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The Emergency Care Handoff

Transitioning Patients from the Emergency Department to Primary Care

By Jeanine Limone Draut

A woman arrives at the hospital emergency department with her 5-year-old daughter, who is struggling to breathe. The girl is treated for an acute asthma attack. Her mother is given some instructions about caring for her daughter after they leave the hospital. She's also advised to contact her child's doctor for follow-up care. The mother says this has never happened before, and her daughter's asthma medications have always worked. She decides to contact the pediatrician only if it happens again.

This story could end in a number of ways depending on luck and a host of factors, but one thing is clear: The girl's care would be better and her case would involve less risk if her primary care physician were aware of the acute episode. This latest development in the girl's condition could pose a risk that her physician could mitigate with a seamless care handoff.

Care Transitions: A Vulnerable and Error-Prone Time

The care handoff—the transition from one care team member to another—is a vulnerable time. This is especially true when the care team is spread across different settings. There is often a communication breakdown across these settings, leading to errors with devastating consequences. In its 2017 report, *Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era,* the Institute for Healthcare Improvement states: "Of malpractice claims related to missed or delayed diagnosis in the ambulatory setting, almost half involve failure to follow up."[1]

Follow-up failures happen when test results and recommendations for further tests and treatment are not communicated between emergency and primary care physicians (or, often, to the patients themselves). Communication breakdowns lead to medication reconciliation problems and gaps in treatment. A comprehensive treatment plan is difficult to create and track if the patient's primary care doctor is unaware of treatment received in the emergency department. Patients often provide limited information about their emergency visits and do not always provide essential clinical details.

Transitions from the Emergency Department

Much of the research on care transitions has focused on the transition from the inpatient hospital setting to home. According to the research, the weeks following hospital discharge are some of the most tenuous and potentially dangerous for patients. During this transition, the patient must go from a setting in which they have limited control and responsibility for their own care to a setting in which they are solely responsible for it and often managing their care alone.

The emergency department has its own unique challenges for ensuring an optimal transition of care. Patients usually come to the emergency department with little information about their health, and emergency physicians are often treating acute episodes of chronic conditions without knowing what kind of treatment the patient has already received. To complicate the issue further, following an ER visit, the primary care doctor may not receive timely information about the ER visit—or any information at all.

Where's the Communication Breakdown?

A common response to the problem is to suggest that physicians build their personal communication skills. This is an important strategy. But it can't be the only one.

Clinicians can have the most sophisticated communication skills,

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but without the right technology or organizational processes in place, information sharing is a struggle. Organizational systems, technology and communication skills all play a part in improving care handoffs from the emergency department to the primary care physician.

Communication Skills for Smooth Care Handoffs

Given the organizational and technical challenges of good care handoffs, it's not reasonable to place the burden solely on individual physicians to improve their communication skills. "Communication training" is a simple and convenient go-to solution to a large, structural problem.

Even so, physician communication skills still matter. Clear, concise and comprehensive communication creates an environment where physicians work better with the care team within the emergency department and share relevant information with the patient's primary care physician.

Good communication isn't just about speaking or writing clearly. It's also about choosing the most relevant and pressing information from all the bits of information accumulated and assessed while the patient was in the emergency room. It's about helping the listener or receiver—in this case, the primary care physician—sort through what happened in order to take the next step in the patient's care. For emergency physicians, this means honing the skill of "perspective-taking"—the ability to step outside the world of emergency care and imagine the pressing information needs from the primary care perspective.

TeamSTEPPS®, developed by the Agency for Healthcare Research and Quality (AHRQ) and the U.S. Department of Defense, is an evidence-based system to improve communication and teamwork among healthcare providers.[2] It offers a structured tool for care handoffs between care team members that, although designed primarily for handoffs between teams located in the same physical space, can be used to support care handoffs between emergency and primary care physicians. The tool is called **I PASS the BATON**. (See insert.)

Emergency and primary care physicians alike will benefit from building communication skills for good care handoffs. However, it bears repeating that the tool intended to be the main communication vehicle—the EHR—is not set up to transmit this type of information in this order. If physicians are to put these communication skills into practice, it will require changes to the "sociotechnical" environment—meaning, the EHR and the way it is used for care handoffs.

Primary Care: Preparing for Transitions

The nature of an emergency makes preparation impossible, but for many patients with complex chronic conditions, emergency visits are a part of life. Primary care doctors who prepare for these emergency visits and the transition back to primary care will reduce the risk that needed follow-up care is not delivered.

The American Medical Association has worked with its partners to develop the SafeMed model for care transition, a set of guidelines for working actively with patients likely to need emergency care. This model, originally developed at the University of Tennessee/Methodist Le Bonheur Healthcare and funded by a Health Care Innovation Award from the Centers for Medicare and Medicaid Services, establishes a network of support that is already in place to transition high-risk patients from the hospital back to outpatient care.

The model recommends four steps:

Step 1:

Develop your care transitions plan. Decide how you want to meet the needs of patients transitioning from hospital or emergency care to the community. What will your process be?

Step 2:

Identify complex patients who are candidates for the program. Decide how you will identify who is likely to need transition support, and how you will indicate this in your EHR or other records.

Step 3:

Assemble and train your SafeMed team. According to the SafeMed model, a SafeMed team often includes three team leaders: a physician, nurse and pharmacist, plus two community health workers, one pharmacy technician, and one licensed practical nurse, medical assistant or health coach. This may be a lot for small practices, so it may make sense to partner with another practice in this effort.

Step 4:

Start the transition process and refine the plan over time. Make sure you have an ongoing process for identifying patients with complex conditions. Consider running a daily report to see if any of these patients received emergency care.

Patient and Family Communication Also Matter

It is ideal to have systems in place that give both emergency and primary care physicians all the information they need for a good transition, but sometimes it's simply not possible to make the connection on a system level. It's a good idea for emergency physicians to hone their patient communication skills so that patients and families understand what they need to do for follow-up care, and what they need to tell their primary care doctor.

Time spent developing communication skills is never wasted. Good communication increases patient satisfaction, improves outcomes and reduces the risk of medical malpractice suits. Karen Smith, MSN, offers the following guidelines for patient communication in the emergency department to improve care and reduce risk of poor outcomes[3]:

- **Acknowledge:** Acknowledge the patient as an individual and listen carefully to their concerns with empathy. Ask the patient, "What's the most important thing I can do for you today?"
- **Introduce:** Introduce yourself to patients and family members and explain your role. Give the patient a sense of your expertise and experience to build trust and reassure them that they are in good hands.
- **Duration:** Do your best to set expectations for how long the patient will be in the emergency department. This also builds trust.
- **Explanation:** At every point in the visit, explain what you are doing and why. It helps to build trust and prevents the overwhelming experience of having to share all the information at the end of the visit.
- **Thank you:** Thank patients for their patience through delays, for engaging in their plan of care and for following your instructions.

A resource that offers in-depth training in this area is the Institute for Healthcare Communication's Strangers in Crisis: Communication for Emergency Department and Hospital-Based Clinicians. This online training is designed to help emergency physicians quickly establish the relationships and trust needed for good communication in the emergency department. See healthcarecomm.org for more information.

Organizational Systems and Workflow

Physicians can have the best interpersonal communication skills, but still need good organizational systems and communication tools for a successful care transition. Communication conventions, such as standardized discharge summaries, can help save time by giving emergency department staff a standard way to communicate the details of the visit without having to reinvent the format or method used to share information. Templates can also prompt physicians to include all relevant information and reduce confusion.

For example, Watkins and Patrician[4] found that after introducing a standard electronic Emergency Provider Written Plan of Discharge (eEPWPD) template, follow-up care improved for patients presenting in the emergency department with chest pain. With a standard template, the emergency physician doesn't have to think about how to share the information, and the primary care physician will likely find it easier to locate the relevant information shared.

Templates and standard processes can help bridge the communication divide between emergency and primary care settings, but more can be done to align communication processes. Emergency physicians communicate quickly and efficiently—as close as possible to the time of discharge. Primary care clinicians must organize their time a bit differently, setting aside time before, between and after appointments to do paperwork and follow-up with patients. This may be why Rider, et al[5] found that emergency department clinicians prefer to connect with their primary care counterparts by telephone, while primary care clinicians prefer "asynchronous" communication—messages sent through the EHR instead of a telephone conversation.

The challenge is to create tools that align with the workflow demands of both settings. One possible solution is a HIPAA-compliant mobile app, for example, that allows emergency clinicians to send messages to the primary care physician, while also giving the primary care clinician the option to respond immediately or delay responding if it's safe to do so.

Working with the EHR

The electronic health record, or EHR, can improve patient care by making medical history and medication information readily available. It can also help clinicians, including emergency physicians, with clinical decision support. But the EHR is typically designed to capture data–not necessarily to improve handoff communication between providers.[6] Recording something in the EHR is often viewed as a task separate from care transition communication. The EHR interface is not always intuitive and doesn't ask for information in the way that clinicians would give it if they were writing a note or having a phone conversation. It can be difficult to create a cohesive picture of what is happening with a patient from the EHR.

In "Death by 1,000 Clicks,"[7] a joint reporting effort by Kaiser Health News and Fortune Magazine, Fred Schute and Ericka Fry note: "Many doctors

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An emergency room doctor can be saddled with making up to 4,000 mouse clicks per shift." As one emergency room physician pointed out, "the odds of doing anything 4,000 times without an error is small."

Indeed, the report found that some EHRs make it too easy for users to choose the wrong medication or diagnosis from a long pre-populated drop-down menu of choices that may or may not be relevant for the particular patient. In some cases, software glitches prevented the EHR from updating a patient's medication list, attaching care notes to the right records, or communicating essential follow-up activities like test orders and referrals.

As a result, emergency physicians sometimes use "manual workarounds" to get vital patient information communicated. They use handwritten notes, whiteboards and, yes, telephone calls to primary care doctors. As challenging as EHRs may be, they have the potential to provide information about a patient that physicians only dreamed of having a decade or two ago. By continuing to share how they use EHRs and what they need from them, both emergency and primary care physicians can improve the usability of these systems, making them even more useful for communication and care handoffs.

Good care handoffs require both skills and infrastructure that put the patient at the center. Infrastructure, such as EHRs and organizational workflow systems, can be slow to change; advocates of whole-person care will need to be persistent in making the case for change to organizational leadership. In the meantime, emergency and primary care physicians can best serve patients by working to meet each other's communication needs—and doing what they can to meet each other halfway.

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