

Handoffs and Care Transitions

Accreditation Council for Graduate Medical Education

- [Issue Brief No. 5: Care Transitions](#)

Agency for Healthcare Research and Quality

- [Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions](#)
- [Medications at Transitions and Clinical Handoffs \(MATCH\) Toolkit for Medication Reconciliation](#)
- [Patient Safety Primer: Handoffs](#)
- [Perspectives on Safety: Handoffs and Transitions](#)
- [Re-Engineered Discharge \(RED\) Toolkit](#)
- [TeamSTEPPS® Tool: Handoff](#)
- [Toolkit to Engage High-Risk Patients in Safe Transitions Across Ambulatory Settings](#)

American College of Obstetricians and Gynecologists

- [Communication Strategies for Patient Handoffs](#)

American Data Network

- [Patient Handoff Templates: An Executive Guide to Safer Transitions](#)

American Hospital Association

- [Handoff: Use a Handoff Tool for Optimal Patient Transitions of Care](#)

American Medical Association

- [With Handoff Risk Quantified, 3 Ways to Improve Care Transitions](#)

Anesthesia Patient Safety Foundation

- [All Handoffs Are Not the Same: What Perioperative Handoffs Do We Participate in and How Are They Different?](#)
- [The Evidence Base for Optimal Conduct of Handoffs](#)

Association of periOperative Registered Nurses

- [Reducing Adverse Events: 4 Areas of Focus](#)

Emergency Medicine Patient Safety Foundation

- [Safer Sign Out for Emergency Physicians](#)

Institute for Healthcare Improvement

- [SBAR Tool: Situation-Background-Assessment-Recommendation](#)

I-PASS Patient Safety Institute

- [Resources](#)

MedPro Group

- [Case Study: Numerous Lapses Lead to Medication Error and Subsequent Patient Death](#)
- [Checklist: Reducing Risks Associated With Patient Handoffs](#)
- [Checklist: Strategies for Improving the Discharge Process](#)
- [Communication in the Diagnostic Process: Preventing Breakdowns and Missed Opportunities](#)
- [Improving Care Transitions for Patients With Suicide Risk](#)
- [Improving Communication in Collaborative and Team-Based Care](#)
- [Ineffective Communication in Cardiology: Addressing a Persistent Risk Factor in Malpractice Claims](#)
- [Preventing Patients From Slipping Through the Cracks](#)
- [Risk Management Review: Treatment Delays Cause Complications Following Cerebrovascular Accident, Resulting in Brain Damage; Malpractice Lawsuit Follows](#)
- [Risk Q&A: Handoffs and Signouts](#)
- [Risk Q&A: Hospitalist Communication](#)
- [Risk Q&A: Transition Orders in the Emergency Department](#)

- [Risk Resources: Hospital Discharge and Readmissions](#)
- [Risk Resources: Medication Safety During Care Transitions](#)
- [Risk Tips: Implementing Warm Handoffs](#)

National Transitions of Care Coalition

- [Healthcare Professionals](#)

Office of the National Coordinator for Health Information Technology

- [Safer Guide: Self-Assessment: Clinician Communication](#)

Pediatric Quality and Safety

- [Improving Patient Handoffs and Transitions Through Adaptation and Implementation of I-PASS Across Multiple Handoff Settings](#)

Pediatrics

- [Handoffs: Transitions of Care for Children in the Emergency Department](#)
- [Standardization of Inpatient Handoff Communication](#)

The Joint Commission

- [Sentinel Event Alert 58: Inadequate Hand-Off Communication](#)
- [Quick Safety Issue 26: Transitions of Care: Managing Medications](#)

World Health Organization

- [Transitions of Care](#)

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