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CARE TRANSITIONS:

Through the Lens of Malpractice Claims

SEPTEMBER 2021

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What You'll Learn From This Report

- Specific types of care transitions that pose the greatest vulnerabilities (office-to-office, emergency department-to-home, unit-to-unit within a hospital, and from hospital to post-acute care facility), and how you can reduce risk in each situation.
- The top specialties to trigger claims: general medicine, surgery, and emergency medicine.
- How communication, coordination, and documentation factor into the overall risk of care transitions.
- How poorly executed care transitions can result in patient harm and notable financial impact to healthcare providers.
- General principles for managing risk and improving safety for patients who will visit multiple healthcare providers, departments, or facilities during their episode of care.

When implemented at the right time and in the right way, care transitions enhance care delivery, improve patient outcomes, and move organizations toward successful attainment of the triple aim: better health, better care, and lower cost through improvement.[1]

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Introduction

This report provides insight into notable trends and root causes of claims involving care transitions.

Healthcare in the United States is incredibly complex and inevitably fragmented. Patients are often assessed, treated, and monitored by multiple clinicians in multiple facilities which can result in a rushed and complicated episode of care that includes many players and interactions.

Coverys claims data shows that while care transitions—in and of themselves—are not a major primary allegation in malpractice claims, they are more likely to result in indemnity payments and significant patient harm than many other types of events that trigger claims. And because U.S. healthcare often involves care transitions, it stands to reason that many malpractice claims that allege other primary causes (e.g., medication, diagnostic, or surgical error) might also have a component of risk related to one or more care transitions.

Coverys evaluated 5,270 events that closed between 2017 and 2019 and identified 210 specific events where the care transition directly led to an alleged medical error. This report provides insight into notable trends and root causes of claims involving care transitions, based on an analysis of those transition-related events.*

Our goal in sharing this report is to provide clinicians and other healthcare professionals with fresh perspectives, data-driven insights, and more effective strategies to meet the needs of the patients whose care begins, ends, or transitions through their purview.

**Unless otherwise indicated, statistics and other information in this publication were derived from this proprietary data.*

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A Fresh Approach to Claims Data

At Coverys, we refer to claims data as "signal intelligence." Our conclusions from analysis of the data are not absolute findings. Rather, they are hypotheses—signals from the past about where vulnerabilities existed and may still be at play.

Typically, a fully investigated malpractice claim will include:

- Allegations.
- Patient health and demographic information.
- Injury severity.
- Physician specialty.
- Risk management issues.
- Location of the alleged error (e.g., office/clinic, emergency department, hospital unit).
- Financial costs.
- Expert reviews and opinions.

Coverys uses this information to create evidence-based recommendations to help mitigate future risks in the delivery of care.

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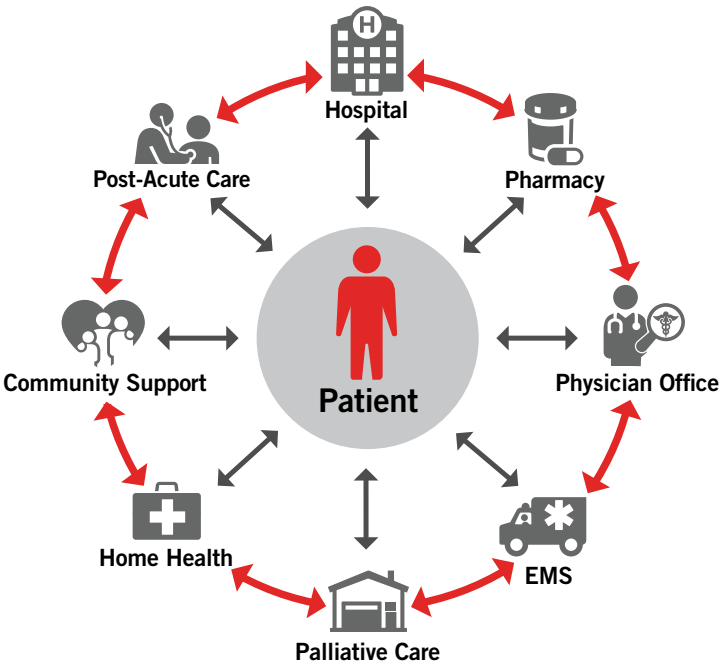
Care Transitions Defined

Each time a patient is wheeled from one hospital department to another, is referred from a primary care physician to a specialist, is discharged from the emergency department to their home, or is sent from an acute-care environment to a nursing home or other post-acute care setting, they are participating in what is known as a "transition in care." These distinct moments of patient handoff are laden with risk; a notable study found that 80% of serious medical errors are caused by ineffective care transitions.[2]

Care transitions involve situations where:

- Multiple providers and influencers must collaborate, coordinate, and communicate fully and effectively on behalf of their shared patient.
- Differing cultures (among hospital departments, between different facilities or practices, and between patient and provider) can result in miscommunication with negative consequences.
- Resources can be stretched thin during periods of emergency or high volume and during shift changes.
- Reliance upon electronic medical records can pose complications and increase risk.
- Discharge decisions can be rushed or incomplete.
- The patient's ability to understand the process and treatment, as well as their functional capability, is vital.



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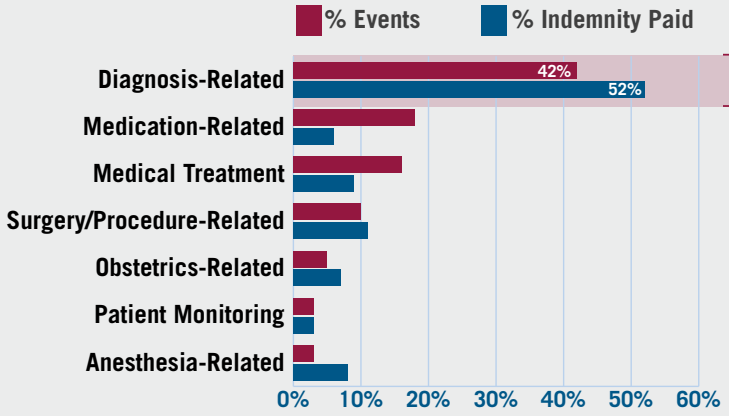
Care-Transition Events at a Glance

Top Allegations

Most care-transition events allege a diagnostic error.



Top diagnosis-related allegations involved **receipt or transmittal of test results** and **physician follow-up with patient**.

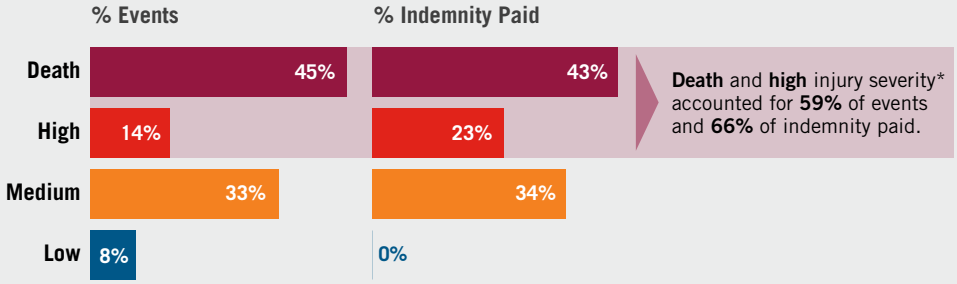
N=210 care transition events closed 2017-2019.

Top Diagnosis-Related Conditions

	Cancer	Cardiac/Vascular	Infection	Neurological
% Events	50%	20%	11%	7%
% Indemnity	38%	19%	24%	14%

N=88 care transition events closed 2017-2019, resulting from delayed or missed diagnosis.

Injury Severity



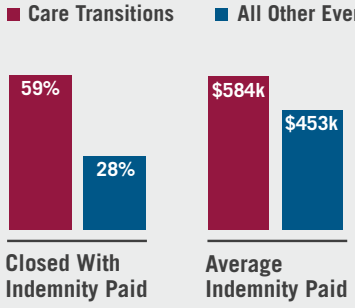
Death and **high** injury severity* accounted for **59%** of events and **66%** of indemnity paid.

N=210 care transition events closed 2017-2019.

*High injury severity is a category that includes major permanent injury (like blindness in both eyes, paraplegia, bowel injury requiring permanent colostomy) and grave injury (like severe cerebral palsy, vegetative state, or untreatable and widespread metastatic cancer).

Claims Metrics

Claims stemming from care transitions are 29% more costly than claims arising from other allegations.



N=210 care transition events closed 2017-2019. N=5,270 all other events closed 2017-2019.

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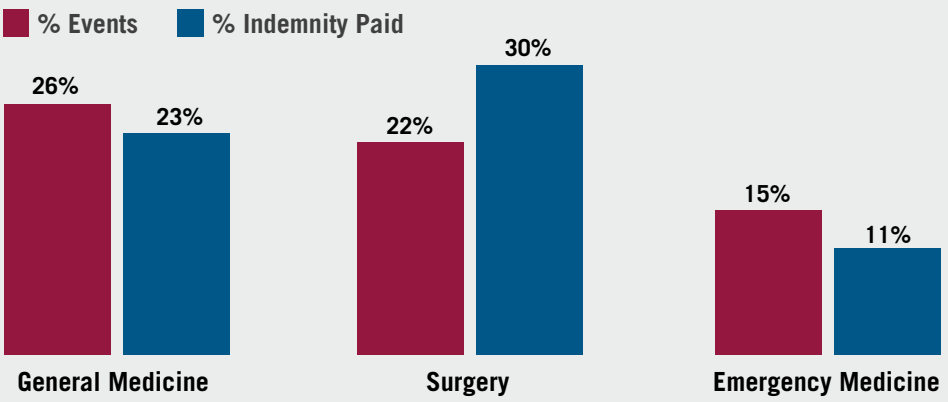
Top Specialties*

Just three medical specialties—general medicine, surgery, and emergency medicine—were implicated in 63% of events and accounted for 64% of care transition cases with indemnity paid.



N=210 care transition events closed 2017-2019.

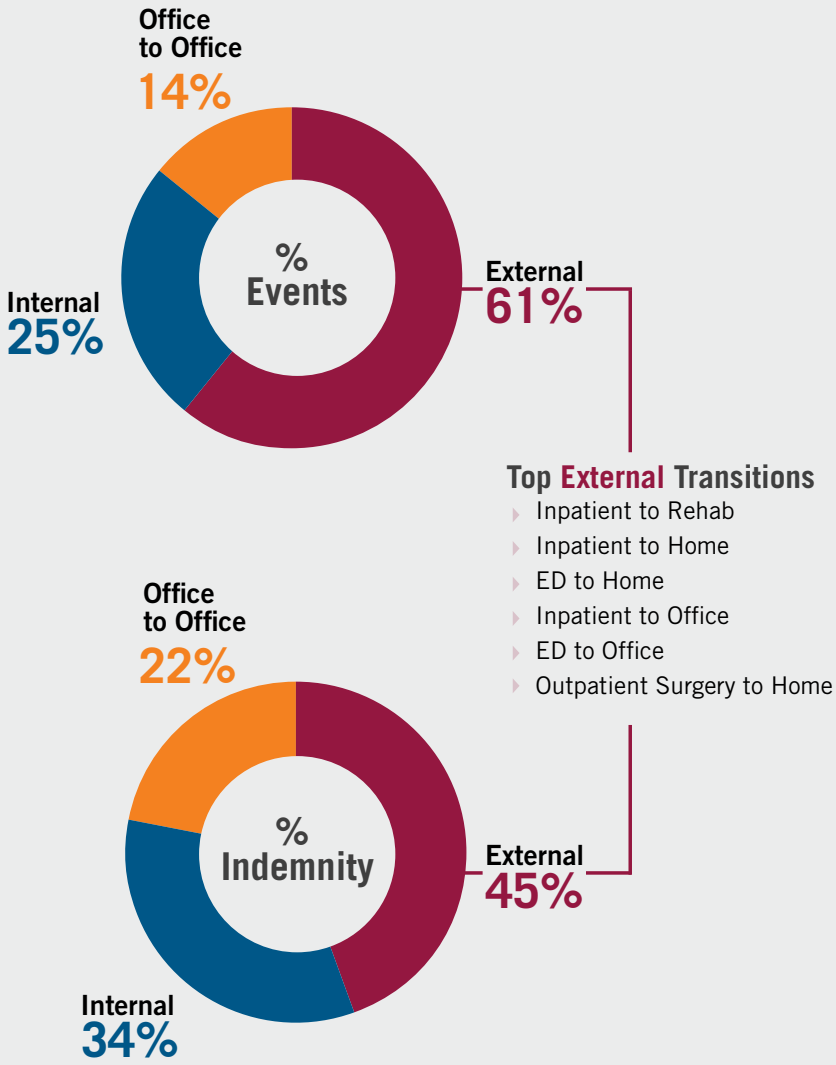
*For events with a medical specialty identified.

Top Locations

External: Transfer from one facility to another facility or medical office. (Most of these involved transition from hospital to another facility.)

Internal: Transfer within the same facility (e.g., emergency department to radiology).

Office to Office: Transition from one medical office to another (e.g., primary care physician to gastroenterologist).



N=210 care transition events closed 2017-2019.

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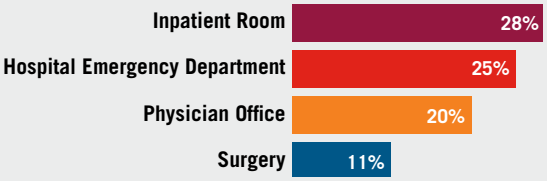
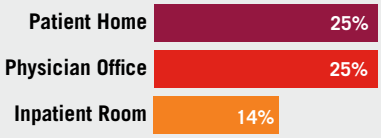
Where Transition Events Begin and End

84% of events **originated** in four locations.

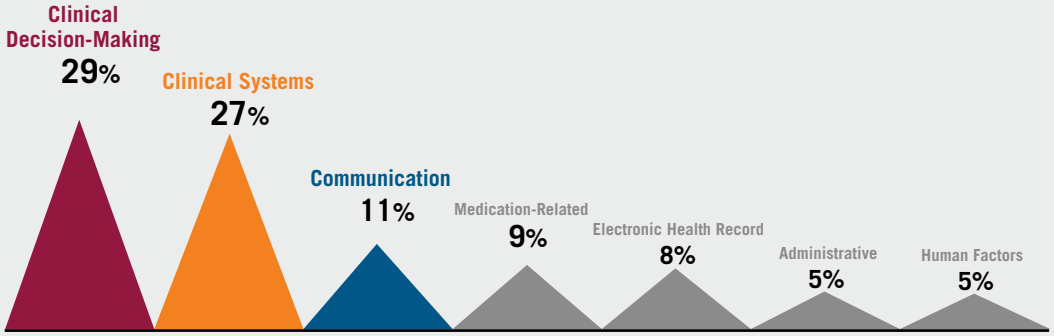


64% of events **ended** in three locations.



N=210 care transition events closed 2017-2019.

Top Risk Management Issues



Clinical Decision-Making

- Lack of integration of family/personal history into decision-making.
- Negligent post-operative monitoring and/or treatment.
- Failure to obtain consult and/or referral.
- Inadequate and/or inappropriate testing.
- Narrow diagnostic focus.
- Failure to rescue.

Clinical Systems

- Results and/or specimen(s) lost, misfiled, and/or physician unaware of results.
- Lack of coordination of care.
- Failure or delay in follow-up or in notifying of incidental findings.
- Failure to manage patient's follow-up care.
- Premature discharge.
- Failure to inform patient of test results.
- Failure to promptly review test results.

Communication

Deficiencies in communication during:

- Physician-physician interactions.
- Physician-nurse interactions.
- Phone or email treatment of patient.
- Physician-patient interactions.

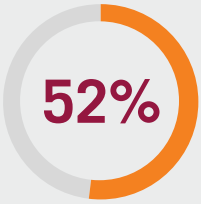
N=563 risk issues identified in care transition events closed 2017-2019. (An event can have up to three identified risk issues.)

Patient Comorbidities

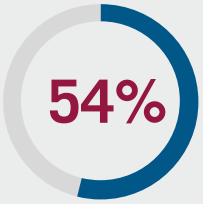
Top Comorbidities:

- Hypertension
- Cardiovascular disease
- Chronic pulmonary disease
- Obesity
- Smoking

Patients with at least **one** comorbidity.



Indemnity paid involved patients with comorbidities.



N=210 care transition events closed 2017-2019.

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Themes and Trends to Watch: The Stories Behind the Numbers

In an era of productivity and profitability, physicians and their support teams are challenged to do more with less time—more procedures, more patients, more billing codes, more diagnostic mysteries to solve, more specialists to consult. These pressures can have patient-safety consequences. Throughout this report, we provide risk management recommendations, case studies, statistics, and an analysis of the state of risk when it comes to care transitions overall.

Some clear themes that emerged include:

- **The patient and their family can be crucial to outcomes.** Sometimes the strongest predictor of patient outcomes is an accurate assessment of the patient's functional readiness to care for themselves or convey crucial information to other medical providers. When healthcare practitioners hand off a patient without fully understanding whether the patient understands their next steps, adverse events are more likely to follow. When discharging patients to home, patients and family members become caregivers, and when discharging to a post-acute care facility, nursing home, or other doctor's office, the patient is often the only single person who traveled the entire medical journey—serving as their own historian for the benefit of others. If the patient and/or their family are not offered the conversations, written discharge instructions, and other resources needed for ideal outcomes, even good communication and documentation to other providers might not be enough to ensure that risk is managed. And when the patient is unable to speak or act reliably on their own behalf, it's important for medical providers to recognize this and offer additional layers of safety.
- **Communication is imperative (and verbal is not enough).** As demands on healthcare providers increase, delivery of care can become rushed. For example, complicated home-care instructions are offered verbally to a nodding and anxious patient but are not confirmed via a teach-back or reinforced with detailed written instructions; prescriptions for expensive medications are written without confirming whether the patient can afford to fill them. And it's not just good communication with patients that matters, as communication happens at multiple levels: provider to patient and provider to provider. One notable study estimated that 80% of serious medical errors involve miscommunication during the handoff between medical providers.[3] Communication was the third-most frequent risk issue during transition-related events that triggered malpractice claims in the Coverys analysis.
- **Accountability saves lives.** With patients receiving their care from multiple providers across separate, sometimes disconnected healthcare systems, even the most experienced provider or the most lucid and savvy patient is left wondering "Who's on first?" when it comes to taking accountability for the patient's overall care. It's never been more important for there to be clarity about who's coordinating the care and what comes next. Shared accountability among multiple individuals and groups can be

imperative to ensuring good outcomes. "Let me check that with the nursing team" or "I'd like to have a conversation with the radiologist before your appointment" or "Please confirm this suspicion with the patient and then circle back with me" can be simple moments of shared accountability and confirmation that can help reduce injury to the patient. Failure to follow up or improper follow-up is the second-most frequent risk issue in transitions-in-care events, according to the Coverys dataset.

- **Fragmented environments are ripe for structured improvement.** It has been estimated that at a single academic medical center, more than 4,000 care transitions happen each day, and it's safe to assume that kind of frequency of handoffs is the norm at other types of hospitals and health systems as well.[4] With patients transferring from medical centers to nursing homes to rehabilitation centers to doctors' offices to their own homes, the complexity of caring for even a single somewhat-stable condition can be daunting. Implementing a proven care-transition model and being diligent about internal processes, communication, documentation, discharge planning, and patient assessment and education are key factors for successful care transitions.

- **Some patient populations are at higher risk than others.** We know from the data that elderly patients, cancer patients, patients who come to the doctor or the hospital unaccompanied, and those who have language, health literacy, or cultural barriers are at much higher risk during or after a transition in care. Providers and organizations that take this into account and work to identify and assess at-risk patient populations can help level the opportunity for good outcomes. Systematizing the use of social workers and interpreters and having access to language translation services for discharge instructions is also important. Patient-centered care is all about remembering to meet the patient where they are—not simply treating the disease or condition.

- **Proactivity and thorough assessment can identify gaps and create opportunities**. No two healthcare facilities are exactly alike, but they can all be assessed through common filters to determine areas of vulnerability and opportunity when it comes to care transitions. Taking the time to look at your practices through the lens of best practice can help identify where improvements are needed. Assessment tools are available through medical professional liability companies, and you can engage consultants to help you improve your culture of accountability, communication, and safety when it comes to care transitions. You should also regularly analyze your outcomes data (e.g., readmissions, completed referrals, patient complaints, and patient morbidity and mortality statistics).

- **Standardization and practice contribute to successful outcomes.** When communicating with a patient about their condition and their upcoming care transition, and when sharing vital patient information with your medical colleagues and collaborators, doing it "the same way every day" can improve safety and outcomes. Adopt one of several handoff mnemonics to help you ensure a thorough conversation and/or written document, develop meaningful checklists and ensure they are used, and consider implementing a proven care-transitions model that has worked well at similar organizations or in service to similar patient populations as yours. Routine and rigor are vitally important because delivering healthcare—especially in the areas at most risk of handoff error, like general medicine, surgery, and emergency medicine—is highly complex and full of variability.

- **Patients may be pressed for time or face challenges in paying for their care.** If the care transition plan is not executed in the context of your patient's reality, it is more likely to result in patient harm. Some questions to consider: Does the patient work full-time while raising children alone and therefore might have to go weeks or months before following up with the primary care doctor or specialist you are referring to? Is a co-pay for an MRI something they can afford or might the promise to pursue additional diagnostics be the patient's way of maintaining their pride in the face of a medical request they know they can't fulfill? Is it possible that a discharge to home, while it might be situationally sensitive for a patient who doesn't have coverage for rehabilitation services, isn't in the patient's best interests if they don't have the functional capacity to manage medications or daily activities?

TRANSITION ISSUES IN THE EMERGENCY DEPARTMENT

Care transitions happen everywhere but are perhaps no more consequential than they are when they begin in a hospital emergency department (ED). Our data revealed:

39%
of transitions between the ED and home resulted in death.

25%
of all care-transition events that trigger claims began in the ED.

15%
of care-transition events involved emergency medicine.

11%
of care-transition indemnity paid involved emergency medicine.

As hospitals and patient-safety leaders explore improved models for care transitions, the ED is an ideal place to focus initial efforts and to begin improving outcomes and saving lives.

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Unique Issues That Impact Patient Handoffs

Healthcare providers must often rely on colleagues with whom they have little synergy and perhaps no relationship.

Clinical referrals can be difficult. Patient discharge instructions can be difficult. Even transferring a patient from one unit of a hospital to another can be difficult. Much of that difficulty arises because of one or several unique but predictable factors:

- As healthcare organizations seek to be optimally productive and fiscally responsible, patient loads per provider can be heavy and burdensome. When you don't have much time to spend with a patient, it can be very difficult to ensure thorough handoffs.
- Effective care transitions require some level of teamwork and rapport among clinicians and their patients, but cultural divides (even differences in how the cardiology department and the emergency department function and speak) can create unintended consequences. In serving their patients, healthcare providers must often rely on colleagues with whom they have little synergy and perhaps no relationship.
- The EMR has, for better or for worse, come to replace word-of-mouth information and the over-reliance on these records causes many transition-in-care issues, from the assumption that the EMR is complete despite some crucial notes or test results not having been dictated yet, to the common occurrence of a patient having records for the same condition and care journey in multiple EMRs at multiple facilities with no interconnectivity to one another.
- A stable patient can become unstable in a short period of time, and when a handoff takes too long, the entire situation can quickly go from "under control" to perilous.
- Since the advent of the hospitalist model and the ever-increasing trend for many U.S. patients not to have a primary care physician, there is often no single source of relationship or information about a patient's health. And unless the patient is an incredibly capable communicator and documentarian, much can slip through the cracks. Follow-up is not a given, and patients are often forgotten.

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The Patient's Role in Care Transitions

Transition-related events sometimes involve a certain degree of patient involvement or a lack of buy-in—cases where a stronger focus on shared decision-making and a shared mental model between provider and patient might have led to better outcomes.

Take, for example, a patient who nods, smiles, or verbally confirms that they understand the prescribed next steps (e.g., referrals, home care) but doesn't truly understand. Clinicians may not be aware of the patient's confusion or ensuing decision-making that results in poor outcomes until they hear from their malpractice insurance carrier.

Think also about patients who don't have a primary care physician (PCP) or haven't seen their PCP in many years. When you treat a patient and discharge them to a PCP who doesn't exist or with whom there is no maintained or trusted doctor-patient relationship, the care transition becomes immediately vulnerable. The most common type of intended patient "receiver" cited in care transition events is a general medicine physician, though many of those physicians were not aware that the patient should have been coming to see them.

A patient's functional status—their ability to walk, their cognitive abilities, and their ability to perform daily activities—are important considerations. Something as simple as relying on a patient to use eye drops or change a bandage can be imperiled by a misunderstanding about what the patient is truly capable of managing on their own.

Patients often fail to make or keep critical follow-up appointments. The Agency for Healthcare Quality and Research (AHRQ) reports that more than one-third of patients with an inpatient status who were discharged from hospitals requiring more care ultimately failed to get that care.[5] Coverys data shows that such absent care contributes to hospital readmissions and poor outcomes. One of the primary measurements of ineffective care transitions is hospital readmission. For events where care started in an inpatient setting, 38% resulted in the patient being readmitted to the hospital, and these cases accounted for 47% of indemnity paid for care transition events. The most frequent readmissions occurred within 30 days.

Improved patient engagement during transitions can help. Medical practices and hospitals that have lower-than-average transition-in-care risk are typically those that have systematized phone, text, and email follow-up (with patients and receivers alike) to ensure that referrals are completed as advised.

Healthcare providers rely upon patients to act in their own best interests and often count on families and caregivers to help ensure optimal outcomes. The National Transitions in Care Coalition (NTCC) offers Patient and Family Engagement/Education as one of their seven essential intervention categories. They suggest having families and patients explain the details of their care plan in their own words. The NTCC reminds providers that there are several ways to double-check that families are prepared and clear about what to do next and that it's a provider's responsibility to educate families and patients through verbal and written means that can improve the health literacy of these stakeholders.[6]

CASE STUDY #1: Fragmented Care

A patient with a lesion in her left breast received a biopsy positive for cancer and had a clip placed for a planned lumpectomy. During a pre-op chest MRI, a second left breast lesion was identified, superior to the known cancer; the second lesion was biopsied and clipped, and the pathology results were negative. The patient's surgeon referred her back to radiology for needle localization of the cancerous lesion. The radiologist was unaware that there were two lesions in her breast, both marked with clips, and that one was benign.

The radiologist located only one clip and placed a needle for the lumpectomy. The lesion was surgically removed without complication and the patient was discharged to home. Ten months later, it was discovered that the lesion that had been localized with a needle by the radiologist and removed by the surgeon was the benign lesion. The cancerous lesion remained untreated in the patient's left breast for nearly a year. Multiple handoffs took place in this case—as is common during the complexity of cancer care—and multiple communications failures led to this error. The surgeon was criticized for failing to communicate—verbally and/or via written documentation—to the radiologist that the patient had two lesions and two clips. Fragmented care contributed to the outcome, as the first biopsy and clip placement were performed at a different hospital from the other procedures, and the radiologist did not have access to the patient's EMR at the other hospital.

CASE STUDY #2: Poor Planning at Discharge

A post-partum inpatient female who developed leg pain and fever was treated with gentamicin and clindamycin, then discharged to home before her final blood culture results were known. The culture was positive for group B strep. A few days after returning home with her baby, the patient returned to the emergency department (ED) with continuing leg pain and fever. The discharge summary from the prior labor-and-delivery hospitalization had not yet been dictated, and, as such, the emergency physician was not aware of the recent group B strep culture results. The patient was unaware of her strep B infection as well, was treated in the ED with pain medication, and was discharged to home, where she remained without appropriate antibiotic coverage for strep B and ultimately developed septic arthritis of the hips, resulting in bilateral hip replacement. In this case, two key transition issues contributed to the outcome: hospital discharge prior to review of or plan for final blood culture results, and lack of timely documentation to ensure subsequent treaters had access to a complete patient record.

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CASE STUDY #3: Miscommunication and Missed Communication

After shoulder arthroscopy, a 43-year-old male patient was discharged to home with a continuous nerve-block catheter in place for post-operative analgesia. The patient was instructed to pull the catheter when the medication from the pump had been fully depleted. Two days after the surgery, the patient's wife attempted to remove the catheter tubing, which caused immediate severe pain for the patient. At her husband's insistence, the wife continued to pull until the catheter was out. The patient was diagnosed with permanent severe brachial plexus injury, which was presumed to have occurred when the catheter was pulled against resistance. The physician reported that the patient and his wife were instructed to discontinue removal attempts if there was any resistance or pain when doing so and that they should go to a physician's office or hospital ED for assistance. The patient insists he received no such warning and allowed his wife to remove the catheter despite encountering severe pain. It is unclear from the records whether the patient was provided with written discharge instructions.

RISK MANAGEMENT RECOMMENDATIONS

Empowering and Understanding Your Patients

- Start discharge education early and reinforce it often. Discharging a patient is a multi-step process for which planning should be started at the *beginning of treatment.*
- Always provide written discharge instructions to support any verbal instructions you provide. Written instructions should be in plain language. Also called plain English or simple language, plain language is defined as clear and concise writing that is easy to understand the first time your audience reads it.[7] Ensure you know whether the patient can read and understand those instructions.
- Implement "teach-back" strategies as part of your discharge process. These strategies improve patient self-management and outcomes.
- Encourage questions from patients and families. Be welcoming of family and other caregivers during important conversations. Creating a culture where patients are put at ease improves the likelihood that patients will be candid with you.
- Adopt a system for following up with transitioned patients—via phone, text, or email—to ensure they don't have additional questions and that their care plan is proceeding as intended. Ensure that electronic communications are sent through encrypted applications and documented in the medical record.

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Who Is Responsible for High-Quality Care Transitions?

Someone needs to help each patient navigate the healthcare system and the treatment of their condition, ensuring they are well informed and properly cared for at every step. Ask yourself each time you interact with a patient: "Am I that navigator, ally, or informer? And, if not me, who?"

The NTCC argues that there are three components to enhancing the transition-in-care process through shared accountability across providers and organizations. Both senders and receivers of patients, they argue, should work to ensure:

- Clear and timely communication of the patient's plan of care.
- Clarity that a healthcare provider is responsible for the care of the patient at all times.
- All parties (providers or organizations) assume responsibility for the outcomes of the care-transition process.[8]

The sheer volume of participants in patient transitions can be overwhelming—from physicians to advanced practice providers (APPs), to nurses, administrators, EMTs, pharmacists, and even medical assistants, orderlies, and volunteers. With the rise of the hospitalist model (and the abandonment, at least to some degree, of private physicians in primary care and specialties making rounds to visit their patients who arrive in an ED or a hospital unit), the hospitalist plays a crucial role in patient transitions. The very nature of the hospitalist's role is to interact with others in the hospital and beyond; care transitions are embedded in what they do. But are we doing enough to properly train, resource, and staff hospitalists and their teams for this heavy burden?

The healthcare team as a whole is changing. As more care is provided by APPs, like nurse practitioners and physician assistants, these clinicians find themselves at the center of care-transition challenges. In the Coverys data, 19% of care-transition events involved an APP (typically a nurse practitioner or physician assistant).

U.S. healthcare is fragmented for a variety of reasons. With patients obtaining diagnostic, treatment, and monitoring services at multiple facilities—often across multiple health systems—additional vulnerabilities arise. When a patient is known to have been seen at more than one care facility, it's important for providers to gain insight into the pieces of the patient's medical record that might not be easily accessible. Relying on the patient to fill in the gaps is often not enough. Making a phone call to other providers—especially those you don't know or have never collaborated with—can drastically improve outcomes.

CASE STUDY #4: When Chronic Disease Becomes Acute Crisis

A 67-year-old patient in acute renal failure was sent from the emergency department (ED) to be admitted to the care of a hospitalist who had gone home for the day. Based on the history provided to him by the emergency physician, the hospitalist did not think it was necessary to return to the hospital to evaluate the patient. The hospitalist provided verbal orders to the nursing staff regarding the patient's care. In the ensuing hours, the patient rapidly decompensated and was referred to the intensive care unit, where he was diagnosed with a perforated peptic ulcer. The patient hemorrhaged and died, never having been seen by the hospitalist. It remains questionable whether the hospitalist was fully informed about the patient's condition—including his unstable vitals, free air under his diaphragm, and abnormal blood chemistry results—by the ED physician. The patient's diagnosis and treatment focused on renal failure, without suspicion of an intra-abdominal bleed.

RISK MANAGEMENT RECOMMENDATIONS

Individual and Team Accountability

- Assess your hospitalist model and ensure that staffing issues and inconsistencies aren't complicating handoffs.
- If you're a primary care doctor or hospitalist, remind yourself that you are the quarterback for the patient and that the patient is relying on you to ensure optimal communication and coordination during care transitions. If you're a consulting specialist or work in the emergency department or an urgent-care center, find and confirm who is taking primary responsibility for the patient so you can clarify and perform your role on the team.
- Train and empower everyone in your organization (including APPs, physicians, nurses, medical assistants, and volunteers) about what information is crucial to convey during a transition and how and when to speak up if they feel something is amiss.
- Implement technology solutions that increase your visibility into other EMR systems and get in the habit of saying "I'd like to speak with the other doctor who has been treating you. Give me just a moment while I see if I can catch them on the phone."

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Monitoring and Medication Management Issues

Important details can slip through the cracks when one provider assumes another provider is keeping tabs on them.

Managing a patient's medications is a complex endeavor, even in the absence of multiple care transitions. In our 2017 report *A DOSE OF INSIGHT; A data-driven review of the state of medication-related errors and liability in American healthcare*, Coverys analyzed more than 10,000 closed medical malpractice claims to discover that medication-related issues were the fourth-leading claim allegation. So we were not surprised when, in reviewing the transitions-in-care data for this report, medication management surfaced once again as a major contributor to poor outcomes. Medication issues were the second-most frequent allegation in care-transition events.

Similarly, medication-related events that involved the highest levels of injury severity (including death) were those that involved an alleged failure to properly monitor a patient's condition during and after a transition.

It is understandable how the continuation of or management of medications, as well as the ongoing monitoring of patient vitals, can be difficult during swift, complicated, or disorganized care transitions. These important details can slip through the cracks when one provider assumes another provider is keeping tabs on them.

CASE STUDY #5: Handoff Communication Failure

A 9-week-old female patient was received from a transfer hospital and admitted to the pediatric ICU for sepsis, fever, and malnutrition. A septic workup was obtained, and she was started on empiric antibiotics and placed on non-invasive cardiopulmonary monitoring. She remained fever-free during her stay, but despite aggressive feeding, the infant's nutritional status continued to decline. A transfer was arranged to take the baby, via emergency medical services, to a tertiary care facility for further evaluation. The patient was transported via ambulance with an IV in place but without cardiac monitoring. The physician thought it was understood that the patient's status would be cardiac-monitored. Upon arrival at the tertiary care facility, while still in the ambulance, the infant was bradycardic, and she arrested. CPR was performed, and the infant later died.

CASE STUDY #6: The Forgotten Medication

A 67-year-old female, after undergoing surgical repair of hip and radius fractures, was transferred from the hospital to a rehabilitation facility with discharge instructions that stated: "Continue Lovenox for 3 weeks." No dosage or frequency was listed. Lovenox was not included in the medication list sent from the hospital, and it wasn't ordered at the rehab. The patient's rehab physician and her orthopedist both failed to note that the patient wasn't on Lovenox (or other anticoagulant therapy) during their rounds at the rehab. Ten days after leaving the hospital to enter rehab, the patient was readmitted to the hospital with extensive deep vein thrombosis and pulmonary embolism, and she died shortly thereafter.

RISK MANAGEMENT RECOMMENDATIONS

Monitoring and Medication Management

- Communicate clearly, concisely, and directly during handoffs. Never make assumptions about what the receiver understands or their capabilities to care for the patient.
- Standardize all processes related to patient handoffs both internally and externally. Implement checklists and handoff tools that provide consistent information that needs to be understood by the receiving party. Allow time for the receiving organization or provider to ask questions.
- Partner with agencies and organizations within your community to evaluate the quality of your patient transfers. Proactive and ongoing evaluation of transitions may help prevent future issues and improve safety.
- Train all staff members on teamwork and expectations regarding handoffs.
- Implement and monitor your medication reconciliation process. All providers caring for and prescribing medications should review the medication list prior to discharge.
- Investigate pharmacist-led care-transitions programs and develop a new level of rigor around regular communications between a patient's clinicians and their pharmacist.

COVERYS

Failures in Provider/Patient Communication

The importance of effective communication during patient transitions cannot be overstated. Common communication breakdowns between clinicians and patients include:

- Language barriers, cultural barriers, and functional challenges (such as when a patient is hard of hearing or has undiagnosed dementia) can lead to adverse events. (See Case Study #8.)
- Whether through oversight or intentional judgment, providers may fail to share incidental but important findings with patients and families (like when a CT scan to diagnose an inflamed appendix also reveals a hiatal hernia).
- In the most chaotic of situations, major diagnostic findings can be unintentionally withheld from patients. (See Case Study #7 and Case Study #11.)
- When discharge planning isn't begun early during a hospital admission, families and patients can be left feeling overwhelmed and rushed when they learn that a transition to rehab, post-acute care facility, nursing home, or hospice needs to take place. Communicating effectively with patients and families once they have become anxious and stressed can be difficult and rife with risk.
- When conversations between providers and patients don't go deep enough, providers can miss the opportunity to improve outcomes through an understanding that a patient might not have a PCP, might be uninsured or underinsured, or might be coping with a personal situation that will impede their ability to complete the transition plans as outlined.

CASE STUDY #7: Discharged to Nursing Facility Without Vital Information

A 76-year-old woman who was residing in a nursing home was admitted to the hospital ICU with a diagnosis of urosepsis. During the admitting history and physical, a necrotic-appearing labial lesion was noted, and gynecology was consulted. A discussion took place regarding the risks and benefits of a procedure to excise the necrotic tissue, and the patient signed an informed consent. The lesion was excised and sent to pathology, and the patient was discharged back to the nursing facility. The pathology report, which stated that the lesion was consistent with malignant melanoma, was sent to the surgeon and intensivist with the surgeon's copy noting that the PCP was aware of the results. Neither the patient nor her adult son was aware of the pathology results until a readmission for a vaginal bleed 16 months later, during which the son was asked about the details of the workup and treatment of the melanoma. It was during this readmission that the patient was diagnosed with metastasis, put on comfort measures, and passed away. It was later determined that the physician who discharged the patient back to the nursing home had recommended a one-week, outpatient

gynecological evaluation but did not tell the surgeon and said that it was the responsibility of the PCP to obtain the discharge summary outlining the follow-up referral.

CASE STUDY #8: Language Barrier

A Spanish-speaking 60-year-old male patient underwent cataract surgery with retrobulbar injection of anesthesia. The patient was discharged with an eyepatch that was to be removed within a few hours, but due to confusion over discharge instructions, the patient left the eyepatch on until the following day, when it became visually apparent that he had a significant hemorrhage. The hemorrhage injured the patient's optic nerve and ultimately required orbitotomy with drainage of lateral hematoma. He had no subsequent return of vision. Had the patient removed the patch earlier, as allegedly advised, the complication might have been recognized and addressed, possibly saving the patient's vision. The nurse who discharged the patient after the initial cataract surgery gave verbal instructions in Spanish, but written instructions were in English.

RISK MANAGEMENT RECOMMENDATIONS

Provider/Patient Communication

- Ensure loop closure with all incidental or unexpected findings by discussing these findings with the patient and with all key members of the patient's care team.
- Identify which provider is ultimately accountable for all follow-up care. Ensure the patient's primary care provider receives a copy of all instructions provided to the patient, as well as test results and information on follow-up appointments.
- Include the patient and caregivers in all discussions regarding follow-up care. Provide the patient with written instructions that describe the diagnosis, expected results, side effects, or new symptoms that could arise and require attention; whom to contact if they have questions or concerns; and suggested follow-up care with providers, as well as appropriate contact information.
- Recognize potential language barriers and provide discharge instructions in a way that the patient can understand. Utilize interpreter services to ensure full comprehension.
- Find ways to include the patient in the decision-making that leads to a differential diagnosis. Adjust how you provide information to patients during consultations (such as positioning your assessment as a "working diagnosis" rather than a definitive answer) and encourage them to actively examine test results and other information in online portals; an engaged patient is typically a safer patient.
- Widen your diagnostic scope by honestly examining diagnostic culture and other influences that create overconfidence in medical diagnoses. How do production pressures, diagnostic uncertainty, or threats to self-image —in the face of admitting uncertainty of a diagnosis—lead to overconfidence and erroneous, delayed, or missed diagnoses?

COVERYS

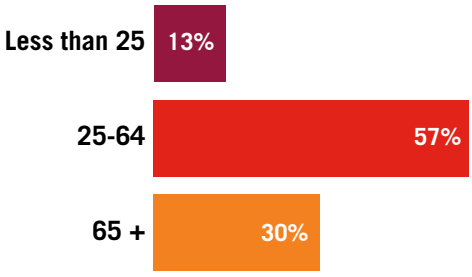
Vulnerable Patients

As evidenced by the case studies reviewed for this report, patients from all demographics and with a wide range of health conditions are at risk of harm through a poorly handled transition in care. But some patient populations are at higher risk, including:

- Patients with cancer, cardiac/vascular conditions, and infection (the top three patient conditions involved in transition-related events).
- The elderly.
- Patients with severe frailty, physical disabilities, or end-stage disease.
- Patients being received from or sent to nursing homes, hospice, or post-acute care facilities.
- Patients with cognitive impairments.
- Patients with functional challenges (e.g., those who are unable to dress themselves, change bandages, or manage their medications).
- Patients who don't have a primary care physician.
- Patients who are uninsured, underinsured, and/or living in poverty.
- Patients who don't speak and read English.
- Patients who lack basic health literacy.
- Patients who live in under-resourced communities or remote rural areas.
- Patients experiencing homelessness.
- Patients with behavioral health conditions.
- Patients who are unaccompanied or who don't have a committed family member or caregiver.

It is vital that decision-makers in healthcare—in clinical and administrative roles—are attentive to the practical realities that can impede a patient's safe and thorough passage through a care transition. The small detail that a patient might not be able to afford the co-pays for life-supporting medications can be the first domino that falls in a disastrous or even deadly cascade. Or a patient who is hard of hearing being unable to use the phone to make an important follow-up appointment with a cardiologist could find themselves susceptible to harm.

Vulnerable Age Groups



N=210 care transition events closed 2017-2019.

73%

of events involving seniors resulted in high injury severity or death.

RISK MANAGEMENT RECOMMENDATIONS

Vulnerable Patients

- Review and analyze your readmission data by payer. Evaluating your non-Medicare readmissions may identify patterns in underinsured or Medicaid populations.
- Perform an inventory of the different post-acute and community-based services in your primary area. You may identify additional clinical, behavioral, and social service resources that can support your patients' transitional care needs.
- If possible, create a "high-risk for readmission" flag in your electronic medical record. Automating this process assists the clinical team in rapid identification of high-risk patients and promotes reliability.
- Implement a "whole-person" needs assessment that includes social and behavioral health issues. Patients cannot be expected to self-manage their care if they have unmet social needs.
- Keep written information simple. Materials should be provided to patients at an elementary reading level and contain basic self-management information.
- Anticipate and link patients to post-hospital care. Ensuring that patients are able to follow up and have the necessary support to access care after discharge will improve the likelihood of a successful transition.

COVERYS

Diagnostic Issues and Clinical Decision-Making

Clinical decision-making is the heart of optimal healthcare delivery.

Before a patient experiences a transition in care, they nearly always receive a diagnosis, even if only preliminarily. So a discussion of care transitions must include a review of the diagnostic process and the degree to which diagnostic accuracy is a precursor to the quality of a patient's care transitions. Coverys 2018 report—*A DOSE OF INSIGHT; Diagnostic Accuracy: Room for Improvement*—found that diagnostic-related errors were the leading root cause of medical malpractice claims. Our review of 10,618 closed claims revealed that 33% were diagnosis-related, and 47% of indemnity paid over a five-year period was for diagnosis-related claims.

Even when a diagnosis is accurate and timely, arriving at it often triggers the need for one or more care transitions—referrals to specialists, transfer to different hospital units, transition to radiology or other diagnostics, or discharge to home or nursing facility. And referral management is complex and full of risk. In our 2018 report on diagnostic error, we revealed that 9% of all diagnosis-related claims alleged an issue with referral management.

When making a diagnosis and preparing a patient for a transition to another provider or care environment, strong clinical decision-making is key. In our review of 3,466 closed claims with diagnosis-related allegations, 53% were determined to have an issue with clinical decision-making. Thoughtful, big-picture clinical decision-making is vital before, during, and after care transitions. Sending a patient to the wrong location, at a premature time, or without proper safety nets in place creates vulnerability to patient harm. In examining the 210 transitions-in-care events that form the basis for this report, two of the largest indemnity payments ($3M and $5M) involved allegations of a failure to diagnose and treat conditions that caused serious injury or death. See Case Study #10 for further illustration of this point.

Clinical decision-making is the heart of optimal healthcare delivery. As such, we were not surprised to see that of the myriad risk issues at play (563 risk factors across 210 patient events), a failure in clinical decision-making accounted for 29% of those risk issues. The most common types of clinical decision-making issues were failure to obtain a full family or personal history, negligent post-operative monitoring and treatment, failure to obtain a specialty consult or referral, inadequate or inappropriate testing, narrow diagnostic focus, and failure to rescue.

CASE STUDY #9: Premature Discharge

A 26-year-old male patient with end-stage renal disease on hemodialysis was admitted to the hospital with sepsis, where he arrested and was resuscitated. Multiple consults were obtained for the patient, but the source of the sepsis was never identified. The patient was discharged to home without documentation of adequate oxygenation and with an elevated white blood cell count. The patient suffered anoxic brain injury a day after being discharged, was returned to the hospital in a vegetative state, and subsequently died. This patient had multiple consultants but no coordination of inpatient care and no one "quarterbacking" the patient's transition or readiness to go home. There was also inadequate communication with family caregivers prior to the patient's discharge.

CASE STUDY #10: Human Factors Contribute to Adverse Outcome

After undergoing hip arthroscopy surgery without issues, a 62-year-old male patient with a history of coronary artery bypass graft surgery was transferred to the post-anesthesia care unit (PACU) where he began to experience chest pain and shortness of breath. Cardiac enzyme levels were obtained, and an EKG was performed; the EKG results noted "possible inferior infarct." Despite the noted EKG abnormality, the patient was transferred from the PACU to a medical-surgical floor without a cardiac referral or further cardiac evaluation. On the medical-surgical floor, the patient continued to deteriorate. Pulmonology was consulted for continued decline of oxygen saturation, and different respiratory therapies were prescribed. Despite the patient's extensive cardiac history, the signs of heart distress, and the decreased oxygenation, the pulmonologist never ordered a cardiac consultation or considered a cardiac pathology to be the cause of the patient's shortness of breath and chest pain. The patient continued to deteriorate through five hours of misguided lung therapy while his heart condition, continuing to worsen, went unmonitored and untreated. Eventually, the patient was completely unable to breathe. A chest X-ray showed an enlarged heart and fluid in his lungs, and several hours later, the patient suffered cardiac arrest. The patient was finally transferred to the cardiac catheterization lab, though this transition in care came too late. His heart condition was irreversible, and the patient died.

CASE STUDY #11: Lack of Accountability and Follow-Up

A patient in a rehabilitation facility after knee replacement was sent to the ED for evaluation of right lower quadrant abdominal pain, where a CT scan ruled out appendicitis but could not rule out obstructing colonic lesion. A colonoscopy was recommended, which the ED physician thought could be done as an outpatient procedure. The patient was diagnosed with abdominal pain and a urinary tract infection (UTI) and sent back to rehab. No records were sent back with the patient, and the rehab physician relied only on the patient's self-report that the CT was negative. So when the abdominal pain persisted, the rehab doctor ordered laxatives. The patient's pain increased, and the patient was sent back to the hospital ED, where a perforated bowel was diagnosed, and the patient died. The rehab physician was never apprised of the abdominal CT results and need for colonoscopy, and they never tried to get the records from the ED visit.

RISK MANAGEMENT RECOMMENDATIONS

Diagnostic Accuracy and Clinical Decision-Making

- Treat the whole patient regardless of their admitting diagnosis or procedure.
- Ensure that key tests and/or lab values are communicated from one setting to another and from one provider to another.
- Establish protocols for abnormal findings that clearly define "next steps." Build these protocols into the EMR. Hardwire your processes whenever possible.
- Establish a process/procedure to ensure that necessary information is communicated to the next care setting.
- Know who will be responsible for following up on recommended post-discharge procedures. Close the loop.

COVERYS

Technology, Tools, and Best Practices

There is cause for optimism about improving patient outcomes through the implementation of new systems, technologies, tools, models, and protocols.

While the stories and statistics about what can go wrong during patient transitions warrant our serious attention and concern, there is also cause for optimism about improving patient outcomes through the implementation of new systems, technologies, tools, models, and protocols. Fine-tuning an organization's care transition practices is inherently difficult because process changes can be difficult to sustain over time, and care transitions are highly human in nature. The good news is that doing something (anything!) to bring structure, safety nets, and additional thoughtfulness to patient handoffs can and will have a positive impact.

There are several areas you might examine to get started improving care transitions, including:

- Conduct a formal, thorough assessment of your practice or facility as it relates to care-transition processes and behaviors.
- Reconsider the design and utilization of your EMR, knowing that it is a key component of transition-related communications. EMR systems can be pre-populated with clinical referral templates and other helpful tools to ensure good patient outcomes.
- Audit your current discharge protocols and identify ways to improve them.
- Consider ways in which you can categorize patients into different populations based on transition risk. Then provide additional layers of support and safety for those who are most vulnerable to harm during a transition.
- Rethink older technologies that your team could be using more effectively, like telephone, email, and your practice's portal, to ensure timely communication with other providers and patients alike.
- Closely examine the way in which you interact with radiology. When it comes to care transitions, the role of radiology is crucial and in need of attention. While claims involving radiology occur infrequently, they often result in high indemnity payments.

COVERYS

Care-Transition Models

As more attention is brought to the risks of care transitions, more models for improvement are being introduced and tested.

Beyond the tools and technologies are entire ways of practicing, thinking, and collaborating to ensure more effective care transitions for all patients. Some proven models include:

- **BOOST (Better Outcomes by Optimizing Safe Transitions)**[9]—A model focused on using "the 8 Ps" to screen for high-risk patients (Problems with medications, Psychological, Principal diagnosis, Physical limitations, Poor health literacy, Patient support, Prior hospitalizations, and Palliative care). This comprehensive program offers step-by-step guidance and mentors. Consider using this model if you have not yet formally started any kind of care-transition improvement work, are in the beginning phases, or want to implement an effective readmission improvement program.
- **Transitional Care Model (TCM)**[10]—Developed by the Hartford Institute for Geriatric Nursing, this model focuses on patient's needs, engagement of patient and family/caregivers, early identification and response to healthcare risks, and a multidisciplinary approach that involves collaboration among care providers. This model is a combination of several others, inclusive of the Joint Commission's National Patient Safety Goals. Consider this model if you are Joint Commission-accredited (or considering accreditation soon) or if you have a large geriatric patient population.
- **Care Transitions Intervention (CTI)**[11]—Also known as the Skill Transfer Model, CTI offers a four-week support program to patients with complex care needs through which family caregivers receive specific tools and work with transitions coaches. This low-intensity, evidence-based intervention includes a home visit and/or hospital visit and three phone calls. This model is designed to teach patients to self-manage their care and conditions. By pairing patients and their families with transitions coaches and ongoing phone monitoring, healthcare facilities can provide patients with tools to avoid issues and complications. Consider this model if you are actively working on or considering patient engagement/shared decision-making improvements. This model has been shown to improve patient satisfaction scores and key questions related to this model have been incorporated into HCAHPS (the Hospital Consumer Assessment of Healthcare Providers and Systems survey).
- **Project Re-Engineered Discharge (RED)**[12]—Developed and tested by the Boston University Medical Center and the Agency for Healthcare Research and Quality (AHRQ), the RED toolkit helps organizations re-engineer their discharge processes. Consider this model if you serve a diverse population of patients

and if you have been impacted negatively by the financial implications of hospital readmissions under the Affordable Care Act, which allows Medicare to reduce payments to hospitals with "excess readmission rates" for heart attack, heart failure, and pneumonia.

- **Chronic Care Model (CCM)[13]**—Developed by the MacColl Center for Health Care Innovation at the Group Health Research Institute, CCM identifies the essential elements of a healthcare system that encourage high-quality chronic disease care. These include: the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. This model can be applied to a variety of chronic illnesses, healthcare settings, and target populations. The focus of this model is the primary care physician and the role PCPs play in the management of chronic conditions. Consider this model in your physician office practice to proactively mitigate risks associated with chronic conditions or if working toward becoming a medical home.
- **PArTNER (PATient Navigator to rEduce Readmissions)[14]**—This care-transition model is designed for minority-serving institutions (MSIs) and aims to increase support to patients and caregivers at the hospital through their transition to home. Typically, transitional care strategies are designed for and delivered by clinicians; interestingly, patients and caregivers collaborated on the design of PArTNER to address the overall patient experience. The program includes a community-based patient navigator and a peer coach via a telephone support line. Consider this model if you are a healthcare system serving a high percentage of patients from minority populations.

As more attention is brought to the risks of care transitions, more models for improvement are being introduced and tested. Programs that are pharmacist-led or that utilize pharmacy technicians are showing promise,[15] [16] transition clinics are popping up to support high-risk populations,[17] and video-conference-based programs are serving patients in remote, under-resourced communities that have a history of low access to medical care.[18] What is most exciting about process improvement for care transitions is that no matter how much work you have to do, you are not alone, and there's no need to start your own program from scratch. There are many established evidence-based models; it's just a matter of finding the right fit and committing to start.

USING MNEMONICS

You can immediately begin to improve your handoff effectiveness by structuring your actions and communications based on one or more of several helpful mnemonics. A few of the most popular options include:

- I-PASS: Illness severity, Patient summary, Action list, Situation awareness, Synthesis by receiver.
- SBAR: Situation (patient is scheduled for what procedure or testing or transfer), Background (including allergies, oxygenation, fall risk, cognitive state, and more), Assessment, and Recommendation for transport.
- Ticket to Ride: An actual slip of paper (ticket) that must be initialed by the sender, transporter, and receiver of the patient.
- SIGNOUT: Sick or not sick (DNR/full code included), Identifying patient information, General hospital course, New events of the day, Overall health status, Upcoming possibilities with a plan, Tasks to be completed overnight.

COVERYS

Managing Risk and Improving Patient Safety

Throughout this publication, we have provided data-driven recommendations for reducing risk and improving outcomes related to the transition of patients from one provider or one setting to another. Following is a final list of recommendations that apply broadly to care transitions in U.S. healthcare.

What you save through speed may cost you in patient harm. A great deal of transition-related adverse events involve brief interactions where time pressures can make it difficult for discharge instructions or referral information to be clearly conveyed and patient questions thoroughly addressed. And when one appointment or admission is handled sub-optimally, it can require return visits or hospital readmission, ultimately costing patients, providers, and hospitals more time in the episode of care and a higher likelihood of poor patient outcomes.

Discharge is not a medical term for goodbye. Discharge or referral should be thought of as a beginning and not an end. Discharge to home, rehab, post-acute care facility, nursing home, or hospice is the beginning of the next phase of the patient's treatment or healing. Providers who pass a patient along to the next step in a medical journey should be immediately thinking about when and how they will follow up and check in—with other providers, with caregivers, and with the patient.

Functional teams, safer patients. Effective teamwork has long been a focus of surgical departments and other high-risk medical environments. It is equally important that teams of providers—across departments in hospitals and health systems, and between providers who refer patients to one another—prioritize ways to improve their interdependent processes and communications to ensure improved patient safety.

Collaboration and community at the core. Excellent patient care involves a "we" mindset from providers and caregivers, who should always be thinking about "our patient" and "what we can do to support them," rather than the default mindset of "that other provider has taken over at this point." True collaboration keeps the patient as the core focus at every step and in the mind of every provider.

Documentation is not "paperwork" but an extension of care. Imagine what the U.S. healthcare experience would look like if providers thought about transition documentation as the book version of the movie—the whole story, just in written form. If you value the readers and decision-makers who reference the EMR and other handoff or discharge documentation as customers who need "the whole story," how might patient outcomes be improved for the better?

A balance of listening, speaking, and written instructions is needed. For a provider to insist that "I'm more of a talker than a writer" or "I answered all the patient's questions, so I didn't think it necessary to outline a full transition plan" or "They were given written instructions—that's all they should need" is simply not adequate. Ensuring clarity in communication requires a thoughtful balance of listening, speaking, and written instructions.

Process, rigor, and consistency are key. Offering thorough, safe, compassionate patient experiences is not something we can do "some of the time" or "most of the time." Working in healthcare—as a clinician or administrator—requires a commitment to best practices every day, in every way. Organizations that have implemented rigorous models and demand consistency from their employees breed the kind of discipline that can result in safer patient care and long-term results.

Medication management and patient monitoring never go on pause. If a patient requires medication and/or monitoring, ensuring that these "two Ms" are managed by the next provider is your responsibility at the handoff juncture. Medication lists are more than perfunctory, and monitoring plans should be considered as crucial as treatment plans.

Fresh focus on vulnerable populations. Some patients have luck on their side, and they'll survive and even thrive after less-than-ideal care transitions. But many patients are at high risk for something going wrong. Pay close attention to patients who are unaccompanied or don't have a caregiver at home, are 65 or older, have chronic conditions (including behavioral health conditions) and dangerous comorbidities, are experiencing homelessness, have limited financial means, contend with language barriers, or lack basic healthcare literacy.

Mindset matters. Perhaps the most common phrase heard during a hospital morbidity and mortality review or during a deposition or trial in the wake of a malpractice lawsuit is "I didn't think that" or "I assumed that." Our perspectives, frames of reference, assumptions, and mindsets matter when it comes to patient care—sometimes to a life-and-death degree.

Stitching together a fragmented healthcare environment begins with you. Healthcare providers and administrators face a daunting daily task—serving patients optimally in a system that often fails when it comes to interoperability. So while it's true that broader ecosystems are sometimes at fault for individual cases of patient harm, the stitching together of process gaps, dysfunctional teams, or siloed systems happens one provider and one leader at a time. It begins with you.

COVERYS

Conclusion

Every day in the United States, millions of care transitions take place for patients in hospital, out-patient, and continuing-care settings, most without major incidents but all with inherent risk for poor outcomes.

At Coverys, we see the stories within our care transition event data as signals—signs of vulnerability and clues for continuous improvement. In this report, we identify key factors that can contribute to poor care transitions and ways to mitigate these factors. We also recognize that relationship building, partnerships, and effective communication belong to all stakeholders—healthcare professionals, patients and families, as well as communities.

Data is a good place to start when determining what creates quality or puts it at risk. It is our hope that the insights offered in this report will inspire improvement and that care transitions are safer because of your commitment to know better, do better, be better, and inspire better.

COVERYS

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