Welcome to Telligen's High-Risk Medication ECHO® Series: Communication Across the Care Continuum

We will get started momentarily

- Using chat, enter your organization and state
- Please complete the poll

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Project ECHO®

High-Risk Medication ECHO® Series

Session 6 – Communication Across the Care Continuum

April 12, 2023

Guest Speaker: Dr. Gregory Gahm, MD

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QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Project ECHO®

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Begin With the End in Mind

During the presentation, visualize and plan how you will use the information:

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase collaboration within your network to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 and 90 days?

Objectives

- Define ways to collaborate with each other/providers to enhance care coordination for medication prescribing
- Recognize opportunities to build communication using Leadership and Organizing in Action (LOA) framework
- Discover mitigation strategies to build communication across care services

Today's Speaker(s)

Dr. Gregory Gahm, MD

Chief Medical Officer

Vivage Beecan Colorado

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Communication Across the Care Continuum

April 2023

Gregory Gahm, MD

Coming together is a beginning;

Keeping together is progress;

Working together is success.

– Henry Ford

What is Communication Across the Care Continuum?

- Everyone talking to everyone to make sure we all have access to the same information at the same time
- EMRs were ‘supposed’ to fix this problem, but… *did they?*

Case Study – What Happens When We Do an Admit?

- The hospital provider hasn't dictated the discharge summary and/or it didn't come with the patient
- The verifying provider is either not the provider who will be following the patient or the one you speak to is in a hurry
- All parties assume that everyone before them knew the patient's history and medications, so they must be right
- A significant number of patients have no idea what the 5, 10 or 20 drugs prescribed are, when they take them, the dose, *or if they are the ones they were taking before they went to the hospital?*

Sound familiar?

Is There a Way to Fix This?

- Sadly, no… because we can't stop everyone from being in a hurry or control what everyone else does, but…
- We can improve it! *How?*

Improved Communication Improves Outcomes

These are not all the possibilities, but perhaps some of the following is a place to start.

1. When admitting a patient, look for the **discharge summary**. If it isn't there, check COHRIO (Colorado's hospital EMR) or its equivalent in your state OR call the hospital to ask for it to be sent immediately *(before verifying orders).*
    - *When it doesn't come, call to verify orders, but maybe the hospital will get the message if we don't stop asking*

Improving Communication

2. When verifying orders, start with the **diagnoses**, not the drugs.
   - *If there are medications that don't fit one of the diagnoses, it is probably not a necessary medication that was added for unnecessary reasons, e.g., a sleeper, antipsychotic, PPI, benzodiazepine…*

Improving Communication

3. As you verify **medication orders**, pause to get an accurate diagnosis for each one.
4. If the provider does *not* know why a drug is ordered, ask if it can be ordered for three days only with clarification by the provider who will be following in the NH on the next business day.
    - *Include an order for a F/U call on day three if the provider doesn't address it*

Improving Communication

5. Pharmacy is supposed to do a review in the first 24 hours to see if there are questionable or dangerous medications.
   - *Hold them to it; develop a system to routinely follow-up by documenting the reviewing pharmacist's name and their questions/observations/conclusions;*
   - *Build a QI system to make sure the provider immediately addresses it (may require your Medical Director to intervene)*

Improving Communication

6. Ask your Medical Director to let providers know that person-to-person communication between themselves and the hospital provider is a **routine** expectation.
   - *A brief call answers more questions than 30 minutes wading through copy/pasted, lengthy chart notes*
   - *If everyone did it, hospitalists might start making the calls themselves in advance of a transfer…*

Improving Communication

7. When sending a patient back to the ER or hospital…

   what if…

   - **Nurses and Providers** were expected to call the hospital or ER to let them know in advance why the patient was coming?

     (Oh… and document that they did so)

Improving Communication

8. When approaching discharge…
   - Social workers/nurses call home health, DME, transportation, families… *what if…*
   - The patient's pharmacy was identified with prescriptions sent or called in advance; and
   - **Providers were expected to call the community physician(s) who would be assuming the patient's ongoing care?**

What is the Key to Improving Communication?

Getting people to talk to each other again.

The principles described for an admit can be applied to everything else we do… *imagine if…*

- Providers called consultants before and after visits
- Providers and their midlevels routinely coordinated care on their patients
- Pharmacists and providers spoke when there were questions
- Providers were required to attend PsychPharm meetings (I require this)
- Providers, social workers, therapists and nurses talked to each other about patients instead of assuming everything important was in the EMR…

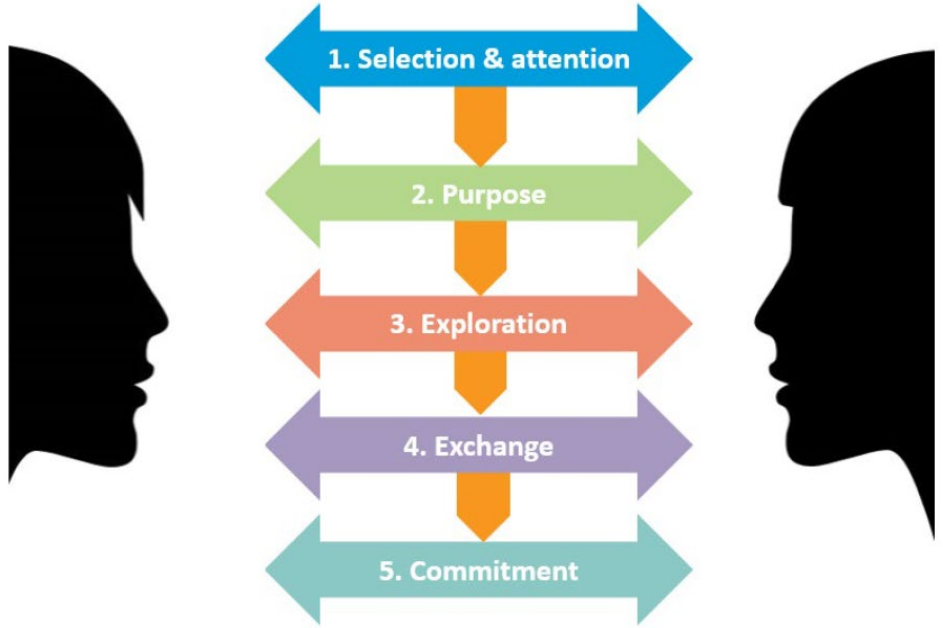
How Would You Improve Communication?

Communication Tools

SBAR Communication Form

- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendation

One-on-One



https://pathway-interact.com/wp-content/uploads/2021/08/15-INTERACT-SBAR-Communication-Form-2021.pdf

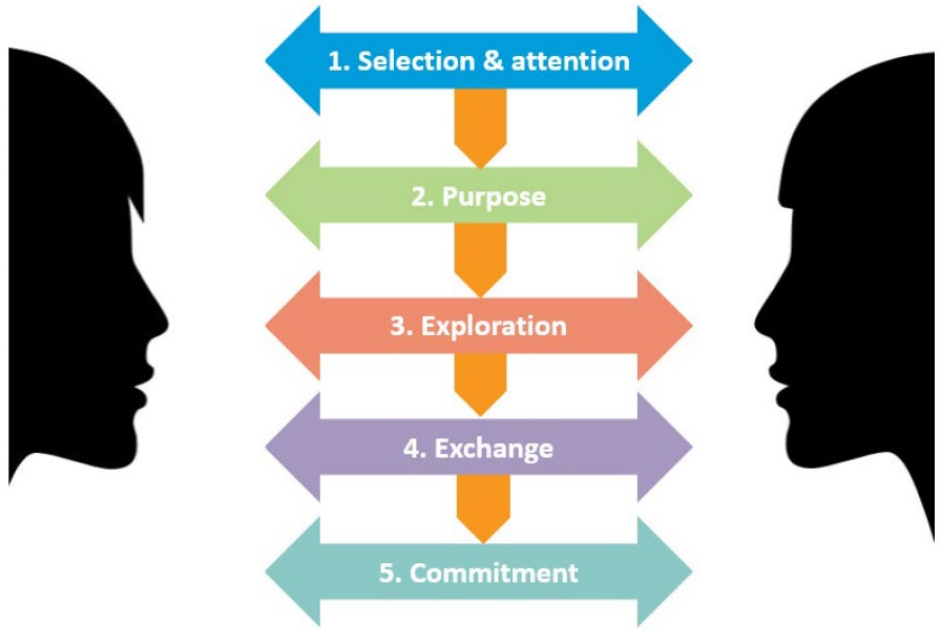
Graphic: LEAD! LOA Training

Case Study

Resident Background

- Robert is an 80-year-old long-term care resident with a dementia diagnosis. He has lived in Telligen Senior Living for about a year. He has a care plan in place for combative behaviors and is on 2mg of risperidone PRN. Risperidone hasn't been given to him for 6 months. Robert had combative behaviors over the weekend, and an agency nurse gave him 2mg of risperidone without following his established care plan to deal with combative behaviors. Robert is now sleepy, has missed a meal and had a fall without injury.

One-on-One



Graphic: LEAD! LOA Training

Next Steps – Lead into Action

Quality Assessment & Assurance (QAA) Team

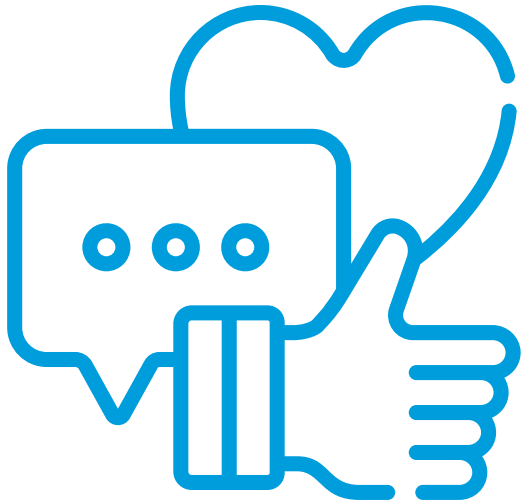
- Identify the problem
- Review the data
- Create a SMART goal
- Build a team charter
- Deploy an improvement team

Improvement Team

- Identify contributing factors and root causes for the problem
- Select changes/interventions to eliminate each root cause
  - Include collaboration with prescribing physicians, pharmacists, hospitalist, etc.
- Run Plan-Do-Study-Act (PDSA) cycles
- Create sustainability plan

https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf

How Did We Do? Let Us Know:



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Upcoming High-Risk Medication ECHO® Series Sessions

Join us on the following Wednesdays beginning at 7:30 a.m. MST/8:30 a.m. CST

ECHO® Session Dates and Topics:

- Session 7: 4/26/23 – Communicating with Residents and Families

Access prior session presentations and recordings here!

See all Telligen events here:
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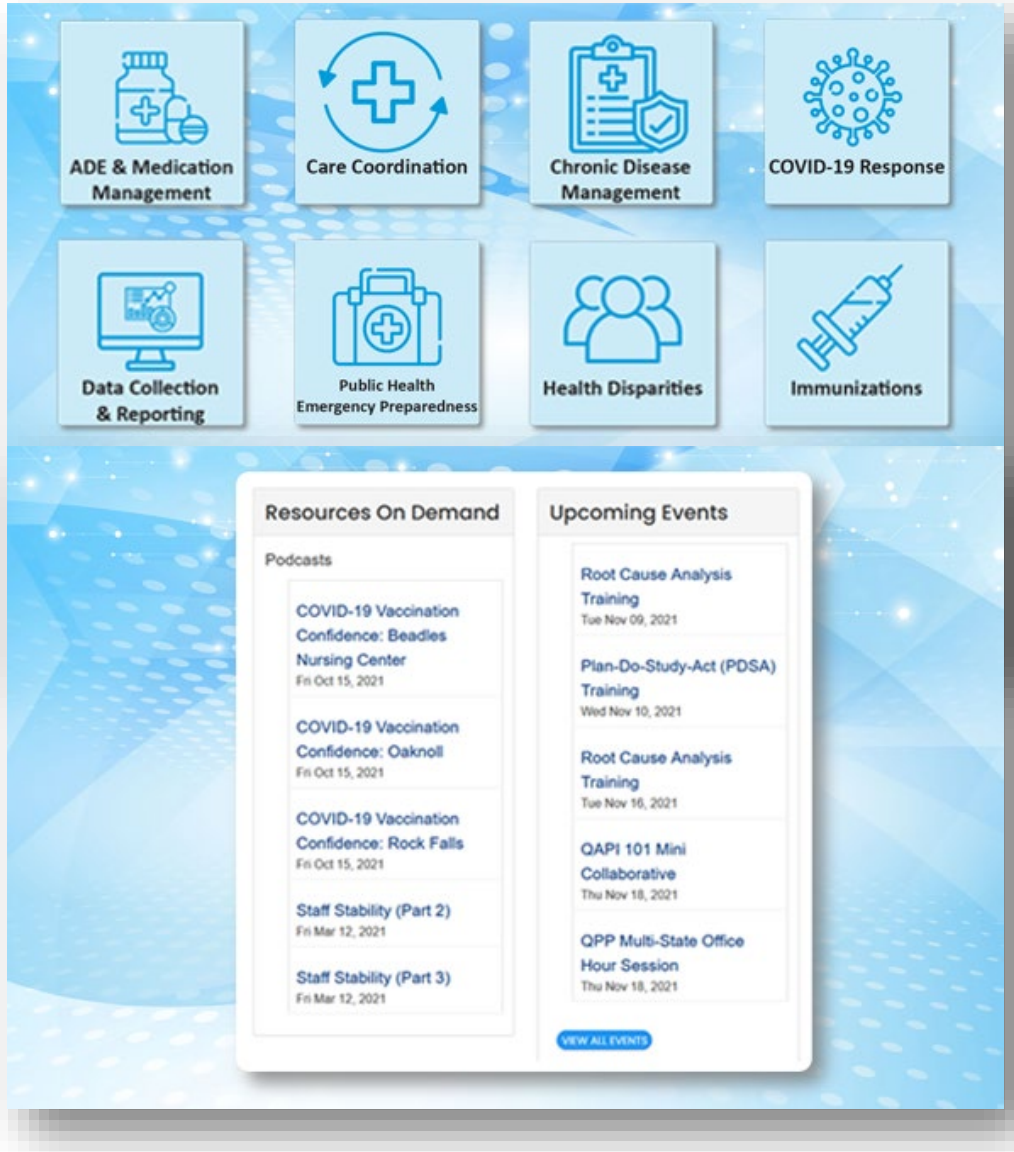

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The online network offers an opportunity to share and learn about innovative practices, all at no cost.

Access the Portal

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