

## TRANSITIONS OF CARE

The term “Transitions of Care” refers to specific interactions, communication, and planning required for patients to safely move from one service or setting to another. These transitions traditionally apply to transfers between the inpatient and outpatient setting. Transitions also occur between or within acute care facilities, and to or from subacute and non-acute facilities. Hospitalists provide leadership to promote efficient, safe transitions of care to ensure patient safety, reduce loss of information, and maintain the continuum of care.

### KNOWLEDGE

*Hospitalists should be able to:*

- Define relevant information that should be retrieved and communicated during each care transition to ensure patient safety and maintain the continuum of care.
- Analyze potential strengths and limitations of patient transition processes.
- Describe the value of available ancillary services that can facilitate patient transitions.
- Distinguish available levels of care for patients and select the most appropriate option.
- Analyze strengths and limitations of different communication modalities utilized in patient transitions.

### SKILLS

*Hospitalists should be able to:*

- Utilize the most efficient, effective, reliable and expeditious communication modalities for each care transition.
- Synthesize medical information received from referring physicians into care plan.
- Develop a care plan early during hospitalization that anticipates discharge or transfer needs.
- Organize and effectively communicate medical information in a succinct format for receiving clinicians.

### ATTITUDES

*Hospitalists should be able to:*

- Appreciate the impact of care transitions on patient outcomes and satisfaction.
- Strive to utilize the best available communication modality in each care transition.
- Appreciate the value of *real time* interactive dialogue between clinicians during care transitions.
- Strive to personally communicate with every receiving or referring physician during care transitions.
- Appreciate the preferences of receiving physicians for transfer of information.
- Recognize the importance of a multidisciplinary approach to care transitions, including specifically nursing, rehabilitation, nutrition, pharmaceutical and social services.
- Expeditiously inform the primary care provider about significant changes in patient clinical status.
- Inform receiving physician of pending tests and determine who is responsible for checking results.
- Incorporate quality indicators for specific disease states and/or patient variables into discharge plans.
- Communicate with patients and families to explain their condition, ongoing medical regimens and therapies, follow-up care and available support services.
- Communicate with patients and families to explain clinical symptomatology that may require medical attention prior to scheduled follow-up.
- Anticipate and address language and/or literacy barriers to patient education.
- Prepare patients and families early in the hospitalization for anticipated care transitions.
- Review the discharge plans with patients, families, and healthcare team.
- Take responsibility to coordinate multidisciplinary teams early in the hospitalization course to facilitate patient education, optimize patient function, and improve discharge planning.
- Engage stakeholders in hospital initiatives to continuously assess the quality of care transitions.
- Lead, coordinate or participate in initiatives to develop and implement new protocols to improve or optimize transitions of care.
- Lead, coordinate or participate in evaluation of new strategies or information systems designed to improve care transitions.
- Maintain availability to discharged patients for questions during/between discharge and follow-up visit with receiving physician.