Handoffs in Hospital Medicine

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KEYWORDS

- Care transitions • Medication reconciliation • Discharge planning
- Hospital readmission

HOSPITAL MEDICINE CLINICS CHECKLIST

1. Care transitions encompass transitions from one facility to another, or from outpatient to the hospital and back home.
2. Risks of care transitions include adverse drug events, symptomatic worsening, hospital readmission, and missed follow-up.
3. Patients with depression, substance abuse, multiple prior hospitalizations, and/or complex medication regimens are at high risk for readmission.
4. Readmissions may be costly for your hospital if the Medicare readmission rate is too high.
5. Discharge planning should include patients and their family and caregivers and should start early in the hospitalization.
6. Communication of discharge instructions should be done using teach-back and other strategies to improve information retention.
7. Discharge summaries should be completed on the day of discharge and provided to the next care provider and the primary care provider.
8. Discharge summaries should include a summary of the hospitalization, updated medication list, outstanding tests, and key recommendations for follow-up.
9. Careful medication reconciliation is best accomplished with a dedicated program, and may reduce adverse medication events at discharge.
10. Multidisciplinary programs, such as Project RED, Project BOOST, and the Care Transitions Intervention, may help reduce preventable readmissions.

BACKGROUND

1. What are transitions in care?

Transitions in care have emerged as a key topic for hospitalists and other physicians.

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Transitions in care occur as patients move from one facility to another and from one provider to another. Most commonly, this term refers to discharge from the hospital to any less acute care setting or discharge from a rehabilitation center to home as a patient recovers from an acute illness or injury. In addition, care transitions occur at the beginning of this episode, from the outpatient arena to the hospital. At all of these times, primary responsibility for patient care moves between providers: from primary care doctors to hospitalists and inpatient teams, and then to a broad range of postdischarge providers, including nursing home doctors, visiting nurses, physical therapists, and primary care doctors.

2. What are risks of care transitions?

Transitions of care represent vulnerable times for patients. Patients have shorter lengths of stay and are discharged sicker and quicker than in the past,[1] and care is often fragmented among many providers and sites. Data remain sparse on this vulnerable time,[2] but it is known that approximately 1 in 5 patients suffers an adverse event following discharge,[3] including up to 12% of patients who develop new or worsening symptoms within 5 days of discharge.[4] Studies have identified several risks particular to this time of a patient's care.

These risks include the following frequent events:

- Symptomatic worsening or procedural related injury
- Adverse drug events
- Missed results from pending tests
- Lack of appropriate follow-up
- Hospital readmission

Symptomatic Worsening or Procedural-Related Injury

After hospitalization, patients are at high risk of clinical deterioration and symptom recurrence requiring rapid treatment to avoid poor medical outcomes and rehospitalization.[3,4] In particular, patients are at risk for direct complication or infection from a procedure or surgery undergone during hospitalization such as surgical-site complication, infection, or thromboembolic event. Up to 7% of patients undergoing general surgery procedures suffer these procedural complications after discharge from the hospital.[5]

Adverse Drug Events

Adverse drug events include adverse reactions, drug interactions, and side effects from new medications, which may range from mild to life threatening, and may require no treatment, outpatient care, or readmission. About one-fifth of elderly patients discharged from the hospital will suffer an adverse drug event in the month following discharge, with adverse events more common in patients discharged on several new medications.[6] Adverse drug events also include inaccurate medication reconciliation at care transitions, leading to incorrect or missing medications and incorrect dosages. Medication discrepancies are common, and occur in up to 50% to 70% of patients on hospital admission.[7,8] These discrepancies place patients at risk both during hospitalization and at discharge. Adverse events related to medication errors at discharge are more limited but also prevalent, affecting 11% to 59% of patients.[7,9]

Missed Results from Pending Tests

Patients are frequently discharged with pending test results, such as the final report from a radiologic study or final result from a blood or urine culture. One study showed

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