Internal Medicine Residents' Views About Care Transitions: Results of an Educational Intervention

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ABSTRACT

PROBLEM: Suboptimal care transitions can lead to re-hospitalizations.

INTERVENTION: We developed a 2-week "Transitions of Care Curriculum" to train first-year internal medicine residents to improve their knowledge and skills to deliver optimal transitional care. Our objective was to use reflective writing essays to evaluate the impact of the curriculum on the residents.

METHODS: The rotation included: Transition of Care Teaching modules, Transition Audit, Transitional Care Site Visits, and Transition of Care Conference. Residents performed the above elements of care transitions during the curriculum and wrote reflective essays about their experiences. These essays were analyzed to assess for the overall impact of the curriculum on the residents.

Qualitative analysis of reflective essays was used to evaluate the impact of the curriculum. Of the 20 residents who completed the rotation, 18 reflective essays were available for qualitative analysis.

RESULTS: Five major themes identified in the reflective essays for improvement were: discharge planning, patient-centered care, continuity of care, goals of care discussions, and patient safety. The most discussed theme was continuity of care, with following subthemes: fragmentation of the healthcare system, disjointed care to the patients, patient specific factors contributing to lack of continuity of care, lack of primary care provider role as a coordinator of care, and challenges during discharge process. Residents also identified system-based gaps and suggested solutions to overcome these gaps.

CONCLUSIONS: This experiential learning and use of reflective writing enhanced the residents' self-identified awareness of gaps in care transitions and prompted them to generate ideas for systems improvement and personal actions to improve their practice during care transitions.

KEYWORDS: Education, internal medicine, internship and residency, transitional care, patient transfer, frail elderly

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Introduction

Transitions of care refers to the process where the care of a patient shifts from one care setting to another, for instance from hospital to skilled nursing facility (SNF), or from hospital to home.[1] A transition in care is a vulnerable period for patients as pertinent information needs to be communicated from one healthcare setting to another.[1,2] Patients can suffer negative outcomes if the transitional care is suboptimal.[2,3] The patients who are most often harmed by bad transitions are older, frail, complex individuals, especially those who lack sufficient agency. Key factors contributing to poor care transition include gaps in communication,[4] lack of formal training of clinicians in care transitions, breakdown of cross-site communication and collaboration, lack of knowledge of patient wishes, abilities, and goals of care (GOC), and medication reconciliation breakdown.[2,5-11]

Older adults experience higher number of care transitions than younger and healthier adults. The medical staff caring of older adults are inadequately trained in care transitions[3] and get infrequent formal education in transitional care.[2,12] As geriatric population is growing, it is important to have interprofessional and educational training on care transitions integrated into the medical education. Coronavirus disease 19 (COVID-19) pandemic has added to the existing challenges in transitional care as hospitals attempt to discharge patients early to prepare for COVID-19 surges making it more prudent to improve care transitions for older adults as they transition across different health systems.[13] Some educators have begun to develop evidence-based, integrated discharge planning and transitional care curricula, which focus on systems-based practice by relying on inter-professional and experiential learning

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strategies.[12,14-16] Aboumatar et al[12] implemented a transitions of care workshop consisting of 2 sessions; Sign-Out Success and Transitions To Home, with objective of educating the first-year Internal Medicine (IM) residents about patient handoff and discharge planning. Authors concluded that Sign-Out Success session improved quality of communication and hand-off during sign-out and Transitions To Home led to enhanced self-confidence in communication of discharge instructions with the patients.[12]

Miller et al[17] describe a curriculum for first-year IM residents that included 1-hour didactic sessions on Transitions of Care followed by post-hospital visit for 1 cohort of residents and SNF visit focusing on important aspects of care transitions. Both cohorts were prompted to reflect on their experiences. Outcomes included improved awareness of care transitions among learners.[17]

Building on these works, we report on our learners' experiences with a "Transitions of Care Curriculum" (TOCC) which was a 2-week long immersive curriculum for first year IM residents and included: Transition of Care Teaching modules, Transition Audit, Transitional Care Site Visits, and Transition of Care Conference. At the end of the rotation, the residents were given a prompt for a Reflective Essay to describe the impact of the care transition on the patient and their doctor-patient relationship, the impact of the experience on their future practice of medicine and to identify barriers that would limit this change. Our objective was to use reflective essays (RE) to evaluate the impact of the curriculum on the residents.

Methods

This curriculum was created using the 6-step framework of curriculum development.[18] It was implemented at a single urban academic internal medicine training program during the 2012 to 2013 academic year. Twenty first-year internal medicine residents participated in a 2-week TOCC rotation as part of their core internship training. In this curriculum, they were exposed to main areas of care transitions using 4 structured areas teaching using transition teaching modules, audits, site visits, and participation in transitions of care conferences.

Study procedure

The curriculum was co-created by a multispecialty team of clinicians from the general internal medicine, geriatrics, and hospital medicine specialties using principle on curriculum development.[18] Two clinician educators from the geriatrics and general internal medicine specialties then facilitated and implemented the 2-week rotation.

The 2-week rotation included:

1. Transition of Care Teaching modules: Residents were given evidenced-based written hand-outs on medication reconciliation, GOC and advance directives, and functional assessment. Functional assessment and GOC modules were further augmented with practical instruction and case-based videos respectively.
2. Transition Audit. Residents practiced the skills introduced in the Transition of Care Teaching Modules during their rotation. They audited the history and physical summaries completed by their peers and assisted the medical team with medical reconciliation, GOC and advance directive discussions, and assessment of functional status of the hospitalized patients. The same patient was then followed up in a post-acute care setting. This was by offering extended outpatient clinic appointments. In this setting the resident performed audits of the patients' discharge summaries with focus on the elements of goals of care, functional status, and medication reconciliation. Residents then verified this information by performing independent functional assessment, GOC discussion, and medication reconciliation during these outpatient visits to identify changes in the functional status, discrepancies in the medications, and changes in their goals of care.
3. Transitional care site visits: Residents rotated through acute inpatient rehabilitation, subacute rehabilitation, and SNF centers; and, attended home visits with the home care team with an objective to provide a basic understanding of the services provided in those care settings
4. Transition of Care Conferences: Residents presented a Transition Conference based on 1 of their patient-based care transition experience observed during the rotation and collaborated with multidisciplinary team members to reflect on the impact of the care transition on the patient.

At the end of the rotation, the residents were provided with a prompt to complete a brief RE to reflect on their experiences during the rotation. The prompt included following areas for reflection: (1) impact of the transition on the patient and their doctor-patient relationship, (2) the impact of the experience on their future practice of medicine and, (3) identifying barriers that would limit this change. The RE were reviewed by the course facilitators and feedback was shared with the resident at the end of the TOCC rotation.

Data collection and measures

Post-rotation REs were collected from 18 of the 20 first year IM residents who completed TOCC rotation in the year 2012 to 2013. These essays were analyzed using a standardized rubric. The research team ensured the essays de-identified the patients and care team members.

Data analysis

Qualitative analysis of the RE was performed by extracting broad themes. Content analysis was used as the methodology

Table 1. Gaps in safe care transitions.

THEME	QUOTE
Inadequate discharge planning	"Discharge is our chance to lay out the details of medical care to the patient in a logical, comprehensible manner, to impart all the myriad of necessary instructions. . ."
	"It takes an additional step to take a pause and to think about their home situation, their support systems, and everything else that goes into a patient transitioning from an inpatient to an outpatient setting. That most patients are real people, living most of their lives outside of the hospital is something that goes unsaid but is often unnoticed in an inpatient setting."
	". . .there were multiple factors that contributed to his disjointed care. . . lack of a formal discharge summary, multiple healthcare providers, lack of communication between providers, incomplete medical record. . . and poor patient health literacy."
Patient engagement at discharge	"I learned that among patients who are frequently re-admitted, it is crucial to assess whether there are other underlying factors. . .. Many times, I believe the answer lies in the patient's psychosocial situation."
	". . .healthcare works best when we function as team of physicians, nurses, social workers, behavioral specialists and for those of our patient at highest risk, ensure that a good portion of their care happens in the home and that this care is high-quality care."
Silos in care transitions	". . .[this] experience exemplifies the fragmentation of American health care at large and highlights the importance of transparent, clear communication during times of health care transitions. . . where a primary care physician might act as a coordinator of care provision and ensure coherence and non-redundancy in the delivery of medical services."
	"As isolated providers, we. . . may be more motivated to take a few extra moments to better coordinate care when we see egregious breakdowns of the fragmented system."
	"The ever-changing [health] system can be frustrating as both a patient and physician with many hand-offs of patient care and numerous lists of 'changed'/'new'/'stopped' medications."
Goals of care discussion	"I really don't think that we do an adequate job teaching patients and families. . . [there is] an incredible gap in the knowledge patients have of advanced resuscitative measures and the reality of what these interventions truly mean."
	". . .goals of care discussions may need to be revisited several times before a decision is made, but being realistic about providing benchmarks/deadlines reflecting clinical scenarios is equally important."
Patient safety	"This experience has prompted me to think very critically about how to best safeguard my patients from medical errors."

to analyze the data and to elicit the patterns in the RE. Two researchers (FS, EG) reviewed all RE independently and extracted the themes from the RE using thematic analysis.[19] Disputes were resolved by discussion with other researchers (CC, AA) who served as the arbitrators when disputes persisted. Researchers chose the quotations from the RE that were most representative of the responses to include in the manuscript.

This educational research study was reviewed by an institutional review board (IRB) at Johns Hopkins University and evaluated for ethical considerations. It was approved by IRB as a retrospective educational study.

Results

A total of 20 residents participated in this curriculum, and 18 out of the 20 residents completed RE that were available for analysis. There were 3 distinct themes identified within the RE which fell into 3 broad content areas - gaps in safe care transitions, system-based solutions to gaps in care transition, and the impact of poor care transitions on patients, residents, and the doctor-patient relationship.

Gaps in safe care transitions

The 5 key elements in this theme include: inadequate discharge planning, patient engagement at discharge, silos in care transitions, GOC discussions, and patient safety during care transitions (Table 1).

The primary subtheme cited in the RE as a gap in safe care transitions was inadequate discharge planning. The learners identified inadequate discharge planning led to poor anticipation of the patient's needs for safe discharge leading to a lack of knowledge of social determinants, namely the patients' current living situation and support system. Other elements identified in that domain were lack of time for the discharging team and inadequate interdisciplinary care coordination at the time of discharge. This is demonstrated in a reflection excerpt from 1 resident,

> *"It takes an additional step to take a pause and to think about their home situation, their support systems, and everything else that goes into a patient transitioning from an inpatient to an outpatient setting. That most patients are real people, living most of their lives outside of the hospital is something that goes unsaid but is often unnoticed in an inpatient setting",*

Table 2. System-based solutions to gaps in care transition.

THEME	QUOTES
Inadequate discharge planning	". . .discharge is the one place where all of these disparate pieces of information can be summed up and woven together in a manner that is sensible to the patient."
Cohesive discharge plan	". . .Communicating this information to the health care teams 'downstream' (eg, inpatient, sub-acute rehabilitation facility, etc.) would also be paramount. This information could be a multi-disciplinary summary of a patient's information and specific, and potentially unmet, needs."
Care team communication	". . .to communicate more deliberately and effectively with nursing staff, I hope to better share discharge responsibilities and employ our strengths in a more coordinated effort."
Patient engagement at discharge	". . .education is necessary for a safe transition from the hospital to home for someone with a severe medical disease, new or otherwise."
	"'teach back' methodology, which can be vital in assessing patient understanding."
Silos in discharge planning	". . .when a primary care doctor gets the chance to observe and help in decision making, provide education, and share in a patient's life trajectory; that there is great strength in the relationship of caring and connection."
Role of primary care doctor in transitions	"Repetition, clear communication, time and space for contemplation, and reaching out from beyond the clinic and hospital wards will serve our patients well in each of their transitions. . ."
	". . .how critical the role of the primary care physician is when it comes to care transitions, and how crucial it is for physicians to communicate with each other."
Goals of care discussions	". . .get all essential parties (family members, caregivers, etc.) to attend goals of care meeting with medical team."
	". . .to assess general goals of care along with code status and healthcare surrogates when possible on admission."
Access to care	". . .more care needs to happen in the home where the majority of health maintenance really happens."
	". . .multi-disciplinary approach to patient education will facilitate improved patient education and self-management as patients transition from the hospital to their homes."

Table 3. Practice pearls.

PRACTICE PEARLS
Suboptimal care transitions can lead to re-hospitalization and other adverse events for patients
Older adults are most vulnerable to adverse events as they experience higher number of care transitions than younger and healthier adults
Education about care transitions needs to be embedded into the curriculum for medical residents. Reflective essays when used to evaluate a curriculum can promote self-learning.
Discharge planning, patient-centered care, continuity of care, goals of care discussions, and patient safety are some of the potential areas of improvement for care transitions of patients
Role of a primary care provider in care transitions is vital and can include: coordination of medical care for the patient, decision making and education of the patient through various care transitions, and communication across healthcare settings during care transitions

Another commonly cited subtheme was patient engagement at discharge, where there was insufficient patient-centered care approach. There was a lack of assessment of the patient's health literacy and inadequate knowledge of the patient's understanding of their disease and medication management. Other key features identified by learners in this domain included insufficient patient education, poor health literacy, discoordination within the healthcare team, and lack of adequate understanding of social determinants in medical care were the system-based issues identified by residents in patient-centered-care. A resident in the curriculum noted,

> *"This particular experience sheds light on the importance of anticipating and securing services that, ...provide shelter as people experience transitions of care. This is particularly poignant in people who are homeless or those on the verge of homelessness",*

Several residents cited the subtheme of silos in care transitions, which was associated with disjointed care from one care transition to another. This was thought to cause poor patients' care satisfaction and loss of trust in their care providers. Several learners noted in their reflective writing that fragmented care can potentially lead to: medication noncompliance; avoidable hospitalizations and diagnostic testing; lack of patient understanding of their medical problems and the rationale behind their medical issues; lack of trust among patients for their doctors and poor longitudinal relationship with their doctor; and, frustration about multiple hand-offs

and lack of clarity of medication changes. This was cited by some learners as,

> *"With fragmentation in our healthcare system, it is not surprising that an individual not seeing a primary care doctor would present to the ED in crisis repeatedly",*

> *". . ..there were multiple factors that contributed to his disjointed care. . .. lack of a formal discharge summary, multiple healthcare providers, lack of communication between providers, incomplete medical record . . .. and poor patient health literacy",*

A novel subtheme was the importance of GOC in safe care transitions. In this area, learners identified the overall poor communication of the patient wishes and GOC across healthcare settings, lack of understanding and knowledge of GOC, gaps in knowledge about transitioning a patient to end-of-life, and, limited understanding of the patients' family support system as pertains to GOC. A resident poignantly stated,

> "*Our fragmented system –. . .[locally], regionally, statewide, and or nationally – doesn't facilitate the expedited transfer of pertinent information, especially during an emergency."*

> ". . .*goals of care discussions may need to be revisited several times before a decision is made but being realistic about providing benchmarks/deadlines reflecting clinical scenarios is equally important."*

Within patient safety, a subtheme of gaps in safe care transitions noted poor handoff between care teams and inadequate communication led to medical errors, as reflected below.

> *"This experience has prompted me to think very critically about how to safeguard my patients from medical errors",*

System-based solutions to gaps in care transitions

Learners of this curriculum identified system-based solutions to the gaps in care transitions in their reflective writings. In this category, residents identified 5 leading system-based solutions.

Aligned to the primary subtheme of inadequate discharge planning, the residents proposed : incorporation of patient-centered discharge process, use of discharge summary templates to include pertinent details about the patient like goals of care, shared communication of a multidisciplinary summary of a patient to all the healthcare teams (eg, inpatient, sub-acute rehabilitation facility, etc.), and, creation of a "pop-up" alert in the electronic medical records (EMR) asking about social and living situation of a patient prior to discharge. Quotations that reveal this in the RE include,

> *". . ...discharge is the one place where all of these disparate pieces of information can be summed up and woven together in a manner that is sensible to the patient",*

> *". . .. . .as a systems-based solution, possibly a pop-up that asks a primary care physician to consider a person's living situation or social situation more broadly, prior to deeming a surgery"*

Within the gap of lack of sufficient patient engagement at discharge, residents proposed the use of a multidisciplinary approach to patient education and greater focus on health maintenance. One resident noted

> *"teach-back", methodology, which can be vital in assessing patient understanding."*

Another system-based solution suggested ways to improve continuity of care. The learners reflected primary care provider (PCP) as a bridge to care continuity. PCPs play a central role in their patient's care coordination through various care settings and in establishing clear, streamlined continuous communication between themselves and hospital providers to maintain the good patient-doctor relationship. One resident reflected,

> *". . ..medicine is more data-driven than ever before, yet with the decline of the traditional physician model of outpatient-inpatient provider continuity, in many ways clinical decision-making is less informed than previously. We can't afford to settle. Our patients deserve better."*

Several RE noted further system-based solutions around the gap in GOC discussions. Learners identified using GOC discussions as a framework to discuss code status or hospice during conversations about medical ailments bridges this gap. Other learners suggested early assessment of the patient's GOC on admission, and, engaging family members in these discussions. A learner noted,

> *". . .. . ..discuss hoped for/ acceptable outcomes and patient priorities early, and use these ideas as a framework in discussing medical options (code status, hospice, etc)",*

Lastly, some residents proposed a system-based solution focused on the improvement of access to care would bridge gaps in care transitions. Some proposals included suggestions of care delivery at patient homes and more integration of multidisciplinary teams during care transitions. One resident stated,

> *". . ..more care needs to happen in the home where the majority of health maintenance really happens",*

Impact of poor care transitions on patients, residents, and doctor-patient relationship

Through the experiential learning using RE, residents identified the negative implications of gaps in care transitions to patients. These included: patient frustration and dissatisfaction with care; missed appointments and follow-up care; multiple readmissions; lack of medication and/or non-adherence to medications; lack of understanding of their medical ailments; patients' lack of trust for doctors; overall poor doctor-patient relationship, and, dispiritedness from multiple hand-offs and numerous medication lists.

Residents expressed the impact on learners caused by such gaps adversely affect doctor-patient relationship, through: false assumptions about patients; sense of failure to

the resident; frustration with self, colleagues, and patients; extensive paper-work; resident sense of loss of control over patients' medical condition, and, sense of failure when families (or patients) are not able to reach a decision about their end-of-life treatments.

Residents acknowledged that TOCC experience led to a change in their practice. They expressed increased self-awareness and understanding of the critical nature of the discharge process and identified a need for self-improvement. They acknowledged that an early assessment of the social situation of the patient could help fill some of these gaps. One medical resident wrote,

> *". . ...I will be able to anticipate these challenges and to make sure the transition of care is the best that I can provide for them in the future"*,

During this curriculum, residents collaborated with other disciplines involved in care transitions and expressed a greater appreciation of multidisciplinary roles in patient care and care transitions. As one resident reflected,

> *". . ..next step in my development as a physician, is learning who are my teammates and how they can help"*,

Residents identified the practice of self-reflection as an essential tool to know their patients better, including their social determinants, and to reflect as to what it meant to be a physician. There was a realization that a better doctor-patient relationship led to better communication and hence, better care transitions. One resident expressed,

> *"..I think I often assume that patients have been educated about their diagnoses if they've had them for a while, though that may not be the case."*

In several RE, residents suggested solutions to improve their practices to enhance care transitions. Few residents reflected on this as,

> *"I plan to make a concerted effort to partner more consistently with the nursing staff at discharge."*

> *". . ...I will be able to anticipate these challenges and to make sure the transition of care is the best that I can provide for them in the future"*,

> *"If I am able to communicate more deliberately and effectively with nursing staff, I hope to better share discharge responsibilities and employ our strengths in a more coordinated effort"*,

> *"I recognize and accept that the goals of care discussions may need to be revisited several times before a decision is made"*,

Discussion

Reflection is used in medical education to help learners gain understanding of self or the situations around them.[20-23] In this curriculum, RE were used for qualitative evaluation of the curriculum.

Most interesting finding in our study was that many RE focused on continuity of care as a major gap in care transitions, which can then adversely affect medical care in multitude of dimensions, including; medication noncompliance, avoidable hospitalizations and tests, lack of understanding of medical problems and rationale behind medical problems, lack of trust for doctors and longitudinal relationship with the doctor, and, frustration about multiple hand-offs and numerous lists of medications. Residents identified that this gap can be bridged with PCP as the coordinator of care to foster longitudinal relationship with the patient. Residents showed understanding that that poor care transitions can lead to poor doctor-patient relationship and frustration and dissatisfaction for both patients and physicians. Residents noted that while goals of care discussions are a key element for safe care transitions, there is lack of communication about goals of care across healthcare systems. The lack of communication, along with poor understanding and knowledge about patients' goals of care, can lead to suboptimal care transitions. In RE, residents identified that systems interventions are needed to facilitate the ability of PCPs to support goals of care assessment and communication across care transitions.

Similar curricula for medical trainees have been published focusing on related areas of quality improvement and patient safety[24] and discharge planning.[14,16,25] Aboumatar et al[12] had implemented a transitions of care workshop for IM residents but TOCC differed from this curriculum as it was evaluated by qualitative analysis of RE. Pavon et al[26] implemented a transitions of care curriculum for IM interns with a focus on older adults and incorporated qualitative evaluation through RE. Our teaching methods differed from those of Pavon and colleagues, but our findings from the reflections were quite similar.

This study had limitations. First, it was conducted in a single institution and may not represent experiences with care transitions across the United States. Secondly, it was a short observation of residents limited to 2 weeks in their first year of residency. Lastly, while residents' intentions to change were noted in the reflections, we were unable to follow up with residents' post-curriculum, and we do not know if they altered their behavior as a result. Despite these limitations, study findings lend important insights into resident perceptions of transitional care.

Our study has several strengths. We believe the curriculum is transferable to other training programs and hospitals due to its feasibility of implementation. Moreover, organizational incentives to improve care transitions are strong, since suboptimal care transitions affect all patients independent of age, gender, diagnosis, or treatment in an academic program or hospital. Curricula such as ours could readily be adapted for other learners in other settings with minimal investment of resources. Additionally, RE can be an effective way to qualitatively evaluate such curricula while promoting further self-learning. For TOCC, RE provided rich data about gaps in care transitions as experienced by the residents which prompted them to think

about solutions to bridge those gaps. This data adds to the current literature about care transitions. Lastly, as patients of any age or diagnosis can be adversely impacted by suboptimal care transitions, TOCC was restructured at the end of the academic year 2013 and its contents was distributed across other rotations for first year internal medicine residents so that residents could receive training and education in care transitions longitudinally during their first year of residency.

Conclusion

Care transition education and training is crucial to the curricula for medical residents to equip them with knowledge and skills to improve transitional care for their patients. In TOCC curriculum, residents utilized RE to identify several key aspects of care transitions, identify system-based issues, and suggested solutions to those issues. In their reflections, residents were able to appreciate gaps in care transitions can adversely affect patient care leading to poor outcomes. This experiential learning and use of reflective writing enhanced the residents' self-identified awareness of gaps in care transitions and prompted them to generate ideas for systems improvement and personal actions to improve their practice during care transitions.

Author Contributions

Study Design: Fatima Sheikh, Evelyn Gathecha, and Colleen Christmas. Article Draft: Fatima Sheikh and Evelyn Gathecha. Critical Revisions: Evelyn Gathecha, Alicia I Arbaje, and Colleen Christmas. Authors approve the final version of this manuscript for publication and have agreed to be accountable for accuracy and integrity of the work included in this manuscript.

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REFERENCES

1. Coleman EA, Boult C. Improving the quality of transitional care for persons with complex care needs. *J Am Geriatr Soc*. 2003;51:556-557.
2. Sheikh F, Gathecha E, Bellantoni M, Christmas C, Lafreniere JP, Arbaje AI. A call to bridge across silos during care transitions. *Jt Comm J Qual Patient Saf*. 2018;44:270-278.
3. Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the quality chasm: a new health system of the 21st century*. Washington DC: National Academies Press; 2001.
4. Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med*. 2003;138:161-167.
5. Teno JM, Fisher ES, Hamel MB, Coppola K, Dawson NV. Medical care inconsistent with patients' treatment goals: association with 1-year Medicare resource use and survival. *J Am Geriatr Soc*. 2002;50:496-500.
6. Forster AJ, Clark HD, Menard A, et al. Adverse events among medical patients after discharge from hospital. *Can Med Assoc J*. 2004;170:345-349.
7. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297:831-841.
8. Gandara E, Moniz T, Ungar J, et al. Communication and information deficits in patients discharged to rehabilitation facilities: an evaluation of five acute care hospitals. *J Hosp Med*. 2009;4:E28-E33.
9. Arora VM, Prochaska ML, Farnan JM. Problems after discharge and understanding of communication with their primary care physicians among hospitalized seniors: a mixed methods study. *J Hosp Med*. 2010;5:385-391.
10. Sheu L, Fung K, Mourad M, Ranji S, Wu E. We need to talk: primary care provider communication at discharge in the era of a shared electronic medical record. *J Hosp Med*. 2015;10:301-310.
11. Oulton J, Rhodes SM, Howe C, Fain MJ, Mohler MJ. Advance directives for older adults in the emergency department: a systematic review. *J Palliat Med*. 2015;18:500-505.
12. Aboumatar H, Allison RD, Feldman L, Woods K, Thomas P, Wiener C. Focus on transitions of care: description and evaluation of an educational intervention for internal medicine residents. *Am J Med Qual*. 2014;29:522-529.
13. Keller SC, Gurses AP, Myers MG, Arbaje AI. Home health services in the time of coronavirus disease 2019: recommendations for safe transitions. *J Am Med Dir Assoc*. 2020;21:998-1000.
14. Hunter T, Nelson JR, Birmingham J. Preventing readmissions through comprehensive discharge planning. *Prof Case Manag*. 2013;18:56-63.
15. Phatak A, Prusi R, Ward B, et al. Impact of pharmacist involvement in the transitional care of high-risk patients through medication reconciliation, medication education, and postdischarge call-backs (IPITCH Study). *J Hosp Med*. 2016;11:39-44.
16. Smith LM, Keiser M, Turkelson C, Yorke AM, Sachs B, Berg K. Simulated interprofessional education discharge planning meeting to improve skills necessary for effective interprofessional practice. *Prof Case Manag*. 2018;23:75-83.
17. Miller RK, Keddem S, Katz S. Intern transitions of care curriculum through posthospital home and skilled nursing facility visits. *J Grad Med Educ*. 2018;10:442-448.
18. Kern DE, Thomas PA, Hughes MT. *Curriculum Development for Medical Education: A Six-Step Approach*. 2nd ed. The Johns Hopkins University Press; 2009. www.press.jhu.edu
19. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reported qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89:1245-1251.
20. Moon J. Using reflective learning to improve the impact of short courses and workshops. *J Contin Educ Health Prof*. 2004;24:4-11.
21. Mann K, Gordona J. Reflection and reflective practice in health professions education: a systematic review. *Adv Health Sci Educ Theory Pract*. 2009;14:595-621.
22. de Feijter JM, de Grave WS, Hopmans EM, Koopmans RP, Scherpbier AJ. Reflective learning in a patient safety course for final-year medical students. *Med Teach*. 2012;34:946-954.
23. Block L, Morgan-Gouveia M, Levine RB, Cayea D. We could have done a better job: a qualitative study of medical student reflections on safe hospital discharge. *J Am Geriatr Soc*. 2014;62:1147-1154.
24. Wong BM, Etchells EE, Kuper A, Levinson W, Shojania KG. Teaching quality improvement and patient safety to trainees: a systematic review. *Acad Med*. 2010;85:1425-1439.
25. Phillips CO, Wright SM, Kern DE, Singa RM, Shepperd S, Rubin HR. Comprehensive discharge planning with postdischarge support for older patients with congestive heart failure: a meta-analysis. *JAMA*. 2004;291:1358-1367.
26. Pavon JM, Pinheiro SO, Buhr GT. Resident learning across the full range of core competencies through a transitions of care curriculum. *Gerontol Geriatr Educ*. 2018;39:144-159.