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NATIONAL CAPITAL CONSORTIUM TRANSITIONS OF CARE POLICY

ACGME Institution Requirement: III.B.3

REFERENCES:

(a) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
(b) ACGME Core Program Requirements, 1 July 2022
(c) Section 552a of Title 5, United States Code
(d) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
(e) DoD 6025.18-R, "Department of Defense Health Information Privacy Regulation," January 24, 2003.

1. PURPOSE. This Instruction, in accordance with the authorities in References (a) in accordance with References (c) through (e), stablishes the National Capital Consortium (NCC) policy to outline the roles and responsibilities of physicians, and trainees, and those supervising them on the execution of Transitions of Care (TOC) for patients at NCC member facilities. This institution is committed to providing the highest quality of care to its patients and recognizes that transitions represent vulnerable points in the care continuum.

2. APPLICABILITY. This instruction applies to all NCC member facilities.

3. DEFINITIONS. Transitions of Care can include any of the following patient transfers:
   a. From an admitting service to an inpatient ward;
   b. From an outpatient clinic to an inpatient ward;
   c. From one inpatient unit to another unit for ongoing care; or
   d. From one provider or nurse to another provider or nurse for a period of several hours, as occurs with any other cross cover scenarios.
   e. Transitions can occur from provider to provider, or between nurses and providers.
   f. Transitions can occur at the end of a rotation (both internal and external) between incoming and outgoing teams.

4. The NCC expects that programs will have a documented process by which rotational transitions are managed at each site. Communication about patient care, the clinical learning environment, and the supervisor roles, should be standardized among trainees rotating in each specific clinical learning environment.

- Rotational transitions should follow the same format for all residents transitioning service on general wards while the format of these transitions may differ for residents rotating in an ICU environment.
- Although the format of communication may differ for each separate type of clinical learning environment to address the individual rotation's communication needs, programs are expected to outline a standardized process to ensure continuity for each rotation.

5. POLICY: It is NCC policy that the TOC instruction ensures complete, effective transitions and handoffs as patients move through the care continuum utilizing the I-PASS system. I-PASS is a handoff program that decreases medical errors and preventable patient harm. The I-PASS mnemonic is defined as illness severity, patient information, action list, situational awareness and contingency plans, and synthesis by receiver. The NCC expects that each training program must have their own unique TOC Policy which takes into consideration any scenario in which trainees or teams of trainees transition (See 3 a-f).

6. RESPONSIBILITES:

   a. Programs Directors and Directors, Graduate Medical Education (GME) of NCC member facilities review implementation plan and execution, and monitors compliance for NCC house staff.
   b. Directors, Graduate Medical Education (GME) of NCC member facilities ensure compliance with TOC instruction by all GME programs.
   c. Deputy Directors, Education, Training, and Research (Clinical Learning Environment (CLE)) ensure dissemination and education on TOC instruction.
   d. Program Directors and Assistant Program Directors ensure dissemination and familiarity with TOC guidelines to house staff. Competency is evaluated and tracked on standard house staff evaluations.
      - Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.
      - Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
      - Programs must ensure that residents are competent in communicating with team members in the hand-over process.
      - Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.
      - Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in the ACGME Common Program Requirements in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue, illness, or family emergency.

7. PROCEDURES. Handoffs and transitions for all patients must include the following:
   - **I**-- Illness severity, demographics, and code status.
   - **P**--Patient summary (key items on problem list, key medications, allergies, pending studies, consultants as pertinent to period of care, staff physician of record)
   - **A**--Action List (to do list, time line and ownership of action items)
   - **S**--Situational awareness and contingency plam1ing (Identify most worrisome patients, the anticipated changes, problem solve before things will go wrong)
   - **S**--Synthesis by the receiver (clinically appropriate verbal summary by receiving nurse or physician)

   The format will be set by the medical specialty or inpatient unit/outpatient clinic and dictated by the patients' clinical status. Standardized forms are encouraged. These forms may be developed to fit the specialty or unit. Any protected health information (PHI) and/or personally identifiable information (PII) contained on the forms must be handled and properly disposed of in accordance with references (c) through (e). Particular attention will be given to pain management. In addition to a brief written TOC plan, transitions will include a two-way discussion to ensure synthesis by the receiver.

Per ACGME Institutional Requirements, effective 1 July 2022.

Approved at the 3 May 2023 GMEC meeting.