

INDUSTRY OVERVIEW

Every year, preventable medical errors are responsible for over 200,000 deaths, unnecessary harm to millions of patients, and \$17 billion in direct medical expenses.^{1,2} An estimated 80% of preventable medical errors result from communication breakdowns, which typically occur when data is lost, misplaced, or not transferred to the entire care team in a timely manner.³ Figure 1 provides a representation of the 6 million interactions, commonly referred to as handoffs, that occur between care providers every day. Figure 2 depicts the forensics of a case in which there was an adverse outcome; red indicates instances when communication, which could have averted the error, should have occurred, but did not.

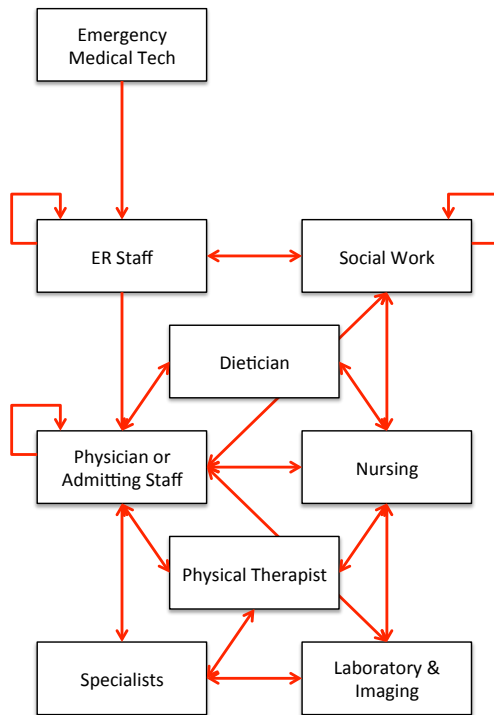


Figure 1: Interactions of the Care Team

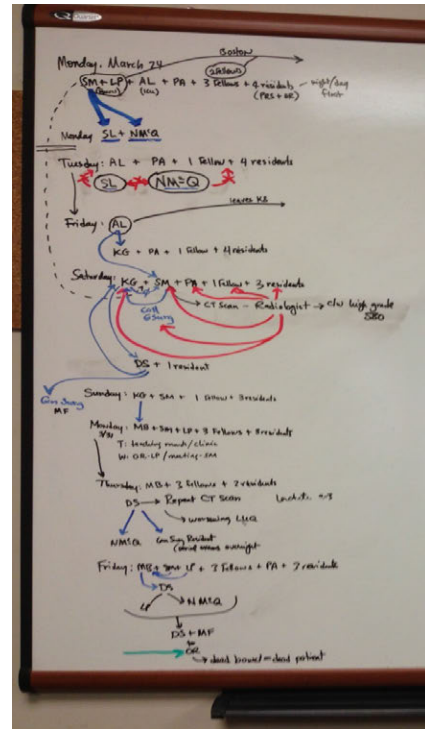


Figure 2: Case Study

As medicine has advanced, so has its complexity: today, care teams operate in complicated networks, in which messages are passed in no particular order, and sometimes the messages being passed contain contradictory information. Despite the increase in the complexity of care teams, the methods used for collaboration have not evolved, and the current standards for communication remain computer printouts, hand written notes, and unsecure, non-compliant text messages. These methods are error prone and under the best circumstances are flawed because they do not enable real-time communication.

¹ James John, PhD. *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*. Journal of Patient Safety. September 2013.

² Anel et al. *The economics of health care quality and medical errors*. Journal of Health Care Finance. Fall 2012.

³ Joint Commission. *Improving Transitions of Care: Handoff Communications*. May 2013.