TRANSITIONS OF CARE POLICY

The Internal Medicine Residency Program fully endorses and adheres to the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements (Section VI.E.3. Transitions of Care, effective July 1, 2017) and the UC Irvine Graduate Medical Education institutional Transitions of Care Policy.

Transitions of care include the following situations:
1. Transfer of care from one health care provider to another on the same service.
2. Transfer of a patient from one unit to another.
3. Transfer of a patient from one service to another.
4. Transfer of a patient from an outpatient to an inpatient setting.
5. Transfer of a patient from an inpatient to an outpatient setting.
6. Transfer of a patient from one facility to another.

ACGME-accredited programs:
1. In partnership with UC Irvine Medical Center, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
2. Must design clinical assignments to optimize the effectiveness and safety of transitions in patient care, taking into account accurate transmission of information, frequency of transitions, and standardization of the process.
3. Must ensure that residents are competent in communicating critical and relevant information with team members in the hand-over process.
4. Must maintain and communicate schedules of attending physicians and residents currently responsible for care. This schedule should be easily available at the clinical site.
5. Must ensure continuity of patient care, consistent with the program's policies and procedures in the event that a resident may be unable to perform his/her patient care responsibilities due to excessive fatigue, illness, or family emergency. The procedure or schedule for this reason must be known to all housestaff and faculty in the program.

Institutional Transition of Care Process:
1. The combined use of the I-PASS verbal handoff tool, the electronic medical records handoff tab, and a face-to-face interactive discussion is the expectation for all transitions of care among all health care providers.
2. Sufficient time in a quiet location without interruptions should be ensured, allowing time for the receiver to summarize the information, ask questions and restate key action items.
3. The electronic medical records handoff tab must be updated regularly with each change in the patient's medical status.
4. Sign-outs must comply with all UCI Medical Center, HIPAA and Protected Health Information policies.

5. Interprofessional staff members (e.g., nurses) and the patient/family should be included whenever possible in the transition of care process to optimize transmission of accurate information and understanding of the patient's assessment and treatment plan.

6. Faculty should formally observe, assess and evaluate handoffs of trainees to ensure competency in safe transitions of care. The "Hand-Off CEX Tool" is recommended by the UC Irvine Office of Graduate Medical Education for this purpose.

A. Hand-Offs

   1. The hand-off process for changes in clinical rotations should begin the day prior to the first day of the new block. Residents need to communicate verbally about patients as well as the logistics of team function. If the resident coming on service does not hear from the resident coming off-service then the former must take responsibility to contact the latter.

   2. Documentation at the time of transitions must include key information including a succinct retelling of the patient's hospitalization, list of any pending lab and imaging results, disposition, and identification of any of the patient's significant others as well as the patient's Primary Care Provider.

   3. Residents are expected to be able to assume full care for their assigned patients from the first day of the rotation.

   4. Relevant team/admission pagers must be handed off person-to-person.

   5. At UCIMC, verbal sign-out to the UCIMC Team H resident must be given on any Internal Medicine consultations done overnight. It is preferred that this sign-out take place in person; however, in the event that the Team H resident is running late then it is acceptable to do this sign-out over the telephone.

   6. Handoffs from night float or bouncebacks must be verbal, preferably face-to face.

   7. In person handoffs should occur every morning and evening at daily sign-out between the night resident and accepting day team by both the cross cover resident and the admitting resident as relevant. All handoffs (verbal and written) should follow the I-PASS format. All written handoffs must utilize the site-specific electronic medical record for HIPAA compliance.

B. MICU Transfers

   1. The MICU senior should verbally sign-out to the Ward On-Call senior about the patients who are being transferred out each day. This interaction needs to be direct, preferably face-to-face.

2. The MICU senior cannot sign-out any patients to the Ward On-Call Senior that are "potential" transfers, i.e., those patients who could be transferred later in the day pending extubation or pending "improvement in clinical status." MICU seniors can only sign out patients who are ready for transfer.

C. Outside Patient Transfers (UCI)

1. UCI Transfer Center receives a call to transfer patient to UCI and calls the accepting Attending on-call at that time.

2. The accepting Attending documents in the HIPAA secure UCI residency Sharepoint site patients who have been accepted and relevant (succinct) medical information and reason for transfer

3. If the patient does not arrive to UCI by the end of the call shift, the accepting day time Resident needs to pass on the name of the pending admission and the history to the Night Float Resident and should include the name of her or his accepting Attending

4. If the Night Float Resident does not get the admission by the end of her or his shift, then she or he needs to pass the pending admission on to the new on-call day Resident and team.

5. If relevant, the admitting team needs to contact the UCI Transfer Center to follow-up on the status of the transfer and determine if the patient's status has changed.

6. The patient is counted as an admission to the team that is accepting admissions when the patient actually arrives to UCI.

These policies must be implemented without fear of negative consequences for the trainee who is unable to provide the clinical work.