ECHO Session Partnership Resource – Session Three:
Communication Pathways

This resource adapts the **TeamSTEPPS** ("Team Strategies & Tools to Enhance Performance and Patient Safety") communication elements to specifically address care transitions.

SITUATION
What is going on with the patient?

"Dr. Lu, this is Alex, a nurse from your 5th Street office. I am calling about your patient, Mr. Webb. He reports being in substantial discomfort and that there is not much urine in his catheter bag."

BACKGROUND
What is the clinical background or context?

"Mr. Webb is an 83-year-old patient that has a catheter in place during his recovery from bladder cancer treatment."

ASSESSMENT
What do I think the problem is?

"He also reports a temperature of 100.4 and that the urine in his bag is cloudy and slightly red. I am concerned he may have an infection and that his catheter may be clogged."

RECOMMENDATION OR REQUEST
What would I do to correct it?

"I would like him to come into the office this morning for you to see him. When he arrives, would you like us to get labs, including blood cultures, to check for infection?"

I-PASS

The preferred handoff tool for care transitions

I
Illness Severity
- Stable, watcher, unstable

P
Patient Summary
- Summary statement
- Events leading up to admission or care transition
- Hospital course or treatment plan
- Ongoing assessment
- Contingency plan

A
Action List
- To-do list
- Timelines and ownership

S
Situation Awareness & Contingency Planning
- Know what's going on
- Plan for what might happen

S
Synthesis by Receiver
- Receiver summarizes what was heard
- Asks questions
- Restates key actions/to-do items

Handoff

A standardized method for transferring information (along with authority and responsibility) during transitions in patient care.

A proper handoff includes the following:

- Transfer of responsibility and accountability
- Clarity of information
- Verbal communication of information
- Acknowledgment by receiver
- Opportunity to ask questions and review

Check-Back

A closed-loop communication strategy used to ensure that information conveyed by the sender is correctly understood by the receiver.

Example:

Dr. Moss:
"Mary, please share the information pamphlet on cholesterol management with Mr. Garcia and arrange for him to come for a followup visit in a month."

Mary:
"Confirmed. I'll share the information pamphlet on cholesterol management and arrange a followup visit for Mr. Garcia in a month."

Dr. Moss:
"Correct."

Relatedly, a key lesson from the CMS-funded Accountable Health Communities Model:[1]

"…technology alone is not the solution. Relationships across care teams, within health systems, with CBOs, and with community members are necessary to equitably and effectively address HRSNs. "

How can you adapt key TeamSTEPPS tools to build strong communication pathways?

Using key steps from **ECHO Session 2 Partnership Resource** (e.g., HRSN Screen, Needs Documentation, etc.), consider these questions:

1. What communication methods are best applied at different points of patient information handoffs?
    a. Verbal (e.g., by phone or in person)
    b. Written (e.g., by email or case note/medical record)

   c. Electronic health record
   d. Social needs platform
   e. Combination
2. Where can hospitals/ACOs & CBOs engage to plan communications and mitigate confusion?
3. Without fully reliable and accessible technology/referral platforms, how can hospitals/ACOs & CBOs use evidence-based/effective communication pathways to ensure continuity of care/effective care transitions (including discharge planning and post-discharge follow-up)?
4. Where can CBOs play a role to facilitate improved communication and outcomes?

The table below offers communication considerations for each step in the transition process.

Step	Typically Involves	Communication Pathway Considerations
HRSN Screen	• Standardized screening tool • Staff responsible and trained • Protocols in place • Data systems to capture results	• What communication protocols facilitate HRSN screening? • Who is involved in developing communication protocols? Do these protocols address hospital/ACO & CBO needs? Are they bidirectional?
Needs Docu-mented	• Staff with appropriate knowledge to review screening results • Data system protocols for sharing results • Protocols for referrals, follow up and discharge planning • Knowledge of available social support resources	• What communication protocols facilitate sharing results? • How is documented information communicated, and to whom? When and how should CBOs be engaged? • What are the barriers to effective communication? For the giver? For the receiver? • Where does the patient and/or family fit in?
Referral to CBO	• Referral protocols • Staff trained and responsible for handoff/referral/documentation in social needs platform • Secure data system for sharing and documenting	• What communication protocols support the referral process? • Where & how can SBAR (Situation–Background–Assessment–Recommendations) augment the process? • What information must be shared, and at what point, to support effective CBO referral? • What communication options circumvent social needs platforms or one-way, read-only, non-interoperable systems?
Follow Up	• Protocols for engaging person and developing a person-centered plan • CBO staff responsible & trained • Secure data system for documenting person-centered plan, services, tracking follow up • Notification of hospital of follow up, results, and plan	• What communication protocols should be in place to ensure closed-loop follow-ups? • What does the hospital/ACO need from the CBO to maintain clear communication pathways? • How can communication tools and methods support a closed-loop process? • What communication barriers do hospitals/ACOs & CBOs experience at follow-up? How can communication protocols help?
Outcome	• Identified metrics tracked at specific time points • Secure data system to capture information that has a feedback loop to the hospital • Protocol for engaging the person over time and documenting outcomes	• What communication protocols support improved outcomes? • What should be documented to measure impact of communication on care transitions and outcomes? • What should CBOs share back with hospitals/ACOs post-discharge, and how? • What do hospitals/ACOs need from CBOs to understand what services/supports were in place and, if applicable, what led to readmission?

What conversations will you have with your partner in the next week to consider community pathways? What will you report out on during the third Peer Working Session on April 2?