Perception vs. Reality: Communication in Medicine- Putting Patients at Risk

Misty Bogle MD

EXPLORE HEALTHCARE SUMMIT

Financial Disclosures

NONE But open to good paying opportunities ;)

2

Perspectives

In the Room:

- Type of practice:
  - Primary Care – Family, internal Med, Peds- placing referrals
  - Radiologist- Reading studies
  - Specialist/Subspecialist- accepting consults
  - Pathologist-Reviewing slides
- Time in Practice:
  - 0-5
  - 5-10
  - 10-20 – The last generations to use Paper
  - 30-40
  - 40-50
  - 50+

3

Perspectives

In each clinic

- Physician or Provider
- MA/LPN
- Patient
- Pharmacy

4

Medication Reconciliation

- Who does it?
  - Physician or Provider
  - MA/LPN
  - Patient
  - Pharmacy

5

Medication Reconciliation

- Who does it?
  - Physician or Provider
  - **MA/LPN**
  - **Patient**
  - Pharmacy

6

Medication Reconciliation

- Who does it?
  - Physician or Provider
  - **MA/LPN**
  - **Patient**
  - Pharmacy
- Do they have the knowledge to understand medication names/differences and the importance of their task?

7

Medication Reconciliation

- Who does it?
  - Physician or Provider
  - **MA/LPN**
  - **Patient**
  - Pharmacy
- Do they have the knowledge to understand medication names/differences and the importance of their task?
- Who Should do it?
- Why is it important?

8

Case Study

- 84yo Male with complex medical hx of HFpEF, PMR, Seronegative RA, CRF, HTN, BPH, CAD, Parox Afib, obesity, DM with neuropathy presents to your office with increased fatigue and a syncopal event last week at home. He had an episode of C. Diff 1 month ago , completed his course of antibiotics and reports symptoms have returned. Your MA rooms the patient and reconciles his meds. He states, "nothing has changed". She marks all as taking and gets his vitals. His blood pressure is 102/60.

9

Medications

- Duloxetine 60mg QHS
- Vancomycin 125mg BID
- Allopurinol 100mg 2 pill QHS
- Pregabalin 50mg BID
- Losartan 50mg daily
- Doxazosin 4mg BID
- Metolazone 5mg QAM on T/T/S
- Potassium Chloride 20meq Qday
- Carvedilol 3.125mg BID
- Prednisone 10mg Qday
- Furosemide 80mg QAM
- Leflunomide 20mg Qday
- Pravastatin 80mg QHS
- Glipizide 5mg BID
- Spironolactone 25mg QAM
- Nitro PRN
- ASA
- Eliquis 2.5mg BID

10

Actions

- You review labs note worsening renal function from baseline and note that his BP usually is in the 130-140/high 80's so is lower than usual; you tell the patient:
  - I want you to decrease your Duloxetine to 20mg
  - Decrease your Pregabalin to just nightly
  - Decrease doxazosin to Nightly only
  - Decrease your losartan to 25 mg – To which he tells you he was already on 25mg not 50 so you say ok ½ the 25mg
  - repeat labs in 2 wks
- You tell your MA to adjust the med list.
  - She documents the dose changes in patient instructions and gives the patient his AVS with the instructions and the med list that reads unchanged from when patient walked in.

11

Follow up

- 2 week F/U labs are worse. Patient had another episode of syncope at home 3 days prior to appt. FSBS at home 60 given soda and sx resolved rapidly.
- You elect to admit the patient.
- 6 day admission
  - Nephrotoxic meds held
  - renal US- chronic atrophy
  - CT Abd/Pelvis unchanged but not normal- known pancreatic cyst, renal atrophy, obesity, fatty liver infiltration…
  - PVR- normal
  - Chest x-ray- chronic changes.
  - Nephrologist orders: "the panel"
  - Basic Labs slowly normalize without any major intervention you discharge pt on

12

d/c med list

- **DISCONTINUE**
- Vancomycin 125mg BID- completed- stop
- Metolazone 5mg QAM on T/T/S
- **CHANGE**
- Allopurinol 100mg 2 pill QHS- to Allopurinol 300mg QHS –Rx sent
- Losartan 50mg daily→ decrease to 25mg- Rx sent
- **CONTINUE**
- Duloxetine 20mg QHS
- Pregabalin 50mg QHS
- Doxazosin 4mg QHS
- Potassium Chloride 20meq Qday
- Carvedilol 3.125mg BID
- Prednisone 10mg Qday
- Furosemide 80mg QAM
- Leflunomide 20mg Qday
- Pravastatin 80mg QHS
- Glipizide 5mg BID
- Spironolactone 25mg QAM
- Nitro PRN
- ASA
- Eliquis 2.5mg BID

13

Side by side

1st office visit

- Duloxetine 60mg QHS-Told decrease to 20mg
- Vancomycin 125mg BID
- Allopurinol 100mg 2 pill QHS
- Pregabalin 50mg BID- told Nightly
- Losartan 50mg daily- told to half 25mg pills
- Doxazosin 4mg BID- told Nightly
- Metolazone 5mg QAM on T/T/S
- Potassium Chloride 20meq Qday
- Carvedilol 3.125mg BID
- Prednisone 10mg Qday
- Furosemide 80mg QAM
- Leflunomide 20mg Qday
- Pravastatin 80mg QHS
- Glipizide 5mg BID
- Spironolactone 25mg QAM
- Nitro PRN
- ASA
- Eliquis 2.5mg BID

D/C

DISCONTINUE

- Vancomycin 125mg BID-completed- stop
- Metolazone 5mg QAM on T/T/S

CHANGE

- Allopurinol 100mg 2 pill QHS- to Allopurinol 300mg QHS –Rx sent
- Losartan 50mg daily→ decrease to 25mg- Rx sent

CONTINUE

- Duloxetine 20mg QHS
- Pregabalin 50mg QHS
- Doxazosin 4mg QHS
- Potassium Chloride 20meq Qday
- Carvedilol 3.125mg BID
- Prednisone 10mg Qday
- Furosemide 80mg QAM
- Leflunomide 20mg Qday
- Pravastatin 80mg QHS
- Glipizide 5mg BID
- Spironolactone 25mg QAM
- Eliquis 2.5mg BID

14

Patient elects to move to granddaughter's home

- Patient gets home and granddaughter helps him with his pill box. Finding that he actually had been taking all the wrong doses prior to admission. Although the dc paperwork says to decrease the losartan his nephrologist had told him to take half of a 25mg pills so taking a 25mg is actually doubling the dose.
  - Duloxetine- he had 60mg pills only
  - Pregabalin 75mg tablets only
  - Doxazosin- was still in AM and PM boxes
- Granddaughter gets on his Walmart pharmacy portal to find 68 available medications for refill. Multiple of the same medication at different doses. The meds at the top are not the most recent scripts.

15

Med Reconciliation and the layers where it can go wrong!

- Are you confused?
- Does an 84yo male have the bandwidth to follow this if you can't?
- Now the patient has to advocate for self and order medications correctly as well.

16

What the patient sees on Wal-Mart profile

17

Who does your med Rec?

- MA- understand level of education
  - Do they know that metoprolol succinate is not the same as tartrate?
  - When a patient tells them a name do they chose what is at top on the list?
  - Are they using the "patient reported" section so you are aware of possibility of inaccuracy?
  - When patient says, "It is all the same" what do they do?
- LPN
  - Minimal pharmacology training
- RN

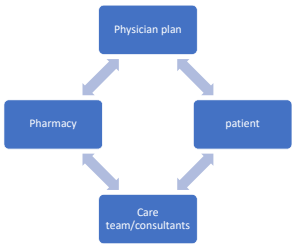
19

Layers of Health care

- Physicians
  - PCP
  - Consultants
- Pharmacists
  - Pharm Techs
- Therapists
- Patients

20

Cycle of lost information



Cycle of lost information

- Physicians plan
  - Communicated to the patient
  - Communicated in the EMR
    - How you address med list, did you change it in the EMR or did you send it to the pharmacy.
    - Did you tell the pharmacy to stop the old dose or to discontinue the medication
      - Did you think you did but the EMR doesn't actually send a notice
  - Sent to consultants- is everyone on the same page?
  - When do you have time to do all this????

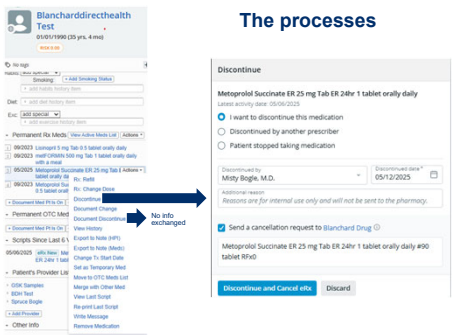
22

Discontinuation of medications

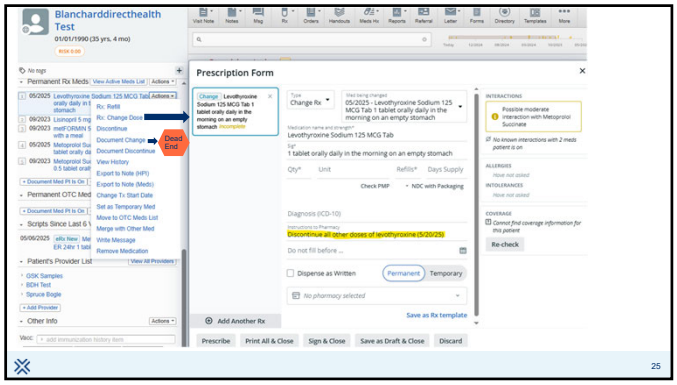
- Where does the info go?
  - EMR dependent
  - Type of discontinuation dependent
- Does your EMR allow pharmacy feedback and adjustment of the med list without approval?
  - One of the largest does
    - Pt fills that 50mg losartan at the top of the Walmart list, or auto-fill occurs and the med list is adjusted but not what you intended.

23

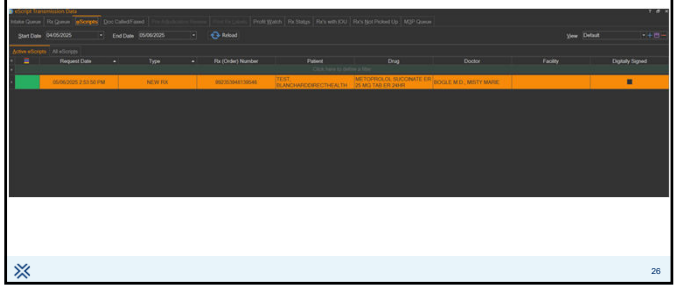
The processes



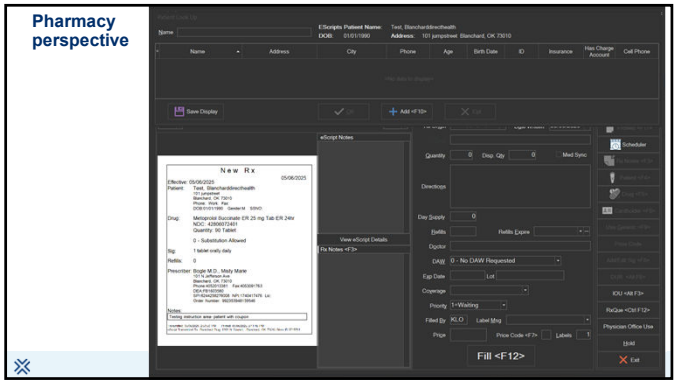
24



Pharmacy perspective



Pharmacy perspective

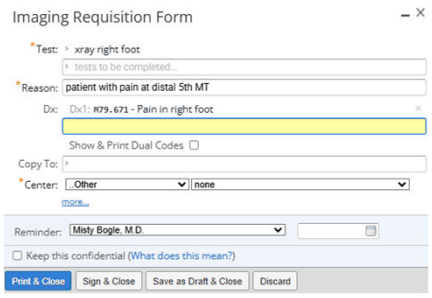


Medication Errors.

- According to the World Health Organization's publication titled *"Medication Errors: Technical Series on Safer Primary Care,"* the following factors have been associated with an increased risk of medication errors in the primary care setting:
  - Lack of therapeutic training or inadequate knowledge
  - Poor communication with patients
  - A language barrier between healthcare professionals and patients
  - Increased workload
  - Interruptions and distractions
  - Lack of accuracy of patient records and a poor interface between prescriber and electronic health records
  - Lack of protocols and standardized procedures in the work environment
  - Inadequate naming, labeling, and packaging of medicines
  - Poor communication with secondary care providers

28

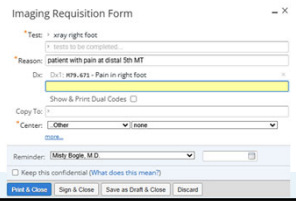
For the Radiologist



29

For the Radiologist

- I get nothing on the read about the 5th MT. I call my radiology friend who tells me all he got was an image and the dx code not the note of my clinical concern.
- I dig
- The "reason", though stared and required by EMR, is not put into the health system computer and order isn't scanned.
- I didn't know all my extra time and effort to help narrow the read to my concern wasn't communicated.



30

Referrals

- Information exchange
- In system vs Out of system referrals
- Pose a Clinical question/reason for the referral.
- What is most helpful from consultants' perspective?
- What is shared with the Consultant? – did you get my last note?

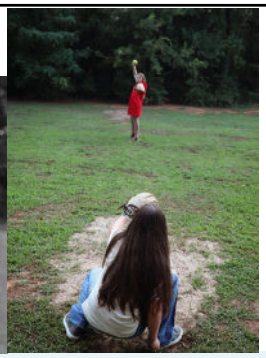
31

Goals

- Scare you into thinking about your clinic's practices and increase intellectual curiosity about how things are communicated on your behalf.
  - Med Reconciliation
    - Who, how, when
    - Communication with dose change and with discontinuations.
      - When you change the dose of levothyroxine all the old doses are still available to the patient if you don't discontinue it first or write a note to pharmacist.
  - Referrals
    - What info needs shared, share it. Make sure your staff also knows expectations.
  - Imaging orders
    - Clinical information is helpful.

32

Discussion



33