Patient Transitions & Handoffs
Improve transitions and handoffs in care with standard processes and communication techniques.

Domain
- Processes to Support Care:
  Processes that are essential to support and maintain the delivery of care to all types of patients, across all units and settings in the hospital

Aims
- Timely:
  Care delivery that is prompt and provided without delay to mitigate any harm to a patient
- Patient Centered:
  Care throughout a patient's experience that is coordinated, informed, and grounded in respectful interactions with care providers that are consistent with the patient's values, expectations, and care decisions
- Safe:
  Delivery of care in a manner that minimizes any risk of harm to a patient

Process Attributes

Cost to Implement
- The monetary resources required to implement this process
- Minimal: Just the cost of the improvement effort itself

Time to Implement
- The amount of time, from months to years, it will take on average to establish this process
- 1 to 2 years

Difficulty to Implement
- The challenges of implementing this process
- Most Challenging: Involves multiple units or disciplines AND requires a substantial shift in culture and/or operations

Level of Evidence
- The degree to which the actions in this process are supported by research and experience; based on the Cochrane scale
- Some Evidence: Level III — Studies published with some control included
Details

Elements

- Communicate interactively in briefings, huddles, and debriefings — both sender and receiver use active communication skills
- Communicate the most up-to-date information
- Enact structured handoffs, including use of tools like SBAR — “I pass the baton.”
- Perform standardized change-of-shift reports at the bedside (Nurse Knowledge Exchange)
- Limit interruptions in handoff communication
- Require a verification process (like repeat back or read back) for critical elements of communication
- Establish huddles for transitions or around specific issues, such as safety, that are important in many transitions

Outcomes

- **Harm:** Decreased harm to patient (e.g., Harms per 100 patient days, as measured by the IHI Global Trigger Tool)
- **Patient Satisfaction:** Increased patient satisfaction (e.g., HCAHPS Willingness to Recommend, HCAHPS Hospital Rating)
- **Reliability:** Increased delivery of evidence-based care 100% of the time

Service Lines and Critical Functions

- Applies in All Patient Settings
- Transitions and Continuity

Key Measures

- Percent of handoff communication that includes all essential elements, patient conditions, care, treatment medications, services, and anticipated changes (NPSG 2.05.01 measure)
- Percent of Handoffs That Use a Process for Verification (NPSG 2.05.01 measure) - Repeat-back or read-back techniques
- Score on the Care Transitions Measure (CTM)

Reasons and Implications

**Importance for Patients and Families**

Patients and families expect that handoffs between caregivers are reliable. They expect that the appropriate information will be transferred so that care is seamless and uninterrupted.
Requirement, Standards, Policies, and Guidelines

- **Agency for Healthcare Research and Quality (AHRQ)**

- **National Priorities Partnership (NPP)**
  - Patient and Family Engagement
  - Care Coordination
  - Palliative and End-of-Life Care

- **National Quality Forum (NQF)**
  - Safe Practice for Better Healthcare—2009 Update
    - Safe Practice 3: Teamwork Training and Skill Building
    - Safe Practice 15: Discharge Systems
    - Safe Practice 17: Medication Reconciliation

- **The Joint Commission (TJC)**
  - 2012 National Patient Safety Goals

Financial Implications

- Expense reduction can occur due to reduction in the cost of care for injuries and due to decrease in the rework that often accompanies failed communication.

Prerequisites

None for this process

Resources

Additional Resources

- [IHI/Commonwealth Foundation How-to Guide: Creating an Ideal Transition Home](#)

- **Care Transitions Quality Improvement Organization Support Center (QIOSC)**
  - The Care Transitions Quality Improvement Organization Support Center (QIOSC) assists Medicare Quality Improvement Organizations (QIOs) to promote seamless transitions from the hospital to home, skilled nursing care, or home health care.

- **Agency for Healthcare Research and Quality (AHRQ)**
  - Reducing Discrepancies in Medication Histories and Orders at Handoffs Toolkit

- **The Care Transitions Program**
  - Tools for Health Professionals Resource Page

- **US Department of Health and Human Services**
  - Partnership for Patients

- **The Joint Commission (TJC)**
  - Communication During Patient Hand-Overs

- **The Care Transitions Program**
  - Medication Discrepancy Tool

- **National Transitions of Care Coalition (NTOCC)**
  - The National Transitions of Care Coalition (NTOCC) is a group of concerned organizations and individuals who have joined together to address problems associated with transitions of care of patients from one practice setting to another. NTOCC was founded in 2006 by the Case Management Society of America (CMSA) and sanofi-aventis, U.S. to define solutions addressing those gaps that impact safety and quality of care for transitioning patients, particularly seniors. The NTOCC website provides links to participating organizations.

- **Agency for Healthcare Research and Quality (AHRQ)**
  - Clinician communication through multidisciplinary rounds may improve with well-designed information tools

- **Agency for Healthcare Research and Quality (AHRQ)**
  - Taking Care of Myself: A Guide for When I Leave the Hospital

- **The Commonwealth Fund**
  - Article: Preventing Readmissions with Improved Hospital Discharge Planning

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http://app.ihi.org/imap/tool/#/process=21e273fb-81fc-4dd2-bf8b-883c10afcdb
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