West Virginia University Graduate Medical Education (GME)

Transitions of Care Policy

I. Purpose

The purpose of this policy is to ensure safe, effective, and standardized transitions of care (ToC) for patients receiving care involving residents and fellows sponsored by West Virginia University (WVU). This policy is designed to minimize risks to patient safety, ensure continuity of care, and comply with Accreditation Council for Graduate Medical Education (ACGME) Sponsoring Institution and program requirements. (1.1.c.)

II. Scope

This policy applies to (3.2.c.):

- All residency and fellowship programs sponsored by WVU SOM.
- Faculty physicians, supervising providers, and clinical staff involved in patient handoffs of resident patients.
- All clinical care settings where WVU SOM-sponsored trainees provide patient care.

III. Definitions

Transition of Care (ToC): The transfer of responsibility and accountability for patient care from one provider or team to another, including changes in shift, service, level of care, or care setting.

Handoff: A specific type of transition of care involving the communication of patient information, responsibility, and authority between healthcare providers.

Standardized Handoff Tool: A structured communication framework (e.g., I-PASS or equivalent) approved by the training program or clinical site.

Direct Supervision: The supervising physician is physically present with the trainee and patient.

Indirect Supervision: The supervising physician is not physically present but is immediately available.

IV. Policy Statement

WVU GME is committed to ensuring that all transitions of care involving residents and fellows are conducted in a standardized, reliable, and patient-centered manner. All programs must implement structured handoff processes that promote clear communication, continuity of care, and patient safety, and that support trainee education and supervision.

V. Policy Requirements

A. Standardized Handoff Processes (3.2.c.1.)

1. Each residency and fellowship program must adopt and utilize a standardized handoff tool appropriate to its clinical environment.
2. Handoffs must include, at a minimum:
    - Patient identification
    - Current clinical condition and diagnosis
    - Active problems and anticipated changes
    - Pending tests, procedures, and consults
    - Medication and treatment plans
    - Contingency plans and clinical priorities
    - Code status and relevant advance directives
3. Handoffs should occur in a setting that minimizes interruptions and allows for questions and clarification.
4. Handoffs must be verbal and written for patients in the acute care setting.

B. Timing and Circumstances of Transitions

Transitions of care must occur during, but are not limited to:

- Change of shift or duty period
- Transfer between services or providers
- Transfer between levels of care (e.g., ICU to floor)
- Admission, discharge, or inter-facility transfer

C. Supervision and Accountability

1. The sending provider remains responsible for patient care until the receiving provider has accepted responsibility.
2. Supervising faculty must be available during transitions of care and provide oversight consistent with program supervision policies.
3. Escalation pathways must be clearly defined for concerns identified during handoffs.

D. Education and Training (3.2.c.)

1. All residents and fellows must receive formal education on effective transitions of care, including communication skills and use of the program's standardized handoff tool.
2. Training must be provided at orientation and reinforced throughout the academic year.
3. Programs must assess trainee competence in transitions of care as part of ongoing evaluation.

E. Documentation

1. Transitions of care must be documented in the electronic health record (EHR)
2. Written or electronic handoff tools must be updated in real time and reflect the most current patient information.

F. Patient and Family Engagement

When appropriate, patients and families should be informed of transitions in care, including changes in responsible providers, to promote transparency and continuity.

VI. Monitoring, Reporting, and Quality Improvement (3.2.a.)

1. Programs must monitor the effectiveness of transitions of care through:
    - Patient safety reports
    - Morbidity and mortality conferences
2. Errors, near misses, or adverse events related to transitions of care must be reported through the institution's patient safety reporting system.
3. Programs must implement quality improvement initiatives to address identified gaps or risks related to transitions of care.

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