

Mind the Gap: A Novel Care Transitions Curriculum for Hospitalists and Residents

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Setting and Problem

Care transitions—which occur when a patient moves from the intensive care unit to the medical floor, from the hospital to a skilled nursing facility or home, or from one team to another—represent high-risk periods for adverse events. These transitions are more complex in older patients. Notably, almost half of patients 85 years and older, and 30% of patients 75 to 84 years old, are discharged to a skilled nursing facility. Potential adverse events in this setting include medication errors, poor communication with the patient and receiving providers, and loss of follow-up of pending tests. Improving these transitions requires an interdisciplinary approach to education and information exchange among hospitalists, trainees, and postacute care teams.

Intervention

In academic year 2013–2014, we implemented a transitions-in-care curriculum for 96 internal medicine residents and 45 hospitalists at our academic medical center. The curriculum was based on a well-received pilot elective in 2011 that led to interest in expanding the curriculum throughout the program. The new curriculum was centered on Extension for Community Healthcare Outcomes–Care Transitions (ECHO-CT), a weekly videoconference that connected hospital-based residents and hospitalists of recently discharged patients with the providers at skilled nursing facilities who received those patients. The ECHO-CT model allows dissemination of specialist care in underresourced locations through telehealth and has been used in caring for patients with hepatitis C and dementia. ECHO-CT results in a multidisciplinary educational experience in which participants debrief the transition to the postacute care facility, review medications with a dedicated pharmacist, and discuss ongoing clinical issues. The model can be adopted at institutions where videoconferencing technology already exists.

We delivered the resident curriculum in 3 blocks throughout the year during preexisting ambulatory weeks, covering topics related to effective transitions, common adverse events, and readmissions. During the year, all residents participated in two 90-minute ECHO-CT clinic sessions in which they led the clinical discussions with

physicians, advance practice clinicians, nurses, and therapists at postacute care facilities. Other key activities included a 1-hour case-based discussion, root cause analyses of readmissions, live interviews with readmitted patients, independent reading of articles, and a 1-hour debrief on key learning points. The hospitalist curriculum consisted of a monthly lecture series covering geriatric and care transition topics, including financing postacute care, pharmacologic changes with aging, predicting prognosis, and caring for patients with advanced dementia.

Outcomes to Date

We evaluated the impact of the curriculum on resident and hospitalist knowledge, attitudes, and skills using a preintervention and postintervention survey with items adapted from previously published instruments. After completion of the course, residents submitted a narrative reflection describing 3 things they had learned, 3 things they would teach others, and 3 things they would change in their practices. We assessed learner skills by examining discharge summaries by residents (rather than interns) and by hospitalists on a nonteaching service.

There was no significant change in knowledge after the curriculum. For attitudes, there was a significant increase in self-reported behaviors for both groups. Residents were more likely to report direct communication with outside providers (2.8 increased to 3.4 on a 5-point scale, $P = .004$) and postacute care sites (2.1 to 2.6, $P = .02$); check for patient understanding during discharge counseling (3.6 to 4.0, $P = .05$); seek feedback regarding the discharge processes (2.0 to 2.8, $P < .001$); and feel comfortable with transitioning medically complex patients (3.0 to 3.6, $P = .02$). The quality of discharge summaries by hospitalists increased (33% of checklist items achieved versus 39%, $P = .02$); no significant change was seen in the residents' summaries (54% versus 53%, $P = .59$). Finally, themes in the narrative reflections included the importance of (1) medication reconciliation, (2) educating the patient and caregivers, (3) understanding differences between levels of postacute care, (4) communication with all parties involved in patient care, and (5) enhanced understanding of the causes of readmissions.

Formal education of providers is critical to safe and effective care transitions. Curricula using multimodal

teaching strategies may help in enhancing further communication and professional behaviors.

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