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PRF NEWS

Covering Practice and Risk Management Issues for Health Professionals www.prfrrg.com · (415) 332-3041

Patient Sign-outs and Hand-offs

BY JAMES HERSHON, MD

"What we've got here is failure to communicate"
—Cool Hand Luke, 1967

Whether it be from surgeon to intensivist, intensivist to hospitalist, hospitalist to primary care physician, obstetrician to obstetrician, or resident to resident, hand-offs and sign-outs that transfer patient care responsibility from a "sender" to a "receiver" are a routine, ubiquitous, and mundane daily occurrence in medical practice.

Yet a 2015 U.S. survey of almost 24,000 malpractice cases arising from hospitals and medical practices concluded that a failure to communicate was at least partially responsible for almost a third of all malpractice claims. Chillingly, these claims represented over 1,700 patient deaths and 1.7 billion dollars in malpractice costs.

NEED FOR A STANDARDIZED HAND-OFF PROCESS

The Provision of Care chapter of the Joint Commission accreditation manual requires that "During transitions of care, there must be a *process* in place to ensure coordination of care among care providers . . . (which) provides for the opportunity for discussion between the giver and receiver of patient information." The Joint Commission has created an infographic with tips for quality hand-offs, which is shown on page 2. The infographic is part of Sentinel Event Alert Issue 58 at www.jointcommission.org.

HOW AND WHERE TO HAND-OFF

- The hand-off should be verbal as well as written and should be conducted in a location that is free from non-emergency distractions or interruptions.
- In a critical care or surgical setting the verbal hand-off may be held at the patient bedside where nursing questions or last-minute clinical developments can be addressed.
- All medical team members should be included, and, if appropriate, the patient and family. This time can be used to consult, discuss, and ask and answer questions.
- Do not rely only on patients or family members to communicate vital information on their own to receivers.
- If a face-to-face hand-off is not possible, communicate by telephone or video conference.

WHAT TO INCLUDE IN THE HAND-OFF

- Identify the most important information that needs to be communicated, i.e., everything needed to safely care for the patient in a timely fashion.
- If information is coming from several sources, organize and communicate it all at one time, rather than individually.
- At a minimum, be sure to communicate:
  - The sender's contact information
  - Allergy list
  - Code status
  - Medication list
  - Dated laboratory tests
  - Dated vital signs
  - Illness assessment, including severity
  - Patient summary, including events leading up to illness or admission, hospital course, ongoing assessment, and plan of care
  - To-do action list
  - Contingency plans

TOOLS TO ASSIST WITH HAND-OFFS

There are a number of standardized forms, templates, checklists, protocols, or mnemonics for written hand-offs. For example, one of the mnemonics is called **I-PASS**. A 2014 multicenter study published in the NEJM found that implementation of this particular mnemonic resulted in a significant 30 percent reduction in the medical error rate.

- "**I**" stands for Illness severity (stable, unstable, code status, etc.)

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Hand-Offs *(continued from page 1)*

- "**P**" stands for Patient summary (a brief history and treatment plan).
- "**A**" stands for Action list (important "to do" tasks like following the hematocrit of a bleeding patient).
- "**S**" stands for Situation awareness (contingency plans like "transfuse if the hematocrit falls below 30").
- "**S**" stands for Synthesis (the opportunity for the receiving and sending physicians to discuss any questions and clarify any issues).

TAKE-HOME MESSAGE

Miscommunication in the medical arena can (and does) lead to preventable medical errors that can have catastrophic consequences for patients. In 2017 the Accreditation Council for Graduate Medical Education found that more than two-thirds of clinical learning environments still did not have a standardized hand-off process. Standardized hand-offs are a demonstrated way to reduce morbidity and mortality due to preventable errors, reduce medical malpractice lawsuits, and safeguard patient health and well-being. ■

Dr. Hershon, a PRF insured, is an intensivist, pulmonologist at CPMC with a special interest in post-surgical care, circulatory support, and transplantation. He is a founding partner of the San Francisco Critical Care Medical Group.

Transgender Care 101

BY HEIDI WITTENBERG, MD

In just the last three years, an American Olympic Gold-medalist announced her new gender identity and appeared on the cover of *Vanity Fair* (Caitlyn Jenner), a film about gender confirmation surgery was released (*The Danish Girl*), and an openly transgender woman won an Emmy (Laverne Cox) while another won election to the Virginia state legislature (Danica Roem). Regardless of President Trump's proposed transgender military ban and rescinding transgender student bathroom rules, it is clear that increasing national recognition of transgender individuals represents a social phenomenon that is both cultural and political.

Despite this emerging awareness and acceptance, from a health perspective, the estimated 1.4 million Americans who identify as transgender represent an underserved population that continues to suffer from stigma, discrimination, and a lack of coverage and access to health care.

MENTAL HEALTH VULNERABILITIES

While increasing public familiarity will likely reduce feelings of stigma and isolation in the long term, at present transgender individuals suffer high rates of life-threatening mental health conditions, particularly substance abuse and depression.

- 29 percent suffer substance abuse (a 3-fold greater incidence than the general population)
- 41 percent have been diagnosed with clinical depression
- 40 percent have ever attempted suicide
- 10 percent have attempted suicide within the last 12 months

In parallel with these daunting statistics are some observations that offer considerable insight into how familial and medical recognition can ameliorate these vulnerabilities. For example:

- 80 percent of transgender children and adolescents have thought about suicide or have attempted suicide if their parents were not supportive—but less than 4 percent if their parents were supportive
- Issuing identification documents that correspond to the individual's gender identity can prevent 230 suicides per 1000 patients
- Access to hormone therapy decreases suicidal ideation by 48 percent.

IMPROVING ACCESS TO HEALTH CARE

Unfortunately, the health care setting itself can be a barrier for transgender people seeking medical care. Just under a quarter of transgender patients report having to teach their provider about being transgender and 15 percent report having been asked unnecessary and intrusive questions about their status as a trans person. Although far less frequently, patients still report being abused, assaulted, harassed, or refused care for being transgender.

SPECIFIC STEPS

- Be willing to see transgender patients. While you feel you may not be adequately equipped, most trans patients realize that there are not many actual specialists in transgender care.
- Better understand the components of an individual's identity/experience.
  - Gender identity is one's internal. sense of feeling of being a woman, man, another gender, or a combination that is irrespective of physical or anatomic appearance.
  - Gender expression is a person's external manifestation of femininity and/or masculinity.
  - Sexual identity refers to the male or female classification of individuals that is assigned at birth.
  - Sexual orientation refers to an individual's enduring physical, romantic attraction to another person.
  - Emotional orientation refers to an individual's emotional/spiritual attraction to another person.
- Learn how to address trans patients in person, on the phone, in registration forms, and in the EMR.
  - Even in an OB/GYN office, do not assume that your patients want to be addressed as she/her/hers and that their partners are male.
  - Train yourself and staff to ask for their preferred name and the pronouns by which they want to be addressed. This may be different than ID and insurance cards.
  - The easiest option is to always refer to someone by their name.
- Registration forms need to have additions:
  - Name you prefer to be called.
  - Pronouns you identify with: (she/her/hers); (he/him/his); (they/them/theirs); (Other____)
  - If appropriate for the specialty: Partner: Male, female, non-binary or other
- Become familiar with the World Professional Association for Transgender Health (WPATH) Standards of Care for Health of Transsexual, Transgender, and Gender Nonconforming People. WPATH creates and frequently updates evidence-based standards of care to help guide health professionals in caring for transgender individuals. There are also now a multitude of transgender conferences, and 2017 had its inaugural U.S. WPATH conference.

TRANSGENDER SURGERY

Many patients are beginning to seek out

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PRF HAS MOVED

Effective December 1, 2017, the offices of Physicians Reimbursement Fund, Inc. have moved. Please note the new address and phone/fax numbers:

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The Basics of Arbitration Agreements

BY ALAN SPARER, JD

Except in an emergency situation, an arbitration agreement should be signed at the first encounter with every new patient. For emergencies, the arbitration agreement should be signed as soon as the patient is no longer under medical duress. Because the doctor-patient relationship is established by the initial visit and usually involves ongoing care, many PRF physicians politely decline to see any new non-emergency patient unless the agreement has been signed. If a new patient is reluctant to sign, it is possible to see the patient with the understanding that an arbitration agreement will need to be signed at the next appointment. But as a legal matter, the arbitration agreement will not cover any visit that occurs before it is signed.

Patients have the right to rescind the arbitration agreement in writing within 30 days of signing, although such rescission rarely occurs. The arbitration agreement applies to all those who provide medical services to the patient who are health care providers and staff within a defined medical group, as well as those outside the group who render services by arrangement with the group. PRF provides arbitration forms free of charge. Because there are special legal requirements for the appearance and formatting of the agreement, it is best practice to have the forms specifically printed with the provider/practice name on all the pages. This is done for a nominal charge.

PRF updates the arbitration agreement forms from time to time. If there are important changes, PRF will notify its members so that existing patients can sign the new form on their next visit. Otherwise, there is no obligation to have an existing patient sign a new form at later visits. But a good rule of thumb is to have patients sign a new form if they have not been seen for an amount of time that would treat them as a new patient under current billing practices. Should any patient transfer their care to another provider within the group, it would also be wise to have a new arbitration agreement signed to highlight that the patient has agreed to arbitration with his or her new physician. ■

. . . a good rule of thumb is to have patients sign a new form if they have not been seen for an amount of time that would treat them as a new patient under current billing practices.

Alan W. Sparer, JD, of the Law Offices of Alan W. Sparer, is the corporate counsel for PRF. He has been working with PRF since 1982.

Transgender *(continued from page 3)*

surgical care to aid in their transition, though not all transgender individuals want gender confirmation surgery. Most surgeons follow the WPATH guidelines to determine eligibility for surgery, which include persistent, well documented gender dysphoria and the capacity to make a fully informed decision for and consent to treatment. The individual has to have lived the gender role they identify for at least 12 continuous months.

Transgender surgery involves a multitude of options. Patients may have "top surgery" in which the chest is surgically shaped to conform with the gender identity of the patient. A patient may also elect to have "bottom surgery." For female-identified patients this may include surgical creation of a vagina and for male-identified patients, the creation of a phallus from existing genital tissue or with a skin graft.

MOVING FORWARD

As more patients who identify as transgender are empowered to seek out care, insurance companies are starting to cover transgender-related health services including hormone therapy and mental health services. Encouragingly, most California plans have coverage and those that do not are under legislative pressure to cover these services.

As providers we can create an inclusive, supportive environment for transgender patients to welcome them from the first contact with the office throughout the entire visit. For most of their care, you would treat them as you would any of your patients whose gender is the same as their sexual identity. ■

A PRF insured, Dr. Wittenberg is board-certified in Female Pelvic Medicine and Reconstructive Surgery. She has had further training in gender confirming surgery and helped start MoZaic Care, a gender confirming surgical group.

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