Chapter 13
Clinic Handoffs and Sign-Outs

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Introduction

Year-end resident clinic handoffs or transfers occur when patients transfer resident primary care providers (PCP) at the time of resident graduation. An estimate of more than one million transfers is done annually [1]. Similar to inpatient handoffs, ambulatory clinic handoffs are critical transitions of care. Proper and diligent clinic handoffs are important to prevent disruption and delay of patient care, to ensure timely follow-up for chronically ill patients, and to improve patient satisfaction during the transition. According to Young et al., the year-end transfers have distinct elements which could lead to increased risk to patients [2]. First, during the transfer, patients may have worsening symptoms both emotionally and physically from the loss of a long-term relationship with their previous physician [3]. Second, different from the end of shift handoffs, the accepting physicians may be interns who have less clinical experience and administrative skills. Third, the year-end handoffs involve a large number of patients which can pose administrative and clinical challenges. Regardless, residency programs and individual resident continuity clinics must establish a standardized protocol for clinic handoffs to provide smooth transition with a goal of optimizing patient safety.

Recognizing the importance of transitions of care, the Accreditation Council for Graduate Medical Education (ACGME) mandates that internal medicine residency programs ensure and monitor the handoff processes. Transitions in care are a focus for the Clinical Learning Environment Review (CLER) [4].

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Learning Objectives

1. Discuss the different models of the end of year clinic handoffs.
2. Identify ways to handle the challenges of clinic handoffs.

Outline

- Basic Strategies
- Different Models of Clinic Handoff
- Clinic Handoff Protocol
- Challenges

Basic Strategies

Many programs already use basic strategies to prevent new residents from becoming overwhelmed when assuming a large panel of new patients. Most commonly, interns are given fewer patients during each clinic session as well as longer appointment times. A variety of models of clinic handoff have been used by different residency programs and resident clinic medical directors. To our knowledge, literature is lacking comparing the different models. However, preparing residents and staff for the handoff process and effective doctor-patient communication skills are essential components for all models. The ultimate goal is to provide a smooth transition of care without causing delay to patient care, loss of patient follow-up, and patient dissatisfaction.

Different Models of Resident Clinic Year-End Handoffs

Model A: Handoff to Interns

One model is to transfer graduating resident patients to interns. The advantage of this approach is that interns begin their clinic experience with a pre-existing panel, thereby giving them a fulfilling and busy schedule right from the beginning of their residency. In addition, this model gives patients a 3-year period to stay with the same physician. However, there are disadvantages to this model. For residency programs with electronic medical record (EMR) system, follow-up appointments cannot be made until a few weeks before interns start and are officially activated in the EMR system. In this instance, patients who are seen by the graduating residents in April or first part of May cannot be given a follow-up appointment until interns start. Keeping track of these patients to ensure timely follow-up

appointments are made can be challenging. This may lead to loss of patient follow-up and delay of care. For continuity clinics with EMRs, graduating residents may have to designate a house staff who will receive their in-basket to make sure clinic laboratory and imaging results and all messages are timely followed up and reviewed during the transition period. In the beginning of the residency training, most interns are new to the EMR system and do not know how to handle clinic lab results due to limited clinic exposure. This may also affect how clinic lab results are handled and how patients are notified. An alternative approach would be to designate a clinic preceptor to receive EMR notification of lab results for each graduating resident. This approach is much safer and prevents undue burdening of the inexperienced house staff. However, in large residency programs with a large number of residents, it may be challenging for clinic preceptors to have to be responsible for so many EMR in-basket results. With this model, new interns may be overwhelmed by having to absorb a large patient panel from the graduating residents. Also, their initial small clinic template may not be able to accommodate the high demand from a large panel. Lastly, depending on the clinic schedule especially for residency programs with a X + Y model, some interns may not start seeing patients in their continuity clinic until mid-August which may delay patient follow-up for those who are chronically ill and require frequent visits. Thus, the success of this model is dependent on early entry of intern names into the EMR system so that appointments can be scheduled in a timely manner, a detailed intern orientation/protocol on how to handle patients' lab results especially for residency programs with EMR lab notification, and a strategy on how to deal with patients who need to be seen by the upcoming interns earlier than the first available appointments. Residency programs which do not use lab notification through the EMR must have a protocol on how to handle lab results during the transition period.

Model B: Handoff to Second Year Residents

Due to some logistic issues with transferring clinic panel to upcoming interns, some programs choose to assign the graduating residents' panel to the upcoming second year residents. This model offers the advantages of timely follow-up appointments because the upper-level residents are already in the EMR scheduling system and follow-up of lab results can be better handled as the upcoming second year residents are more experienced than interns. However, in some instances, the clinic panel may be too large for the second year residents who already have their own panel from their intern year. If this is the case, some patients may be distributed to other residents with a smaller panel and new interns. This may create more administrative and clinical burden for the graduating residents for having to sign out to different colleagues. Understandably, another disadvantage of this model is that in the absence of a panel to take over, new interns may not have enough patients scheduled to their clinic template in the beginning of the academic year; however, these open slots can

be used for new patients, established patients who need to be seen urgently when other upper-level residents' slots are full, and new patients from post emergency room discharge or hospital discharge. Depending on the demographic area where the clinic is located and if the demand for primary care is high, most programs which use this model have no difficulty with finding new patients for the new interns. Lastly, one of the greatest disadvantages of this model is the limited 2-year patient-physician relationship instead of 3 years for model A. This may lead to patient dissatisfaction due to frequent patient transfer.

Model C: A Mixed Hybrid Model

A mixed model is to hand off high-risk patients to senior residents, while the care of others can be safely taken over by interns. The advantage of this model is to ensure timely follow-up appointments for high-risk patients with senior residents who have more clinical experience in handling sicker patients than interns. However, the logistics of having to sign out with different colleagues is an additional burden to the graduating residents.

Clinic Handoff Protocol

Preparation for Clinic Handoff

Whether the panel is taken over by an incoming intern or a rising second year, patient communication and preparation are the keys. Preparation begins at the program level to create a "clinic handoff list" assigning a specific intern and/or second year to take over the panel of a graduating resident. If possible, panel lists can be extracted with the help of the IT team at the institution. In addition, graduating residents should be provided with criteria to identify high-risk clinic patients such as those with numerous emergency room visits and/or hospitalizations and those with multiple medical conditions requiring frequent close follow-ups.

Ways to Inform Patients of the Transition

1. Graduating residents verbally inform patients of their expected departure and tell them the name of their new PCP, if known.
2. If using model B, graduating residents may physically introduce the new PCP to patients.
3. Letters are sent to patients notifying patients of the name of their new resident PCP.
4. A telephone call by the graduating resident and the new resident PCP are additional ways to ease patients' anxiety about the transition.

Creating a standard template for sending a transition letter to the patient can be helpful for the residents [5]. Additions or amendments can be made to the template by them as necessary. The letter should begin with a few words of thanks for the patient, followed by an introduction of the person taking over the care. One example from George Washington University Residency Program is illustrated below:

Dear Ms./Mr. ________________

To begin, I would like to thank you for the trust you have given me over the last 3 years as your primary care physician. Taking care of you has been an honor for me.

As of June 30th of this year, I will be graduating from the residency program at ____________________________ and therefore will no longer be able to provide care for you.

Please rest assured that many highly qualified residents and internists remain at the __________________________________ who will be able to continue meeting your healthcare needs. In particular, I suggest that you follow up with Dr. _______________, one of our new residents who I am sure you will build a good relationship with and will serve as your resident primary care physician. Of course, all of your medical records will remain in our electronic system, to ensure a smooth transition.

Thank you for allowing me to participate in your care. Best wishes for your future health.

Sincerely,

Clinic Handoff Between Residents

Similar to inpatient handoffs, there are many possible ways to perform clinic handoffs between residents:

1. Write clinic handoff notes either electronically or on paper for high-risk patients or all patients if feasible. Notes must contain pertinent medical problems, important psychosocial issues, pending tests and consults, up-to-date preventive screenings, etc.
2. Send a list of high-risk patients through EMR in-basket or secured institutional Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant email to receiving physician with a short summary of patients' condition and pending issues.
3. Call receiving physician(s) to verbally sign out the sick and high-risk patients.
4. Introduce the new physician face-to-face to patients, if possible. This would only be applicable to handoff to second year residents.

Despite different clinic handoff protocols, less than 50% internal medicine-pediatrics programs have outpatient handoffs in place [6]. In 2012, Donnelly et al. published a randomized study on 14 internal medicine-pediatrics residents into an interventional group or control group [7]. The interventional group received an email with specific instructions on how to write clinic handoff note highlighting the

pertinent information. The interventional group had an increased number of outpatient handoffs. In 2014, the same group did an intervention with a standardized template for clinic handoffs versus free text which did not show an improved quality of the handoffs [8]. In 2013, Pincavage et al. collected patient data after the baseline versus enhanced clinic handoffs. The enhanced handoffs included a 60 min resident training versus 30 min for the baseline handoff [9]. As a part of the training, residents were asked to notify patients in person in advance of transfer, clinic staff changed PCP in EMR, and a safety audit was done in October to make sure high-risk patients have follow-up appointments. The end results were that more patients were seeing the correct new PCP within the desired time frame and fewer patients missed the pending tests; however, the intervention did not improve the number of patients missing visits and lost to follow-up.

Challenges

1. Lack of knowledge: Graduating residents may have limited knowledge on how to perform proper clinic handoffs. Clear expectations, standardized protocols, and educational training should be provided to graduating residents.
2. Large number of patients: Due to a large volume, the typical way of signing out all patients either electronically or on paper is logistically difficult. Thus, signing out only the high-risk patients is one option. Defining high-risk patients is essential.
3. Lack of time: Some residents may not have time to complete clinic handoff notes, call the receiving physician, and also send letters to patients. This gets magnified by the need of several graduating residents to take a vacation at the end of June to facilitate transition to their jobs or fellowships. Clinic directors and program directors should consider allotting administrative time to residents to perform year-end clinic handoffs.
4. Lack of monitoring: For programs with a large number of graduating residents, it is challenging to ensure that all graduating residents follow clinic handoff protocols and complete expected tasks. Assigning check out clearance to specific precepting physicians may be helpful.
5. Lack of timely clinic schedules: The clinic director must work with the residency program director to ensure that timely clinic schedules for the upcoming academic year will be available by the end of May. There are several issues that slow down the creation of timely schedules. Administrative delays stemming from accommodation of interns' requests and revisions of schedules are probably the biggest one. However, there are also factors beyond the role of the chief resident or the clinic director. Providers cannot be added unless license and DEA numbers are available. Efforts must be made with the Graduate Medical Education (GME) offices to expedite the providers that are not currently active. Creative solutions such as creation of a bridge or "dummy" provider schedules to accommodate continuous scheduling has also been tried at some institutions.

6. Lack of administrative support: The clinic director may not have a clinic scheduler to help keep track of sick patients to ensure timely follow-up appointments are made to the correct assigned receiving PCP during the transition period. In this case, a request for a clinic scheduler or an administrative assistant should be made.

Conclusion

Year-end clinic handoffs can be quite challenging due to a large volume of patients and immense logistical problems with scheduling and keeping records of patients to ensure timely follow-up appointments are made. Therefore, standardizing clinic handoffs is critical to prevent delay and disruption of patient care, maximize patient safety, and maintain patient satisfaction during the transition period. Both ACGME and CLER emphasize that residency programs should have processes to ensure effective and smooth transitions of care.

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