

ClaimsRx

clinical & risk management perspectives

October 2007

Coordination of Care

Communication Is the Key to Success

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Learning Objectives

To ensure patients receive appropriate, coordinated and comprehensive care. By implementing the risk management recommendations set forth herein, providers will reduce their liability risk exposure by: applying communication and documentation strategies that are clear and comprehensible in addressing a patient's medical condition, and by adopting and adhering to

policies and procedures for hand-offs between multiple providers and facilities.

Target Audience

This activity is intended for all healthcare providers.

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Introduction

Coordination of care has become increasingly complex. A patient's care may involve multiple providers and facilities. In addition to the traditional primary care attending physician in the hospital, the care of a patient with multiple health issues can include specialists,

subspecialists, surgeons, teaching attending physicians, medical residents, hospitalists and various allied healthcare professionals. In addition to hospital care, patients may be receiving hospice, home health or nursing home care. Coordination of care among the

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many members of a patient's healthcare team depends on thorough documentation that supports adequate communication and a system that ensures coordination. Coordination failures can significantly compromise patient safety. Communication and documentation failures of a few members of the patient care team can expose the entire team to liability risk. This *Claims Rx* will discuss ways that all members of a patient's healthcare team can use communication and documentation strategies to ensure that the patient receives appropriate, coordinated and comprehensive care.

Coordination of Care during Transfer of Patient Care Responsibility

Case Study #1

Allegation: *Inadequate provider-to-provider communication, documentation and hospital coordination of care systems results in the death of the patient.*

The patient, a thirty-seven-year-old man, presented to the emergency room with a severe headache. He was examined by Provider #1 (emergency room physician), who ordered a CT scan of the patient's brain. The scan was reviewed by Provider #2 (radiologist), who saw evidence of a blood clot, but determined it was an old injury and not the probable cause of the patient's current complaints. Provider #2 did not contact Provider #1 with the results; and Provider #1, who transferred the care of the patient to Provider #3 (emergency room physician) at the end of his shift, did not follow up with Provider #2 regarding the results of the scan. Provider #3 determined that the patient needed cardiac catheter evaluation and handed off the care of the patient to Provider #4 (cardiologist). The following day, Provider #4 administered Integrilin® (eptifibatide), a platelet aggregation inhibitor, in preparation for a stent procedure. The procedure was then performed by Provider #5 (cardiologist). While the patient was in the recovery room, he reported an unbearable headache. At this point, Provider #5 reviewed the patient's chart looking for an explanation for the headache. She discovered the radiology report showing that the patient had a blood clot in his brain—a condition that contraindicated the

use of Integrilin® (eptifibatide) due to the risk of brain hemorrhage. Shortly thereafter, brain hemorrhage was diagnosed. Despite efforts to control the bleeding, the patient died. The family sued the hospital and Providers #1 through #5, claiming the administration of Integrilin® (eptifibatide) was below the standard of care and was the cause of the patient's death.

Discussion

The defense of the hospital and various providers in this case was complicated by documentation and communication failures on a variety of levels. In this case, the plaintiffs' attorney had a fairly straightforward case to prove: the hospital had evidence of the patient's brain blood clot history, but despite this he was given a contraindicated medication, which caused the exact result warned against in medical literature readily available to the provider who administered the medication.

Documentation

Provider #1's progress notes were unintelligible. Because of this, when Provider #4 obtained the patient's chart, she had no indication that a CT scan had been performed. As the patient did not know he had a history of blood clots in his brain, informed consent discussions between the patient and Provider #4 did not produce any information that would have dissuaded Provider #4 from using Integrilin® (eptifibatide).

Communication

Communication failures between the providers during the patient's hospitalization significantly compromised this patient's safety and contributed to the difficulties encountered in defending the providers in this lawsuit:

- Provider #1 not only failed to follow up with Provider #2, but he also failed to notify Provider #3 that the CT scan results were pending. Provider #1, who did not fully appreciate how difficult it was for others to read his handwriting, assumed that Provider #3 would follow up.
- Provider #2 failed to directly report the results of the CT scan to anyone. Had he done so, Provider #1

or #3 may have had an opportunity to communicate the findings (either verbally or through the progress notes) to Provider #4 prior to the Integrilin® (eptifibatide) administration.

In cases like this, responsibility for a patient's care changes hands multiple times each day during a hospitalization. Each time a hand-off occurs, valuable information can be lost. Consequently, providers should be particularly vigilant during these periods to ensure that subsequent providers have information that adequately informs them about the patient's care, treatment and services, condition and any recent or anticipated changes.

System Errors

Few adverse events can be entirely attributed to individual provider error.¹ At the same time, few adverse events can be entirely attributed to system errors.¹ Although failures in provider communication and documentation were significant causative elements in this patient's death, defense of the hospital was difficult because it had no system in place that would ensure that Provider #4 had the results of the CT scan (ordered by Provider #1) prior to determining that the patient was an appropriate candidate for Integrilin® (eptifibatide).

Ensuring Coordination of Care during Hand-Off

The foregoing case highlights how lost information during transfer of professional responsibility between providers during a shift or service change can have devastating results for a patient. Effective January 2006, the Joint Commission required that hospitals have a standardized protocol for hand-offs (Patient Safety Goal 2E) that allows for each caregiver to ask questions. Implementation Expectations for Requirement 2E include:⁵

- **“1. Interactive communications”**
Unlike the case presented above, this implementation expectation would require providers to go a step beyond communicating information about

patients through the progress notes. Interactive communication requires not only that providers be good reporters of a patient's health information, but also that they be engaged listeners.

- **“2. Up-to-date information about the patient's care, treatment and services, condition and any recent or anticipated changes”**
Taking a moment to review the patient's chart (for example, determining whether information from specialists is included and following up when it isn't) and making notes of significant information for reference during the hand-off is a way to optimize the exchange of this information.
- **“3. A process for verifying the received information, including repeat-back or read-back”**
For example, a registered nurse who has received a physician's telephone order for a medication change would read back what she recorded and planned to administer to the patient.
- **“4. An opportunity for the provider receiving the patient to review the patient's historical medical data”**
- In the foregoing case, had Provider #3 reviewed the progress notes with Provider #1 at hand-off in the emergency room, he could have asked Provider #1 to decipher his handwriting, which may have prompted a conversation about the occurrence of the CT scan and the fact that the results had not been received.
- **“5. Limitation of interruptions during hand-off”**
Hand-off should occur in an environment that is conducive to effective communication, for example, a quiet, closed room.

Coordination of Care between the Primary Care Physician (PCP) and the Hospitalist

Case Study #2

Allegation: Lack of coordination of care resulted in the PCP and hospitalist failing to recognize the clinical signs and

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symptoms of acute glomerulonephritis (a relatively rare cause of acute renal failure accounting for about five percent of cases). As a result, the patient developed end stage renal disease, which necessitated kidney transplant.

The Event:

The patient, a fifty-year-old man, was treated by Provider #1 (PCP), for nearly one year. Over the course of the year, Provider #1 treated the patient for a variety of conditions. During this year, Provider #1 referred the patient to Provider #2 (orthopedic surgeon), who performed knee surgery at Hospital #1. A urinalysis done at admission showed protein and blood in his urine. The urinalysis results were not sent to Provider #1.

Shortly after the surgery, the patient returned to Provider #1 because of a swollen right leg, vomiting, diarrhea, extreme fatigue and brownish urine. Provider #1 suspected deep vein thrombosis (DVT), and immediately referred the patient to Provider #3 (vascular surgeon). A urinalysis ordered by Provider #1 showed both protein and blood in his urine. Provider #1 suspected a urinary tract infection, but did not provide any medication to the patient. Instead, she referred the patient directly to Provider #3 for further management.

Provider #3 diagnosed DVT based on the results of a Doppler ultrasound. The patient was admitted to Hospital #2 through the emergency room, where his care was then transferred to Provider #4 (hospitalist). In addition to the DVT symptoms, during the medical history taken by Provider #4 the patient reported abdominal pain for two weeks, night sweats, difficulty swallowing and increased frequency of urination. He also reported a family history of blood clots and kidney disease. Provider #4 ordered blood tests, urinalysis and urine culture. The blood test results were: hemoglobin 10.5, white blood cell count 14.4 thousand, platelets 638,000, potassium 3.6, creatinine 1.6, glucose 113, 62 percent Neutrophils and BUN 15. Urinalysis showed blood and protein in his urine. (Of note, the

patient's creatinine had increased from 0.9, which was recorded at Hospital #1 prior to the patient's knee surgery. Provider #4 did not have access to those results.) A repeat Doppler ultrasound was obtained which showed no evidence of DVT. Provider #4 diagnosed DVT (charting that the patient's symptoms were consistent with DVT, despite the results of the ultrasound) and UTI. He prescribed heparin drip and Levaquin® (levofloxacin). On the day of the patient's discharge, Provider #4 received the results of the urine culture, which showed 40,000 organisms per ml. The patient was ultimately discharged with a prescription for Coumadin® (warfarin) and Levaquin® (levofloxacin) and instructed to follow up with Provider #1 to monitor his anticoagulation levels (UTI follow up was not included in the instructions) and Provider #3 to follow the DVT. Provider #4 copied Providers #1 and #3 on the discharge summary.

The patient returned to Provider #1 after the hospitalization to have his anticoagulation levels checked—they were within the therapeutic range for treatment of DVT. After this visit, Provider #1 went on vacation and transferred the care of the patient to Provider #5 (nurse practitioner). Two weeks later, the patient was examined by Provider #5. The patient complained of hot and cold flashes, dizziness, vomiting and blood in his urine and stool. Provider #5 noted that the patient was very pale and his abdomen was tender with no rebound. His urine and stool samples were both positive for blood. Provider #5 immediately transferred the patient to Hospital #2, where he was ultimately diagnosed with renal failure.

The patient filed a professional liability lawsuit against Hospital #2 and Providers #1 through #5, claiming they were negligent for failing to recognize that his symptoms were consistent with acute glomerulonephritis and the delay in diagnosis resulted in his kidney failure.

Discussion

Provider #3 (vascular surgeon) transferred the care of this patient to Provider #4 (hospitalist), who had had

no contact with the patient prior to admission to Hospital #2. In this transaction, the entire focus of the patient's care became the treatment of suspected DVT. Provider #4 did not consider obtaining the patient's records from Provider #1 (PCP), nor did Provider #1 consider sending the patient's records to Hospital #2, as she had transferred the patient's care to Provider #3. Provider #4 had no further contact with the patient after he was discharged, never determined whether his treatment of the UTI was successful and never communicated the need to follow up on the UTI treatment. The only communication Provider #4 had with Provider #1 was his discharge summary. Had Provider #4 and Provider #1 discussed the care of this patient (during and/or after her hospitalization), there is a possibility that either one of them would have been alerted to the patient's documented symptoms which, according to experts, should have alerted them to the possibility of progressive kidney failure.

Plaintiff's Expert's Contentions

Plaintiff's expert testified, among other things, that Provider #1 was obligated to:

- Obtain the patient's medical records from the hospital where the knee surgery occurred to determine whether there was a correlation between the lab work there and the patient's current complaints
- Continue her involvement with the patient's care during the second hospitalization for suspected DVT

The expert also testified that Provider #4 had an obligation to review prior blood work from prior hospitalizations to determine whether the patient's symptoms indicated decreased kidney function.

Although the jury rendered a verdict for the defendants in this case, the defense was significantly complicated by the lack of communication and documentation.

Ensuring Communication between Hospitalists and Primary Care Physicians (PCPs)

A hospitalist's communication and coordination efforts

with both the patient and the PCP are necessary to maintain coordination of care and ensure proper follow up. Patients should be advised of the importance of follow up, and patient instructions should be documented in the medical record. During the patient's hospitalization, the hospitalist and the PCP should maintain open dialogue. Hospitalists are encouraged to notify the PCP of clinical impressions, diagnoses, and treatment and discharge plans to ensure proper follow up. The PCP and the hospitalist should document any communication that occurs between physicians in the patient's medical record.

Communication at Discharge

Once the patient is discharged from the hospital, there is a risk that the patient will be lost to follow up if it is unclear which physician will continue to treat the patient. Generally, the hospitalist "refers" the patient back to the PCP upon discharge, and the PCP assumes responsibility for follow-up care. Although follow-up care generally rests with the PCP, PCPs and hospitalists should be aware that they each may have a responsibility to provide adequate follow-up care.⁶

Ideally, communication between the hospitalist and the PCP at the time of the patient's discharge should occur either in person or by telephone or fax (adhering to confidentiality and HIPAA measures). There should be verification that the faxed document was actually received. The hospitalist's responsibility here is to ensure that the PCP has enough information to provide appropriate care to the patient. Discharge summaries should be promptly provided to the PCP and should include any pertinent information the PCP will need to maintain continuity of care. The patient should also be provided with copies of the discharge summary, test results and consultation reports. That this information was provided should also be documented in both the hospital's and PCP's patient medical record. Including the pharmacist in communications about the patient's medication plan is also recommended; this way, the medical care providers, the pharmacy and the patient all have the same

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current information. This can promote better patient compliance with treatment and reduce the chance of a medication error.

More information about the hospitalist-PCP relationship is available in the November 2003 *Claims Rx* entitled "Hospitalists and Primary Care Physicians: Providing Quality Patient Care While Reducing Liability Risks." Available on the NORCAL website at: www.norcalmutual.com/publications/claimsrx/nov_03.pdf.

Coordination of Care among Multiple Facilities

Case Study #3

Allegation: *Failure to perform a colonoscopy results in delayed diagnosis of colon cancer and the ultimate death of the patient due to a perforated bowel.*

The patient, a thirty-four-year-old woman, presented to Clinic #1 with complaints of weakness, loss of appetite, black stool, diarrhea and sharp knife-like bilateral lower abdominal pain. Provider #1 (general practitioner) arranged for her transportation via ambulance to Hospital #1.

At Hospital #1, a CT scan of her abdomen revealed small bowel distention consistent with resolving ileus versus resolving early partial small bowel obstruction; marked mucosal thickening involving sigmoid colon and distal descending colon suspicious for diverticulitis were also revealed. In addition, an upper endoscopy was performed to determine the source of the black stool. The results were unremarkable. During this first hospitalization, the patient was treated for diverticulitis by Provider #2 (gastroenterologist), who determined that the patient needed a colonoscopy. In his report,

Discharge Summary

Kripalani S, et al. recommend sending a discharge summary to a patient's PCP on the day of discharge. They further recommend that the discharge summary include the following:

- Primary and secondary diagnoses
- Pertinent medical history and physical findings
- Dates of hospitalization, treatment provided, brief hospital course
- Results of procedures and abnormal laboratory test results
- Recommendations of any subspecialty consultants
- Information given to the patient and family
- The patient's condition or functional status at discharge
- Reconciled discharge medication regimen, with reasons for any changes and indications for newly prescribed medications
- Details of follow-up arrangements made
- Specific follow-up needs, including appointments or procedures to be scheduled, and tests pending at discharge
- Name and contact information of the responsible hospital physician¹

¹ Kripalani S, LeFevre F, Phillips O, Williams M, Basaviah P, Baker D. 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.

he recommended that it be done on an outpatient basis at a gastroenterology group.

Two weeks later, the patient presented to Clinic #2 with the same complaints. Provider #3 (general practitioner), who did not obtain the records from Hospital #1, was not aware of the gastroenterologist's recommendations for a follow-up colonoscopy. Provider #3 recommended that the patient continue with her medications. He also requested an abdominal CT scan. The CT scan was performed at Clinic #3. It was interpreted to show bowel wall thickening and edematous or inflammatory change. The impression was sigmoid colitis.

The patient returned to Clinic #2 the next week with continued complaints of abdominal pain, constant diarrhea and weakness. She was examined by Provider #4 (general practitioner). She had a weight loss of 10 pounds and loss of appetite. An ECG was performed that revealed sinus tachycardia. A colonoscopy was scheduled at Surgery Center #1. However, this colonoscopy was cancelled by Surgery Center #1 because of the tachycardia.

Two weeks later, the patient presented via ambulance to the emergency room at Hospital #2 with complaints of severe abdominal pain, severe weakness, extreme diarrhea, weight loss and loss of appetite. Provider #5 (emergency room physician) noted that the patient had not had a colonoscopy.

The patient was examined by and admitted to the hospital under the care of Provider #6 (hospitalist). Provider #6's impression following examination was generalized weakness and dehydration. Provider #6's plan was to start Flagyl® (metronidazole) IV, Levaquin® (levofloxacin) and oral vancomycin; order a panculture; monitor the leukocytosis; and monitor her abdomen due to the history of diverticulosis. She also discussed the case with Provider #7 (hematologist/oncologist), as she thought it was unlikely that an infection was causing the patient's high white blood cell count.

Provider #7 noted that the white blood cell count was probably a reaction to acute infection. He therefore ordered a CT scan of the abdomen and pelvis. He also requested an infectious disease consult to determine how the antibiotics regimen should be adjusted for the patient's condition.

On her third day of hospitalization, the patient suffered a hypotensive episode. She was started on dopamine and Levophed® (norepinephrine bitartrate). Her condition improved. The patient's high white blood cell count also improved until it was within normal limits. Her dopamine was discontinued and she was discharged to Rehabilitation Center #1 in stable condition.

The next week, she was emergently transferred back to Hospital #2 with very low blood pressure, signs and symptoms of septic shock and a suspicion of bowel obstruction. She was admitted by Provider #6, who ordered an abdominal CT scan. The scan revealed a soft tissue mass in the sigmoid colon/descending colon junction. Neoplasm was suspected. The patient was taken into surgery for tumor resection and colostomy placement. The mass was determined to be malignant, and it was further determined that the tumor had perforated the patient's bowel. The patient died the next week of septic shock due to the perforated bowel.

The patient's family sued the various providers and healthcare facilities. They alleged that the providers and facilities fell below the standard of care by failing to ensure that the recommended colonoscopy was performed on the patient who presented on several occasions with complaints of symptoms indicating colon cancer. They further alleged that had a colonoscopy been performed, the cancer would have been discovered prior to perforation of the bowel.

Discussion

This entire lawsuit focused on a colonoscopy recommendation that "fell through the cracks" on more than one occasion. Numerous opportunities

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for follow up on the colonoscopy were missed along the chain of providers.

Referral Follow Up

Coordination of care in this patient's case was complicated due to her extreme illness and the sheer number of providers and facilities she visited over the course of a few months. However, somewhere along the course of treatment, had one of her multiple providers followed up on the colonoscopy recommendation, this patient might have survived. Providers who make referrals for tests or treatment are encouraged to either personally follow up or confirm that a PCP is going to take responsibility for following up on treatment recommendations. The referring physician should also inform the patient of the importance of following medical advice and the risks of not receiving follow-up

care. All follow-up efforts should be documented in the patient's medical record.

Coordination of Care and the Elderly Patient

Geriatric patients frequently suffer from a variety of chronic conditions that are treated at multiple facilities. Vigilance on the part of the patient's PCP or another care coordinator relative to new diagnoses, new study results, new treatment plans, medication interactions, medication side effects and contraindications is a significant aspect of coordination of care for an elderly patient. Inadequate communication between PCP/patient coordinator, consultants, hospitals and nursing homes during provider and facility transitions can significantly decrease patient safety, can be frustrating to both the patient and healthcare providers and can increase liability risk.

Coordination of Care

Focus on Early Stage Breast Cancer Patients

The risk of breast cancer recurrence continues throughout a patient's life. Optimal treatment of early-stage breast cancer often requires several physicians to effectively coordinate care in an outpatient setting. Studies indicate that coordination failures contribute to the underuse of effective therapies.¹ Inadequate communication among providers on the patient's healthcare team not only puts the patient at risk for delayed diagnosis of cancer recurrence, but also exposes the members of the healthcare team to liability risk. A variety of strategies is appropriate for early-stage breast cancer coordination of care, including the tracking of referrals, patient support groups, regularly-scheduled multidisciplinary meetings, feedback of performance data to providers, use of protocols, computerized systems and treatment at a single physical location.¹ Providers following early stage breast cancer patients are encouraged to ensure effective documentation and communication between the various members of the patient's healthcare team using the strategies outlined in this *Claims Rx*.

The American Society of Clinical Oncology "2006 update of the breast cancer follow-up and management guidelines in the adjuvant setting" is available on the National Guidelines Clearinghouse website at: www.guidelines.gov/summary/summary.aspx?doc_id=9908&nbr=005304&string=breast (accessed 8/17/2007).

¹ Bickell N, Young G. Coordination of Care for Early-stage Breast Cancer Patients. *Intern Med*. 2001 November; 16(11): 737-742.

A 2004 Rand Study entitled “Quality Indicators of Continuity and Coordination of Care for Vulnerable Elder Persons” includes the following recommendations for this population:⁷

1. Patients should be able to identify a provider or clinic that they can call when in need of medical attention.
2. When a provider prescribes a new medication, the medical record at the follow-up visit should document either a) that the medication is being taken, b) that the medication has been discussed with the patient or c) why the medication wasn't started or was changed.
3. When more than one provider is treating the patient, and a new medication is prescribed or a medication is discontinued, the nonprescribing providers should acknowledge the change in their own medical records.
4. When a patient is referred to a consultant, the reason for the consultation should be documented in the consultant's notes.
5. When a patient is referred to a consultant and then returns to the referring provider for treatment, the referring physician should document the consultant's recommendations or should insert the consultant's note in the patient's record within six weeks.
6. If a diagnostic test is ordered, then the medical record at the follow-up visit should document either a) the test result, b) why the test was not needed or c) that the result is pending.
7. When medication is changed during a patient's hospitalization, the change should be acknowledged in the outpatient medical record within six weeks of discharge.
8. If a patient is discharged from the hospital and test results are pending, the outpatient or nursing home records should include the test results within six weeks of discharge.
9. If a patient is discharged from the hospital, he or she should have a follow-up visit or telephone contact with his or her physician within six weeks of discharge and the medical record should acknowledge the recent hospitalization.

10. If a patient is transferred between emergency rooms or acute care facilities, the medical record at the receiving facility should include the medical records from the transferring facility.

11. If the patient is discharged from the hospital, there should be a discharge summary in the primary care, referring physician or nursing home medical record within six weeks.

Although these recommendations are specific to an elderly patient population, many of the recommendations are applicable to patients of any age relative to coordination of care efforts.

Elderly Patients and Health Literacy

The National Adult Literacy Survey showed that elderly patients are one of the patient populations most vulnerable to and affected by low health literacy. The hearing, vision and/or cognition deficits that are more common among this patient population can significantly compromise provider-patient communication. Miscommunication or inability to communicate can lead to missed appointments, failed referrals and medication errors.⁸ Because elderly patients are also at a greater risk for chronic conditions, health literacy deficits can have an even greater impact on quality of care and quality of life.⁹

Strategies for Increasing Patient Understanding

Providers are encouraged to take advantage of strategies that increase comprehension and retention in patients with health literacy deficits. Leading health literacy researchers recommend testing for health literacy when taking vital signs. Weiss et al. conducted a study which ultimately endorsed a literacy test available in both English and Spanish that is designed to quickly assess literacy without disrupting patient scheduling.¹⁰ The test can be downloaded for free at www.newestvitalsign.org and can be administered by a medical assistant while taking other vital signs. The test is based on the patient reading an ice cream label. The patient is asked to determine total calorie count and whether or not a person with a peanut allergy could

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eat the ice cream based on ingredients. Although simple, the test can identify whether or not the patient can read, do simple math (important for calculating doses for medicine) and use abstract reasoning.

Weiss offers the following six steps to improve communication with patients whose health literacy is limited:¹⁰

1. Speak slowly and spend a small amount of additional time with each patient.
2. Use plain, nonmedical language.
3. Show or draw pictures, which can improve the patient's recall of ideas.
4. Limit the amount of information provided to pertinent tasks at hand. Repeat the information to enhance recall.
5. Confirm the patient's comprehension by asking them to repeat back your instructions.
6. Create a shame-free environment by making patients feel comfortable asking questions. Enlist the aid of others (patient's family and/or friends) to promote understanding.

Additional health literacy information is available in the July 2006 *Claims Rx* entitled: "Health Literacy: A Prescription to Reduce Claims." Available on the

NORCAL website at: www.norcalmutual.com/publications/claimsrx/jul_06.pdf.

NORCAL also recommends the "Health Literacy: Help Your Patients Understand" educational kit developed by the American Medical Association Foundation. This kit is the AMA's primary tool for informing physicians, healthcare professionals and patient advocates about health literacy. Kits can be purchased on an individual basis through the AMA Bookstore or by calling (800) 621-8335. The kit is AMA Bookstore Item #0P221007.

Conclusion

More effective coordination of inpatient care results in lower inpatient morbidity and mortality and higher patient satisfaction. More effective coordination of outpatient care is associated with patient feelings of medical well being and greater receipt of preventive services.¹¹ Although coordination of care can be complex and challenging, increased patient safety and reduced liability risk make it a significant concern for all healthcare providers. ■

Special Thanks to Patricia Daebnke, Esq. of Bonne, Bridges, Mueller, O'Keefe & Nichols for her assistance with the case studies in this edition.

Notes

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² Reason J. Human error: models and management. *BMJ* 2000; 320:768-70.

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⁹ Jenkins L., Baldi S. The national adult literacy survey. Washington, DC: Department of Education. 1992.

¹⁰ Weiss BD. American Medical Association Foundation and American Medical Association. *Health Literacy: A Manual for Clinicians*, 2003. (Table 13, Page 27).

¹¹ Bickell N, Young G. Coordination of care for early-stage breast cancer patients. *J Gen Intern Med*. 2001 November; 16(11): 737-742.

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Coordination of Care: Communication Is the Key to Success

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