TRANSITIONS OF CARE

INTRODUCTION

Transitions of care occur when a patient moves from one level of care to another or from one institution to another. One component of transitions of care is the patient handoff, which refers to the interaction between providers when responsibility for patient care is transferred from one provider to another. Ineffective transitions of care jeopardize patient safety and may result in adverse events, increased healthcare utilization, and patient or caregiver stress. Thus, every transition of care should involve a set of actions designed to ensure that the transfer is safe, efficient, and effective. Pediatric hospitalists are routinely involved in patient transfers and can lead institutional efforts to promote optimal patient handoffs and transitions of care.

KNOWLEDGE

Pediatric hospitalists should be able to:

- Compare and contrast patient handoffs with transitions of care.
- List the critical elements that should be communicated between providers at the time of a patient handoff, and describe how these elements may vary depending on characteristics of the patient or the provider.
- List the relevant information that should be communicated during each transition of care to ensure patient safety and promote the continuum of care.
- Explain the pros and cons of different modes of communication in the context of the various types of patient transfers.
- Differentiate between the available levels of care and determine the most appropriate option for each patient, taking the need for isolation and level of nursing care into account.
- Describe the impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on patient transfers.
- Articulate the National Patient Safety Goals that relate to transitions of care, including effectiveness of communication and medication reconciliation.

SKILLS

Pediatric hospitalists should be able to:

- Prepare concise clinical summaries in preparation for patient handoffs or transitions of care, incorporating key elements as appropriate.
- Utilize the most efficient and reliable mode of communication for each transition of care.
- Arrange safe and efficient transfers to, from, and within the inpatient setting.
- Promptly review the medical information received from referring providers and clarify any discrepancies when accepting a new patient.
- Anticipate needs at the time of discharge and begin discharge planning early in the hospitalization.
- Provide legible and clear discharge instructions that take into account the primary language and reading level of the patient and caregiver and include information about available resources after discharge should questions arise.
- Communicate effectively with the primary care provider and other providers as necessary at the time of admission, discharge, and when there is a significant change in clinical status.
- Accurately and completely reconcile medications during transitions of care.
- Develop systems to ensure the future comprehensive review of patient data that was pending at the time of discharge.

ATTITUDES

Pediatric hospitalists should be able to:

- Appreciate the impact of ineffective handoffs and transitions of care on patient safety and quality of care.
- Demonstrate respect for referring physicians and seek their input when developing protocols for communication during transitions of care.
- Appreciate the impact of the transfer on the patient and caregiver and ensure their goals and preferences are incorporated into the care plan at all stages of the transition of care.

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- Take responsibility for the coordination of a multidisciplinary approach to patient and caregiver education in preparation for the transition of care.
- Maintain availability to patients, caregivers, and providers after transitions of care should questions arise.

SYSTEMS ORGANIZATION AND IMPROVEMENT

Pediatric hospitalists should be able to:

- Lead, coordinate, or participate in the ongoing evaluation and improvement of the referral, admission, and discharge processes at their institution, taking into account input from stakeholders.
- Lead, coordinate, or participate in initiatives to develop and implement systems that promote timely and effective communication between providers during handoffs and transitions of care.

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