Piedmont
ATHENS REGIONAL

GRADUATE MEDICAL EDUCATION

Internal Medicine Residency Program

Transitions of Care (ToC)

Goals and Objectives

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7/1/2018

Transitions of Care (TOC) Curriculum

Overview

Hospital readmissions cost the US health care system over $17 billion annually. Additionally, 49% of patients experience at least one medical error during the transition from inpatient to outpatient medical care. With such a large burden being placed on hospitals and the health care system, physicians must be educated on the proper manner to transition patients after discharge from a hospital admission.

Piedmont Athens Regional Internal Medicine residency program has developed a curriculum to educate and provide hands-on practice for proper transitions of care. This curriculum adds a great benefit not only to the residents, but also to the institution at large.

Systems Based Practice and Practice Based Learning and Improvement are both difficult milestones to teach and assess. By utilizing a formal, and extensive longitudinal curriculum, the program educates residents on transitions of care.

I. Educational Plan

- Provide an educational experience in transitions of care clinic emphasizing the importance of transitioning patients across the health care system.
- Foster continuity of care by providing comprehensive, coordinated care.
- Develop an appreciation for the importance of the physician-patient relationship, patient advocacy, case management and continuity.
- Develop an understanding of the economic issues related to medical care and practice in a cost-effective and efficient manner.
- Understand the social and psychiatric implications of illness.
- Obtain knowledge of disease prevention and screening measures for individual patients and populations.

II. Educational Goals and Objectives

A. Transitions of Care Clinic

- Deliver high quality, evidence based care for patients post-discharge, addressing both acute and chronic diseases.
- Discuss patients' prior hospital course, discharge, and diagnoses
- Evaluate acute health concerns in an ambulatory setting.
- Coordinate care with other health professionals, including specialists, inpatient care teams, nurses, and non-physicians such as physical therapists and dieticians.
- Work effectively within a team of health care professionals, including triage nurses, clinic nurses, medical assistants, pharmacy technicians, pharmacists, and administrative staff.
- Use an electronic medical record to deliver high quality care for a panel of patients.
- Evaluate patients' medical concerns over the telephone, triage such problems for timely and situation-appropriate evaluation, and document telephone encounters appropriately.

- Learn how to bill for transitions of care visits, and what is required to bill the full amount.

B. Large Group Learning

- Learn from different health care professionals about the importance, barriers, and procedures for successfully transitioning patients across the healthcare system.

C. Small Group Learning/Practicing

- Discuss socio-economic barriers that can prevent patients from receiving medical care
- Discuss specific needs to optimize the experience
- Develop standardized policies and procedures for completing transitions of care visits

III. Transitions of Care Clinic

- TOC (Transition of Care) patient's MUST be seen within 7-14 days of discharge date from the hospital and require 45-60min slots (Based on the post discharge phone call)
- TOC patients are seen by any resident after 6 months of internship, to ensure that they are familiar with the electronic medical record system
- The resident becomes the PCP after seeing the TOC patient.
- Residents are paired with a faculty member who completed the TOC training sessions (Noon conference and billing education)
- The visit includes meeting with the pharmacist, and social worker
- Medication reconciliation and social barriers are essential parts of TOC clinic

IV. Expectations and Duties of Residents & Faculty

A. Resident Responsibilities

- Review the goals and objectives of the rotation before starting
- TOC is built within ambulatory curriculum so revise TOC rules sent by RN.
- Check the TOC list daily
- The on-call resident and intern for the clinic will serve as TOC lead
- TOC lead resident and intern will have one hour at the end of the clinic day blocked to help with post discharge phone calls if RN is unavailable or the patient is complicated based on RN discretion
- Document the post discharge phone call as per template
- Perform TOC visit as per template
- Ensure that an attending signs off at least three direct observation tools for TOC assessment
- Provide feedback regarding the TOC process.

B. Faculty Responsibilities

- Attend TOC noon conferences, billing sessions and ensure that the faculty is aware of the most updated flow chart for TOC process which will be posted in the preceptor rooms
- Complete at least 3 DIRECT observations of TOC visits
- Ensure that TOC parts for billing are met including proper documentation of post discharge phone call within 48 hours of discharge (Excluding holidays and weekends)
- Simulated chart recall to verify TOC template use with residents
- TOC OSCE station to be changed each time to reflect areas for improvement every 6 months
- Determine progressive responsibility based on resident performance and the milestones.

V. Milestones/Competencies

Transitions of Care Clinic Specific Competency Objectives: All will be demonstrated during time spent in clinic through patient encounters, oral presentations, discussions with faculty, and through electronic health record documentation.

Systems Based Practice

1. Utilizes available resources to coordinate care and ensure safe and effective patient care within and across delivery systems.
2. Work with faculty & staff to assess, coordinate, and improve multispecialty patient care across inpatient and outpatient settings to prevent readmissions
3. Identify additional resources for caring for ambulatory patients, such as home health care agencies, support groups, outpatient treatment centers, and medication assistance programs.
4. Guide patients through the complex health care environment.
5. Regularly and effectively work with managed care/utilization review personnel, office managers, and other providers within the larger health care system.
6. Demonstrates dedication to high quality patient care.
7. Works to address patient specific barriers to care with our social worker and in-house pharmacist.

Practice Based Learning and Improvement.

1. Use self-assessments of knowledge, skills and attitudes to develop plans for addressing areas needing improvement in ambulatory care.
2. Seek guidance from supervising faculty or from the scientific literature when unclear on best course of action.
3. Use interactions with nursing staff and other professionals as two-way educational opportunities.

Patient Care

1. Perform a TOC focused management plan in accordance with national guidelines

Medical Knowledge

1. Develop well-formulated differential diagnoses for patients having multiple problems, whether evaluated in the office and over the telephone.
2. Demonstrate understanding and responsiveness to social-behavioral issues.
3. Demonstrate knowledge of statistical principles when reviewing the scientific literature.
4. Present current scientific evidence to support hypotheses.

Interpersonal and Communication Skills

1. Engage patients in shared decision making for ambiguous or controversial scenarios.
2. Successfully negotiate most “difficult” patient encounters, such as the angry patient.
3. Ensure successful inpatient-outpatient provider communications to maintain appropriate continuity of patient care including the availability of a discharge summary before the TOC visit.
4. Utilize electronic databases for patient educational materials.
5. Communicates to the patient when to seek additional medical care.

Professionalism

1. Demonstrates empathy, compassion and respect to patients and caregivers in all situations.
2. Anticipates, advocates, and proactively works to meet the needs of patients and caregivers
3. Incorporates patient-specific preferences into plan of care including home visits