patient groups such as the Institute for Family-Centered Care. The morning of the first day was dedicated to presentations covering the AHRQ Stanford Evidence-Based Practice Center's evidence report on care coordination, the literature concerning transitions of care, the continuum of measurement from principles to standards to measures, and the SUTTP document of principles. The attendees then split into breakout groups that discussed the principles and standards developed by the SUTTP and refined and/or revised them. All discussions were summarized and agreed on by consensus and were presented by the breakout groups to the full conference attendees. The second day was dedicated to reviewing the work of the breakout groups and further refinement of the principles and standards through a group consensus process. Once this was completed, the attendees then prioritized the standards with a group consensus voting process. Each attendee was given 1 vote, and each attendee attached a rating of 1 for highest priority and 3 for lowest priority to the standards. The summary scores were then calculated, and the standards were then ranked from those summary scores.

The final activity of the conference was to discuss some of the overarching themes and environmental factors that could influence the acceptance, endorsement, and implementation of the standards developed. The TOCCC adjourned with the tasks of forwarding its conclusions to the SUTTP Alliance and developing a policy document to be reviewed by other stakeholders not well represented at the conference. Two such pivotal organizations were ACEP and SAEM, which were added to the steering committee after the conference. Subsequently, ACP, SGIM, SHM, AGS, ACEP, and SAEM approved the summary document, and they will forward it to the other participating organizations for possible endorsement and to national developers of measures and standards for use in performance measurement development.

Appendix B: Conflict of Interest Statements

This is a summary of conflict of interest statements for faculty, authors, members of the planning committees, and staff (ACP, SHM, and SGIM)

The following members of the steering (or planning) committee and staff of the TOCCC have declared a conflict of interest:

1. Dennis Beck, MD, FACEP (ACEP representative; President and Chief Executive Officer of Beacon Medical Services):

100 units of stock options/holdings in Beacon Hill Medical Services.

2. Tina Budnitz, MPH (SHM staff; Senior Advisor for Quality Initiatives, SHM): employment by SHM
3. Eric S. Holmboe, MD (ABIM representative; Senior Vice President of Quality Research and Academic Affairs, ABIM): employment by ABIM.
4. Vincenza Snow, MD, FACP (ACP staff; Director of Clinical Programs and Quality of Care, ACP): research grants from the Centers for Disease Control, Atlantic Philanthropies, Novo Nordisk, Bristol Myers Squibb, Boehringer Ingelheim, Pfizer, United Healthcare Foundation, and Sanofi Pasteur.
5. Laurence D. Wellikson, MD, FACP (SHM staff; Chief Executive Officer of SHM): employment by SHM.
6. Mark V. Williams, MD, FACP (cochair and SHM representative; Editor in Chief of the *Journal of Hospital Medicine* and former President of SHM): membership in SHM.

The following members of the steering (or planning) committee and staff of the TOCCC have declared no conflict of interest:

1. David Atkins, MD, MPH [AHRQ representative; Associate Director of Quality Enhancement Research Initiative, Department of Veteran Affairs, Office of Research and Development, Health Services Research & Development (124)].
2. Doriane C. Miller, MD (cochair and SGIM representative; Associate Division Chief of General Internal Medicine, Stroger Hospital of Cook County).
3. Jane Potter, MD (AGS representative; Professor and Chief of Geriatrics, University of Nebraska Medical Center).
4. Robert L. Wears, MD, FACEP (SAEM representative; Professor of the Department of Emergency Medicine, University of Florida).
5. Kevin B. Weiss, MD, MPH, MS, FACP (chair and ACP representative; Chief Executive Officer of the American Board of Medical Specialties).

Address for correspondence and reprint requests:

Vincenza Snow, MD, American College of Physicians, 190 North Independence Mall West, Philadelphia, PA 19106; Telephone: 215-351-2417; E-mail: vincenza@acponline.org Received 16 September 2008; revision received 29 January 2009; accepted 10 February 2009.

References

1. Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med.* 2003;138(3):161–167.
2. Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. *Ann Intern Med.* 2005;143(2):121–128.
3. Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med.* 2005;165(16):1842–1847.
4. Tsilimingras D, Bates DW. Addressing post-discharge adverse events: a neglected area. *Jt Comm J Qual Patient Saf.* 2008;34(2):85–97.
5. Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA.* 2007;297(8):831–841.
6. Nawar EW, Niska RW, Xu J. National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary. Hyattsville, MD: National Center for Health Statistics; 2007. *Advance Data from Vital and Health Statistics*; vol 386.
7. Cooper JB. Do short breaks increase or decrease anesthetic risk? *J Clin Anesth.* 1989;1(3):228–231.
8. Cooper JB, Long CD, Newbower RS, Philip JH. Critical incidents associated with intraoperative exchanges of anesthesia personnel. *Anesthesiology.* 1982;56(6):456–461.
9. Wears RL, Perry SJ, Shapiro M, et al. Shift changes among emergency physicians: best of times, worst of times. In: *Proceedings of the Human Factors and Ergonomics Society 47th Annual Meeting.* Denver, CO: Human Factors and Ergonomics Society; 2003:1420–1423.
10. Wears RL, Perry SJ, Eisenberg E, et al. Transitions in care: signovers in the emergency department. In: *Proceedings of the Human Factors and Ergonomics Society 48th Annual Meeting.* New Orleans, LA: Human Factors and Ergonomics Society; 2004:1625–1628.
11. Behara R, Wears RL, Perry SJ, et al. Conceptual framework for the safety of handovers. In: Henriksen K, ed. *Advances in Patient Safety.* Rockville, MD: Agency for Healthcare Research and Quality/Department of Defense; 2005:309–321.
12. Feldman JA. Medical errors and emergency medicine: will the difficult questions be asked, and answered? *Acad Emerg Med.* 2003;10(8):910–911.
13. Coleman EA, Berenson RA. Lost in transition: challenges and opportunities for improving the quality of transitional care. *Ann Intern Med.* 2004;141(7):533–536.
14. Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics.* 2004;113(5 suppl):1493–1498.
15. Blue Ribbon Panel of the Society of General Internal Medicine. Redesigning the practice model for general internal medicine. A proposal for coordinated care: a policy monograph of the Society of General Internal Medicine. *J Gen Intern Med.* 2007;22(3):400–409.
16. Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home. *Pediatrics.* 2002;110(1 pt 1):184–186.
17. American College of Physicians. The advanced medical home: a patient-centered, physician-guided model of healthcare. A policy monograph. 2006. http://www.acponline.org/advocacy/where_we_stand/policy/adv_med.pdf. Accessed March 13, 2009.
18. Coleman EA, Smith JD, Frank JC, et al. Development and testing of a measure designed to assess the quality of care transitions. *Int J Integr Care.* 2002;2:e02.
19. vom Eigen KA, Walker JD, Edgman-Levitan S, et al. Carepartner experiences with hospital care. *Med Care.* 1999;37(1):33–38.
20. Coleman EA, Mahoney E, Parry C. Assessing the quality of preparation for post hospital care from the patient's perspective: the care transitions measure. *Med Care.* 2005;43(3):246–255.
21. American Board of Internal Medicine Foundation. Stepping up to the Plate Alliance. Principles and Standards for managing transitions in care (in press). Available at http://www.abimfoundation.org/publications/pdf_issue_brief/F06-05-2007_6.pdf. Accessed March 13, 2009.