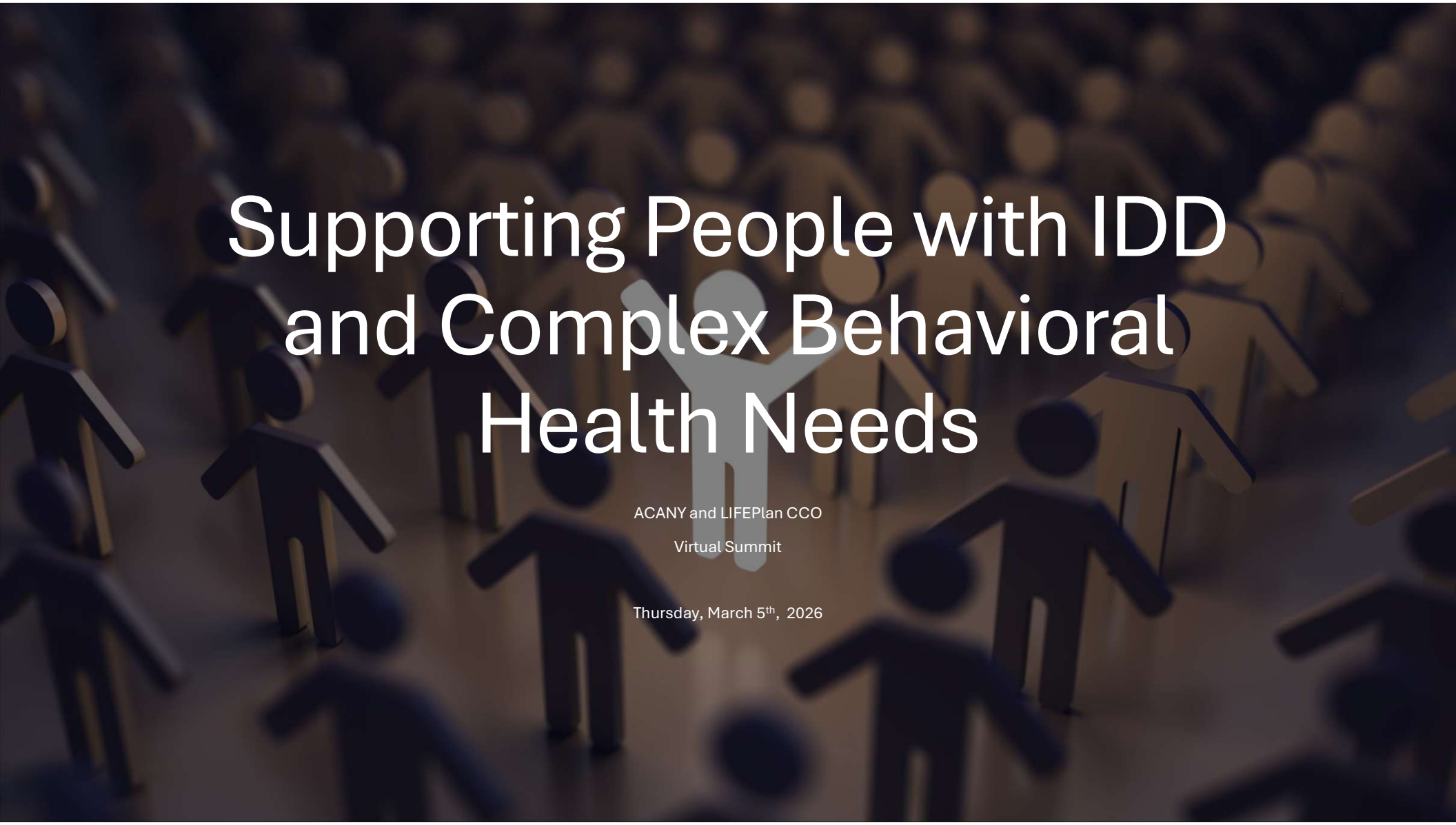

Supporting People with IDD and Complex Behavioral Health Needs

ACANY and LIFEPlan CCO

Virtual Summit

Thursday, March 5th, 2026

THE DEVIL IS IN THE DETAILS

- Preventing Medical Errors in Transitions of Care

- Benjamin A. Margolis, M.D.
- Neurologist and Psychiatrist

BIOGRAPHY / DISCLOSURES

- Board certified in neurology and psychiatry
- Specializing in Behavioral Healthcare for people with I/DD
- Behavioral Health Task Group Co-Chair, AADMD
- Member, OPWDD Medical Advisory Task Force
- Member, Special Olympics NY Medical Advisory Council
- FINANCIAL DISCLOSURES: None
- ARTIFICIAL INTELLIGENCE DISCLOSURE: Microsoft Copilot used in slide layout, otherwise not used.

IDENTIFYING THE PROBLEM

- Addressing the common scenario of medical errors or problems associated with medical transitions
- The error rate in transition at some hospitals in medications exceeds 1 error per transition in some settings (speaking from clinical experience)

- Nationally, error rates have been found to be as high as 47.5% among prescriptions during transition, a substantial portion being missing medications or wrong doses.

Erickson SR, Kamdar N, Wu CH. Adverse Medication Events Related to Hospitalization in the United States: A Comparison Between Adults With Intellectual and Developmental Disabilities and Those Without. Am J Intellect Dev Disabil. 2020 Jan;125(1):37-48. doi: 10.1352/1944-7558-125.1.37. PMID: 31877264.

CONTENTS

We will follow Steven, a patient who is a conglomerate of several real patients, through:

1) Referral to a generic emergency room
2) Medical admission
3) Internal transfer within the hospital
4) Discharge back to his community IRA.

OBJECTIVE

Following this talk, the audience will:

- Be able to understand some of the sources of missing or wrong information upon emergency room visits and during medical admissions
- Have some familiarity with the process of medication reconciliation and history-taking
- Understand how electronic medical records can propagate erroneous information
- Be able to help recognize potential errors and help ensure smooth transitions for themselves and loved ones

KEY THEMES

GARBAGE IN, GARBAGE OUT

LACK OF CULTURAL COMPETENCE / UNDERSTANDING OF I/DD CARE AMONG MEDICAL AND PSYCHIATRIC PROVIDERS MEAN WE DON'T KNOW WHAT WE DON'T KNOW

ALL MEMBERS OF A CARE TEAM CAN HELP PREVENT IATROGENIC HARM DUE TO PROBLEMS IN TRANSITION

MEET OUR PATIENT

- Steven R. is a bilingual 35 y/o cis-gendered man living with:
    - Cerebral Palsy
    - Epilepsy, well controlled with one medication
    - Bipolar I Disorder
    - Autism and associated compulsions, sometimes dangerous
    - Mild to Moderate Intellectual Disability

MEET OUR PATIENT

- Steven R.
  - Loves his day program where he loves his routine and helping out
  - Has a supportive family, they are older and live out of state. They Facetime frequently.
  - Lives in an IRA with 5 mixed-gender peers and they get along well when Steven is psychiatrically stable.

MEET OUR PATIENT

- Steven R.
  - Has a PCP at a large group practice
  - Has a psychiatrist at a community mental health center (Article 31)
  - Has a cardiologist at that large group practice
  - Has a private gastroenterologist
  - Is on a waiting list for dental care
  - Has a private ophthalmologist

MEET OUR PATIENT

- Steven R.
  - Takes 4 psychiatric medications including clozapine and Depakote, and risperidone for autism-related aggressions.
  - Takes 3 medications for chronic constipation
  - Takes medication for his thyroid, for hypertension and for hyperlipidemia
  - Maintains a chopped diet (1/4”), or Level 5 Minced and Moist (IDDSI)

Steven Gets Sick

- Steven begins complaining of severe abdominal pain and has several episodes of emesis (vomiting).
- He is brought by his staff to the Urgent Care associated with his PCP's group practice, and they find him significantly hypotensive.
- RISK FOR ERROR – Is medication list accurate?
- He is referred to the emergency room by Urgent Care.

Steven Reaches the Emergency Room

- RISK FOR ERROR
  - Accompanied by staff
  - Up to date MAR is included
  - How is information communicated to the ER staff?

“How the Sausage is Made” – ER Workflows

- RISK FOR ERROR
  - Accompanied by staff
  - Up to Date MAR is included
  - How is information communicated to the ER staff?
  - On Medical Records Systems

“How the Sausage is Made” – EMRs

- RISK FOR ERROR
- SYSTEMS DON’T NECESSARILY TALK TO EACH OTHER
  - EPIC
  - eClinicalWorks
  - Athena
  - PracticeFusion
  - Cerner
  - Avatar
  - NetSmart
  - Evero

“How the Sausage is Made” – EMRs

- RISK FOR ERROR
- SYSTEMS DON’T NECESSARILY AUTOUPDATE
  - Multiple sources of information
  - Outpatient and Inpatient Medication lists can lead to redundancy
  - Discontinued Medications can auto-load and propogate

“Garbage In, Garbage Out”

IN THE EMERGENCY ROOM

- What is the source of the medication list and history?
- Staff accompanying individuals may be covering
- Who is adding his information to the chart?
- Where does the paper MAR go?

A DILIGENT CARE TEAM CAN BE PROTECTIVE

Steven is Admitted to the Medical Floor

- ARRIVING ON THE MEDICAL FLOOR
- What happened to the medication reconciliation from the ER?
- Some systems are separate between ER and Inpatient
- Did his diet order get communicated?
- What about his psychiatric medications?

Steven is Being Treated for a Partial Ileus

- Does the inpatient medical team have a consultant that can coordinate care?
- The Value of C/L Psychiatry
- Is the inpatient team aware of his outpatient providers and do they have contact information to coordinate care?

Steven is Much Improved Ready for D/C

- Were there changes to his psychiatric regimen? To his constipation regimen?
- Was this able to be communicated to his outpatient team?
- Did he require surgery or procedures?
- Are there changes to his diet?

Steven is Much Improved Ready for D/C

- RISKS AT INPATIENT TRANSITION – SYSTEMS RISKS

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  - Staff turnover and hospitalist turnovers
  - The discharging physician may not be the person who cared for him prior

Steven is Going Home

- OPPORTUNITIES FOR ERROR
- “Ghost Medications”

DISCHARGE SUMMARY MEDICATION RECONCILIATION

- Old problems can propogate
- Forms of medications can change in unexpected ways

- Diets may be inadvertently changed

Steven Arrives Home

- RISKS FOR ERROR

- Not every provider or specialist will be aware of medication changes
- Errors on discharge summaries can compound at this point
- Ensuring followup with outpatient team and collaboration is essential

- Every agency can adapt workflow locally to this problem

Steven Follows Up With His Outpatient Team

- OPPORTUNITIES FOR ERROR

- Discharge Summaries may be missing
- Does the outpatient team understand why changes were made?
- Were changes deliberate or due to missing information?

BEST PRACTICES & TAKE HOME POINTS

- Steven R.
  - OPPORTUNITIES FOR ERROR ARE PRESENT AT EVERY TRANSITION POINT
  - Individuals with I/DD are vulnerable to these errors due to medical and behavioral complexity.
  - Facilitating communication between disparate teams is best protection
  - Current tools to bridge communication are helpful but do not replace direct contact between providers.
  - Agency staff, care managers, loved ones and nursing save lives with communication

Questions/Comments

QUESTIONS