Safety issues and pain points pertaining to clinical systems at transitions of care

Discussion paper
Contents

Introduction 3
Key concepts 4
  Pain points 4
  Transitions of care 4
  The primary:acute care interface 4
Pain points in transitions between the primary care and acute sectors 7
  Quality of referral communication 7
  Admission processes 7
  Pain points at discharge 8
Specific pain points 9
  Discharge summaries 9
  Medication-associated pain points 11
Indicators of increased patient risk at transition 12
Improving transitions 12
  Referral 12
  Discharge 13
  The My Health Record system 14
Appendix - Pain points associated with readmission to hospital following discharge 15
Introduction

This discussion paper supports a project being undertaken by the Australian Commission on Safety and Quality in Health Care (the Commission), on behalf of the National Health Chief Information Officers' Forum. The project aims to identify safety issues and pain points pertaining to clinical information systems at transitions of care between the acute and primary care sectors, with a particular focus on pain points affecting patients with chronic and complex needs.

The Commission has engaged Clayton Utz to:

- Review the literature
- Consult with stakeholders
- Identify safety issues and pain points pertaining to clinical systems at transitions of care
- Develop priorities for improvement, with a focus on the information interface between the acute and primary care sectors.

This discussion paper will form the basis for consultation at three stakeholder workshops to be conducted in:

- Melbourne (24 August 2017);
- Brisbane (30 August 2017); and
- Perth (1 September 2017).

The discussion paper should assist readers to prepare for their participation in one of the project workshops. It includes a number of questions designed to prompt reflection. Not all discussion points, however, will be addressed at all workshops.
Key concepts

Pain points

For the purpose of this project, a ‘pain point’ has been defined as a problem with the delivery of health care and/or the transfer of health care information that affects, or has the potential to affect, the safety of patient care.

Transitions of care

Many patients, particularly those with chronic conditions, receive care from multiple healthcare professionals and services.

A ‘transition of care’ occurs when a person moves between levels of health care or across health care settings.

It is likely that patients expect continuity of care, and smooth transitions between the boundaries of care1,2. From a patient perspective, the Picker Institute reports patients ‘falling through gaps’, ‘being forgotten about’ or ‘having to explain yourself to every professional or service you encounter’3. Patient experience surveys provide valuable insights into how effective movement across the boundaries of care can be perceived by patients.4 5 6

An optimal transition should be well-planned and adequately timed. However, transitions of care do not always proceed smoothly. Many pain points at transition of care are associated with poor communication and incomplete information sharing between health care providers. This is a recurring theme in studies describing reasons for fragmented care across service boundaries7.

Transitions of care are associated with a relatively high rate of adverse events, many of which are preventable8.

The primary:acute care interface

There are numerous and often complex pathways between the primary care and the acute hospital sectors in Australia. (Figure 1).

2 Walsh et al. What are the current barriers to effective cancer care coordination? BMC Health Services Research 2010; May 20.
6 Walsh et al. What are the current barriers to effective cancer care coordination? BMC Health Services Research 2010; May 20.
Patients who are treated in hospitals may:

- Have one or more pre-admission primary care providers (or may not be linked into the primary care system at all)
- Be formally referred to hospital by a primary care provider (or may be informally referred, or self-referred)
- Be treated by a private specialist or sub-acute care provider or have pathology and/or medical imaging investigations during their transitions between the primary care and acute systems
- Not follow a linear pathway as they move through the health care system.

When a patient moves between the primary care and acute sectors they move between levels of care and (usually) across health care settings. Each movement is associated with transfer of responsibility between health care providers for some or all aspects of the patient’s care.

Some patients also:

- Move across jurisdictional boundaries when they move between the acute and primary care sectors. Between 1 July 2004 and 30 June 2009, more than 220,000 patients travelled across a state border to attend hospitals. A further 48,575 patients moved their place of residence interstate between hospital visits, and there were more than 11,000 cross-border hospital transfers.  

- Move to a primary care destination in which there is limited availability of technology to support information exchange, such as in remote or rural Australia.

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Hospital discharge is one of the highest risk transition periods for patients\textsuperscript{10, 11}. Research indicates that a patient’s transition from hospital care to the care of their general practitioner (GP) carries significant risk of unforeseen adverse effects, including emergency department re-admissions, disability and death.

According to a comprehensive Canadian study of patient outcomes following discharge from hospital, an estimated 23% of patients discharged to the community experienced an adverse event, the most common of which were adverse drug events (72%) followed by therapeutic errors (16%) and nosocomial infections (11%). Approximately 50% of adverse events were preventable, a large percentage of these by better and more timely communication of essential patient information between providers\textsuperscript{12}.

### Discussion points

1. Which pathways/interfaces between the primary care and acute sectors are associated with the most significant patient safety risks in Australia? Are there additional risks associated with rurality and/or cross/jurisdictional movements? What is the current or potential effect (positive or negative) of clinical information systems on those safety risks?

(see the Appendix to this paper for a list of common pain points at transitions of care)


\textsuperscript{12} Forster A. Adverse events among medical patients after discharge from hospital. CMAJ 2004; 170: 345-9.
Pain points in transitions between the primary care and acute sectors

Quality of referral communication

Patients may be referred across health sector boundaries by doctors, nurses or other healthcare professionals. Many patients self-refer to hospital emergency departments from the community.

When a referral is made by a healthcare professional, properly constructed referral content can impact positively on the safety of care, and on patient experiences and satisfaction.

In spite of the recognised importance of good communication in transitioning patients between services, there is a lack of studies exploring communication between primary care and hospital clinicians prior to admission or during emergency department visits.

A project undertaken in Victoria used a standardised audit tool to assess the quality and appropriateness of primary care referrals to public hospital specialist clinics. Clerical information was generally considered adequate.

3.8% of referrals were considered inadequate with respect to clinical information, requiring follow-up with the referring clinician before the referral could be triaged. GPs generated higher quality referrals than other primary care providers.

Discussion points

2. How commonly do poor quality referrals significantly impair patient safety at the primary care/acute interface in Australia? What are the underlying causes of poor quality referrals from primary care providers to hospitals? What is the current or potential effect (positive or negative) of clinical information systems on safety risks at that interface?

Admission processes

Relatively few studies have assessed hospital admission and admission processes, tools and techniques. What is known is that poor admission processes place patients, particularly those who have complex conditions, at risk of harm.

Core components of rigorous admission processes include:

- Accurate patient identification processes, supported with the use of protocols for patient identification
- The detailed recording of pre-existing conditions and medications.

Discussion points

3. How commonly do poor quality admission processes impair patient safety at the primary care/acute interface in Australia? What are the underlying causes of poor quality admission processes? What is the current or potential effect (positive or negative) of clinical information systems on safety risks at that interface?

Pain points at discharge

A study published in 2016\(^\text{16}\) comprehensively identified risk factors associated with readmission following discharge from 12 academic medical centres in the United States of America. These factors appear to generally reflect, and helpfully categorise, those identified in the national and international literature as pain points in transitions from the acute to primary care sectors.

The authors identified the following eight main categories of risk for readmission:

- Discharge planning
- Enlisting help of social and community supports
- Educating patients and promoting self-management
- Coordinating care among team members
- Advance care planning
- Monitoring and managing symptoms after discharge
- Diagnostic or therapeutic problem
- Medication safety.

Discussion points

4. Do the categories identified in the study referred to above correlate with the main categories of pain points at the primary care/acute interface in the Australian context? Are there any missing categories, or categories that are not relevant in the Australian context?

The study referred to above identified sixteen pain points (listed below) associated with statistically significant risks of readmission, which is generally accepted as a key indicator of failed discharge:

1. Inappropriate choice of discharge location
2. Patient discharged too soon from the index hospitalisation
3. Inappropriately long time between discharge and the first follow-up with outpatient healthcare professionals
4. Follow up appointments in general were not sufficiently soon after discharge.
5. Patient required additional or different home services than those services included in discharge plans
6. Inpatient assessment of physical needs (e.g. commode, transportation) was incomplete or missed important patient requirements

7. Patient lacked awareness of whom to contact after discharge or when to go (or not to go) to the emergency department
8. Patient lacked awareness of follow-up appointments or other post-discharge plans.
9. Team did not relay important information to outpatient healthcare professionals.
10. Lack of disease monitoring (e.g. following daily weights, etc.)
11. Patient was not able to keep post-discharge appointments
12. Missed diagnosis during the index admission
13. Inadequate treatment of medical conditions during the index admission other than pain
14. Emergency department decided to admit a patient who may not have required an inpatient stay
15. Patient or caregiver misunderstanding of the discharge medication regimes.
16. Inadequate monitoring for adverse effects or nonadherence.

All pain points identified in the study as associated with risk of readmission, and their assessed significance, are included in a table at the Appendix to this paper.

Discussion points

5. Do the pain points identified above and in the Appendix broadly reflect the pain points experienced at the primary care/acute interface in Australia? Which identified pain points are not relevant to the Australian context? Are there any pain points experienced in the Australian context that have not been identified in the study? Does the relative significance of the pain points identified in the Appendix broadly reflect the Australian experience?

Specific pain points

The literature suggests that lack of effective communication between healthcare professionals is the primary factor that adversely affects post-discharge care transitions\(^{17}\). Medication discrepancies also feature prominently in the relevant literature. We discuss these two pain points in more detail below.

Discharge summaries

At a transition of care, the transferring healthcare professional is required to supply comprehensive, complete and accurate information to the healthcare professional responsible for continuing the patient’s care\(^{18}\). Inadequate information held by or accessible to healthcare professionals and/or patients and their carers is a recurring pain point at the primary care/acute interface.

The usual form of communication between hospital-based and community-based healthcare professionals when a patient is discharged from hospital is the hospital discharge summary.


International and Australian studies concerning discharge summaries have addressed:

- GP satisfaction with the quality and timeliness of electronic discharge summaries
- Audits of the accuracy of, and GP satisfaction with, medications outlined on discharge summaries
- Ranking discharge information options by GPs in order of importance; an
- Examination of the reliability, effectiveness, accuracy and timeliness of information transfer from the hospital to the GP.

A study in Australian general practice found that a high proportion (92%) of discharge summaries had been received by GPs following discharge of a patient from hospital. Mostly, they were of good quality. However, some fields were poorly reported, including tests (performed or pending), referrals, medication and authorship. Timeliness was an issue. Although 77% arrived within five working days, in only 55% of cases were discharge summaries received before the post-discharge consultation.

The fourth clinical safety review of the My Health Record system, conducted by the Commission in 2014, included an end-to-end investigation of the accuracy and data quality of electronic discharge summaries. Although the review verified that the information presented in discharge summaries in My Health Record was transmitted accurately from the source hospital, other findings from the review included:

- Information in the discharge summary varies between settings and is not displayed in a consistent order
- Terminology between the hospital discharge summaries and GP software view is inconsistent in some instances
- The breadth of information presented in the GP software view is not consistent with the information presented in the hospital discharge summaries
- The format of medications information across hospital discharge summary templates and the GP view of the My Health Record discharge summary varies.

A discharge summary is a ‘one-way’ communication tool between primary care and acute care clinicians. The Australian Medical Association (AMA) suggests there should also be dialogue between hospitals and GPs to discuss the patient’s progress and treatment in hospital and to ensure that timely arrangements are made for a transfer of care appointment for the patient with their GP. The AMA suggests, however, that verbal contact during the hospital admission should occur only when deemed necessary.

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Discussion points

6. Does the contemporary experience of primary healthcare professionals reflect the outcomes of the Australian study on discharge summaries reported above? Would access by GPs and other primary care professionals to aspects of the inpatient medical record improve patient safety at the primary/acute care interface? Would standardisation of discharge summary content assist? What is the current or potential effect (positive or negative) of clinical information systems on the quality (especially content and timeliness) of discharge summaries?

Medication-associated pain points

Numerous studies have demonstrated a high rate of adverse medication events following discharge from hospital, with many being preventable or ameliorable and a significant proportion resulting in serious injuries\textsuperscript{24}. One prospective study showed that an estimated 14\% of elderly patients have one or more medication discrepancies at discharge. 14\% of these were associated with re-hospitalisation within 30 days, compared with 6\% of the patients who did not experience a medication discrepancy.\textsuperscript{25}

Adverse events after patient discharge are most commonly associated with medication changes that were made during a period of hospitalisation\textsuperscript{26}. Medication changes are frequently not communicated effectively to patients, pharmacists or GPs\textsuperscript{27}. There is a need to reconcile medication regimens before and after the hospital stay and to improve communication between providers regarding medication use. Practical, effective solutions may include better hospital information systems with order entry and results reporting (known in Australia as electronic medical records or EMRs), and semi-automated discharge summary generation.

Discussion points

7. Does your experience of the adverse medication event rate arising at the primary care/acute interface in Australia reflect the rates quoted above? What are the underlying causes of medication errors at the primary care/acute interface? What is the current or potential effect (positive or negative) of clinical information systems on medication safety risks at that interface?

\textsuperscript{26} Forster A. Adverse events among medical patients after discharge from hospital. CMAJ 2004; 170: 345-9.
\textsuperscript{27} Forster A. Reducing adverse events. CMAJ 2004; 170: 1650.
Indicators of increased patient risk at transition

When a patient moves frequently between service providers, it is more difficult for the patient’s GP to monitor the patient's welfare and identify any risks. When a patient moves rapidly it is often difficult for the receiving service provider to immediately gain a clear understanding of the risks the patient faces.

Service providers in all settings should be alert to the possibility that a patient who comes to their attention may be at higher than usual risk of adverse events associated with the transition. The following circumstances are cause for heightened awareness by the receiving health care provider:

- A patient not having a regular GP
- Social issues including homelessness
- Significant mental health problems
- Severe disability
- Information 'patch worked' across a network of providers with no single provider holding the whole picture of a patient's history.

Discussion point

8. Are there other patient characteristics that point to an increased risk to patient safety at transition of care? What is the current or potential effect (positive or negative) of clinical information systems on safety risks at the primary care/acute interface for high risk patients?

Improving transitions

Referral

A range of approaches to improving referral has been trialled and reported in the peer-reviewed literature:

- Most studies focus on documentation associated with the referral process and how the format, content and quality of referral documentation can be improved. Templates and structured referral forms improve referral quality in some settings (e.g. from GP to emergency department)
- In the UK, the NHS has introduced a referral model where patients may be reviewed by members of a multidisciplinary team, rather than seeing a medical consultant as a first option
- The literature suggests electronic referrals may enhance the speed of the referral process. However, processes are not yet in place for the majority of providers to send and receive high quality, accurate, up-to-date and relevant referral information in a manner that streamlines referral
- There is a paucity of studies of education and training of providers to improve referral communication.

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Discussion points

9. What strategies could be implemented to improve the quality of referrals? Are there information system approaches that would assist?

Discharge

Key elements of an effective discharge include\(^\text{29}\):

- Standard screening tools to identify patients at high risk of readmission with protocols and policies that support the use of tools
- Formal documented discharge planning process with multidisciplinary approach
- Clear role of each multidisciplinary team member identified in the discharge planning process
- Designated nurse/physician for discharge planning as contact point
- Clinical pharmacist for medication reconciliation
- Patient education: medication/treatment, concept of discharge process
- Clear process for communication between acute and community providers
- Availability of a home care support program to facilitate transition period from hospital discharge to home if required.

Studies have evaluated interventions that seek to improve patient discharge from hospital to primary care\(^\text{30}\). Multi-component (rather than single component) interventions are more effective. Effective components include medication reconciliation; electronic tools to facilitate quick, clear, and structured summary generation; discharge planning; shared involvement in follow-up by hospital and community care providers; use of electronic discharge notifications; and web-based access to discharge information for GPs\(^\text{31, 32}\).

Systems specifically tasked with coordinating the patient's care over the period of transition between services have been found to improve continuity of care, hospital use and patient satisfaction and reduce unnecessary primary care use\(^\text{33}\).

A range of interventions has been shown to result in statistically improved coordination of care during transitions, including\(^\text{34}\):

- Organising post-discharge services or follow-up
- Use of discharge planning protocols

\(^{29}\) Wong E. Barriers to effective discharge planning. BMC Health Services Research 2011; September 29.


• Early assessment of follow-up needs and resources before the transition occurs
• Cooperation between hospital-based and community-based nurses for patients with relevant community nursing needs
• GP input into discharge planning
• A comprehensive discharge plan that includes follow-up needs and arrangements, planned appointments and recommended actions in the event urgent attention is required or the patient is uncertain about any aspect of their care plan.

Discussion points
10. Have the standards and guidelines noted above been implemented in all jurisdictions? Have they improved patient safety at the interface between the acute and primary care sectors? Would other standards and guidelines assist to improve patient safety at the interface between the acute and primary care sectors?

The My Health Record system

The *My Health Record* system is the Australian national digital health record system. It contains *My Health Records* which are online summaries of an individual’s health information. It was previously known as a Personally Controlled Electronic Health Record (PCEHR).

A *My Health Record* allows an individual’s doctors, hospitals and other healthcare providers to view the individual’s health information, in accordance with their access controls. Individuals are also able to access their record online.

In most parts of Australia individuals need to actively register for a *My Health Record*.

With the introduction of the My Health Record system, it is expected that healthcare organisations will have faster, easier access to more health information, creating a more efficient system, making continuity of care easier and improving treatment decisions.

Discussion points
11. What opportunities does the My Health Record system offer to improve transitions between the primary care and acute hospital sectors? Are there risks of new pain points arising as a consequence of the My Health Record system? How can those be managed?
12. What other strategies could be implemented in Australia to systematically improve patient safety at discharge from acute hospitals to the primary care sector? Are there information system approaches that would assist?
## Appendix - Pain points associated with readmission to hospital following discharge


<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>No. (%) Preventable (n = 169)</th>
<th>Nonpreventable (n = 731)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge Planning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate choice of discharge location (eg, skilled nursing facility vs home)</td>
<td>35 (13.0)</td>
<td>32 (4.4)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Follow-up appointments were not scheduled before discharge</td>
<td>44 (16.4)</td>
<td>67 (9.2)</td>
<td>.001</td>
</tr>
<tr>
<td>Patient discharged too soon from the index hospitalization</td>
<td>52 (19.3)</td>
<td>29 (4.0)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Inappropriately long time between discharge and the first follow-up with outpatient health care professionals</td>
<td>40 (14.9)</td>
<td>46 (6.3)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Follow-up appointments in general were not sufficiently soon after discharge</td>
<td>43 (16.0)</td>
<td>42 (5.7)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Enlisting Help of Social and Community Supports</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient required additional or different home services than those included in discharge plans</td>
<td>48 (17.8)</td>
<td>57 (7.8)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Patient was not able to access services at home or turned them down after plans were made</td>
<td>14 (5.2)</td>
<td>24 (3.3)</td>
<td>.16</td>
</tr>
<tr>
<td>Patient required additional help from his or her family, caregivers, or friends that was not available or sufficient</td>
<td>44 (16.4)</td>
<td>94 (12.9)</td>
<td>.16</td>
</tr>
<tr>
<td>Patient required community programs (eg, elder day programs, meals-on-wheels) not included in discharge plans.</td>
<td>16 (5.9)</td>
<td>28 (3.8)</td>
<td>.15</td>
</tr>
<tr>
<td>Inpatient assessment of physical needs (eg, commode, transportation) was incomplete or missed important patient requirements</td>
<td>21 (7.8)</td>
<td>13 (1.8)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Educating Patients and Promoting Self-management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient lacked awareness of whom to contact after discharge or when to go (or not to go) to the emergency department</td>
<td>50 (18.6)</td>
<td>42 (5.7)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Patient lacked awareness of follow-up appointments or other postdischarge plans</td>
<td>24 (8.9)</td>
<td>24 (3.3)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Patient or family had difficulty managing symptoms at home</td>
<td>115 (42.8)</td>
<td>249 (34.1)</td>
<td>.01</td>
</tr>
<tr>
<td>Patient or family had difficulty managing other self-care activities at home</td>
<td>59 (21.9)</td>
<td>106 (14.5)</td>
<td>.005</td>
</tr>
<tr>
<td><strong>Coordinating Care Among Team Members</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team did not ensure that the patient had a primary care physician</td>
<td>7 (2.6)</td>
<td>14 (1.9)</td>
<td>.50</td>
</tr>
<tr>
<td>Team did not relay important information to outpatient health care professionals</td>
<td>29 (10.8)</td>
<td>17 (2.3)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Test results ordered by the initial team were not followed up appropriately</td>
<td>3 (1.1)</td>
<td>5 (0.7)</td>
<td>.45</td>
</tr>
<tr>
<td><strong>Advance Care Planning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient nearing end of life but still wants hospitalization and full treatment measures</td>
<td>8 (3.0)</td>
<td>56 (7.7)</td>
<td>.007</td>
</tr>
<tr>
<td>Patient with end-stage illness but palliative care not consulted</td>
<td>17 (6.3)</td>
<td>28 (3.8)</td>
<td>.09</td>
</tr>
<tr>
<td>Patient with end-stage illness and goals of care discussion not documented</td>
<td>20 (7.4)</td>
<td>23 (3.1)</td>
<td>.003</td>
</tr>
<tr>
<td><strong>Monitoring and Managing Symptoms After Discharge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of disease monitoring (eg, following daily weights, etc)</td>
<td>54 (20.1)</td>
<td>76 (10.4)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Patient was not able to be reached for postdischarge monitoring (eg, follow-up telephone calls)</td>
<td>5 (1.9)</td>
<td>9 (1.2)</td>
<td>.45</td>
</tr>
<tr>
<td>Patient was not able to keep postdischarge appointments</td>
<td>44 (16.4)</td>
<td>51 (7.0)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Diagnostic or Therapeutic Problems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missed diagnosis during the index admission</td>
<td>30 (11.2)</td>
<td>28 (3.8)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Inadequate treatment of medical conditions during the index admission other than pain</td>
<td>56 (20.8)</td>
<td>47 (6.4)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Discharge without a needed procedure</td>
<td>15 (5.6)</td>
<td>18 (2.5)</td>
<td>.01</td>
</tr>
<tr>
<td>Inadequate treatment of pain during the index admission</td>
<td>17 (6.3)</td>
<td>14 (1.9)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Emergency department decided to admit a patient who may not have required an inpatient stay</td>
<td>34 (12.6)</td>
<td>19 (2.6)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Medication Safety</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Errors in taking the predimension medication history during the index admission</td>
<td>3 (1.1)</td>
<td>4 (0.5)</td>
<td>.39</td>
</tr>
<tr>
<td>Errors in discharge orders</td>
<td>10 (3.7)</td>
<td>8 (1.1)</td>
<td>.006</td>
</tr>
<tr>
<td>Drug-drug or drug-disease interaction</td>
<td>18 (6.7)</td>
<td>24 (3.3)</td>
<td>.02</td>
</tr>
<tr>
<td>Patient or caregiver misunderstanding of the discharge medication regimens</td>
<td>28 (10.4)</td>
<td>28 (3.8)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Patient or caregiver inability to manage medications or inadequate drug level monitoring</td>
<td>42 (15.6)</td>
<td>67 (9.2)</td>
<td>.004</td>
</tr>
<tr>
<td>Inadequate monitoring for adverse effects or nonadherence</td>
<td>40 (14.9)</td>
<td>32 (4.4)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Inadequate steps to ensure the patient could afford medications</td>
<td>13 (4.8)</td>
<td>10 (1.4)</td>
<td>.001</td>
</tr>
</tbody>
</table>