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EDITORIAL

Safety in Numbers: Physicians Joining Forces to Seal the Cracks During Transitions

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A lack of communication and accountability among healthcare professionals in general, and physicians in particular, jeopardizes quality and safety for our patients who are transitioning across sites of care.[1,2] Our patients, their family caregivers, and our health care professional colleagues on the receiving end of these transfers are often left "flying blind" without adequate information or direction to make sound clinical decisions.

Beyond our attempts to ensure effective transitions on a professional level, many of the readers of the *Journal of Hospital Medicine* likely have struggled to ensure seamless transitions for our families, despite the benefits of our training and experience.[3] If some of the nation's most respected healthcare leaders are unable to make this work for their loved ones,[4–8] one can only imagine the challenges faced by those without such advantages.

National and local quality collaboratives aimed at improving communication and collaboration across settings have found physicians difficult to engage as partners in these efforts.[9] All too often there is a false expectation that these types of activities are best left to nonphysician healthcare professionals on the sending side of the transfer or to those receiving the transfer.[10,11]

In this issue of the *Journal,* we commend the leadership provided by representatives of 6 of the nation's leading physician professional societies to join forces toward the common purpose of articulating physicians' roles and accountability for care delivered during transitions.[12] Ensuring effective care transitions is a team sport, yet rarely do we have a clear understanding of who are the other members of our team, how to interact with them, or a clear delineation of their respective roles. Simply stated, this article is a key step to facilitating teamwork across settings among physicians, our interdisciplinary healthcare professional colleagues, our patients, and their family caregivers. These standards clearly convey the type of care we expect for our loved ones.

Drawing from proven strategies used in nonhealthcare industries, the standards assert that the sending provider or institution retains responsibility for the patient's care until the receiving team confirms receipt of the transfer and assumes responsibility. Further, the receiving team is given the opportunity to ask questions and clarify the proposed care plan in recognition of the fact that communication is more than simply the transfer of information. Rather, such communication involves the need to ensure comprehension and provide an opportunity to have a 2-way dialog. These standards distinguish between the transmission of information and true communication.

The timing of the release of these standards is ideal. As physicians concentrate their practice within particular settings we can no longer rely on casual random interchanges in hospital parking lots or the hospital's physician lounge. Rather, we need to take a more active and reliable approach to ensuring timely and accurate exchanges. These standards cut to the essence of how we communicate with our physician and nonphysician colleagues alike, and in so doing move us away from nonproductive blame and finger-pointing.

Although the implications for these standards are far reaching in terms of raising the quality bar, they could reach even further with respect to the types of settings they address. These standards need to extend beyond hospitals and the outpatient arena to include nursing homes, rehabilitation facilities, home care agencies, adult day health centers, and other settings where chronic care services are delivered.

Further, the standards devote considerable focus to the transfer of health information. Even with advances in health information exchange technologies, we must recognize that information is necessary but not sufficient for ensuring safe and high-quality transfers. Implementing these standards will undoubtedly require that we reconfigure our daily workflows.[13] The article in this issue by Graumlich et al.[14] emphasizes the challenges of how to introduce technology into our daily clinical routines. The standards also open the door for how we can best ensure not just the transmission of information, but also the comprehension of transfer instructions to our patients with attention to health literacy, cognitive ability, and the patient's level of activation.[15] Best and Young[16] provide valuable action steps for how to address the needs of diverse and underserved populations.

These standards may serve to uncover the fact that most physicians have not received formal training in executing high-quality care transitions in the role of either the sender or the receiver. Further, few physicians have a mechanism in place to evaluate their performance. The American Board of Internal Medicine and the American Board of Family Practice has developed Maintenance of Certification Practice Improvement Modules (PIM) on care coordination that provide an excellent opportunity to sharpen our skills. The HMO Care Management Workgroup has also attempted to summarize the essential skills necessary to care for patients during transitions.[17]

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Perhaps the greatest value of these standards is that they lay the framework for actionable improvement. Local, state, and national quality collaboratives can immediately incorporate these recommendations into their overall strategy. These standards will likely influence the design and implementation of the Medical Home.[18] As national attention focuses on how to operationalize bundled payment approaches and Accountable Care Organizations,[19] these standards provide a clear consensus on communication, accountability, and ensuring patient-centeredness. The standards are an excellent start and provide a framework for further innovation.

One area in particular may be the opportunity to reinvent the format, content, and medium by which essential information is transferred. For example, one might envision the value of producing a scaled down version of the discharge summary with a limited core set of data elements that could be quickly completed and communicated to the next care team via fax, e-mail, or text messaging.

Complementing new strategies to improve the exchange of health information are opportunities to reconsider the culture within which this communication occurs. Our profession has a long-standing tradition of not providing directives to our colleagues on the details of clinical management. Hospitalists develop important insights during a patient's hospital stay and are in an ideal position to anticipate potential developments in the subsequent course after discharge. Contrast this with the 5 to 10 minutes that a primary care physician or specialist may have to come up to speed on the hospital and posthospital events in order to manage the patient in the ambulatory arena. Thus, rather than the traditional historical orientation to a discharge summary, one could envision a more future-orientated document characterized by a series of "if-then" statements that outline a series of possible clinical scenarios that may play out over the weeks after discharge along with recommendations for adjustments to the treatment plan.

At a broader level, the release of these standards demonstrate to our communities and to our nation that physicians can join forces to address a particularly complex and challenging aspect of healthcare. Change can indeed come from within our profession rather than being imposed by outside influences such as government administrators, regulatory bodies, or malpractice attorneys. I applaud such efforts and believe that hospitalists will continue to play a central role in national efforts to improve transitions of care.

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