Assisted living beginning to feel the sting from transition hiccups

Transitions of care from one senior living setting to another are fraught with risk. In spite of all the bells and whistles and policy manuals and webinars, health care staff are still human.

That doesn't change the critical need to get every detail right. One small mistake in communicating an in-hospital procedure or a new medication order can cascade into a series of problems that could land a resident back in the hospital, or worse.

While many critically ill people discharged from a hospital go directly to a skilled nursing facility or hospice, experts warn to expect more and more to end up in assisted living, which is taking on sicker residents than ever before.

Behind the numbers

Statistics generated by poor handoffs are sobering.

Roughly half of all nursing home admissions are the direct result of an acute care stay, according to the National Care Planning Council. And many of those healthy enough to leave after a short-stay rehab stint transition to alternate settings like assisted living. For every 100 elderly patients in a nursing home in a given year, 38 will recover or stabilize so they can be discharged. The rest stay inside the skilled facility until hospice or end of life.

Poorly executed care transitions not only result in increased hospital readmissions, but also duplication of services and wasted resources, according to the American Medical Directors Association (AMDA).

Poor prescriber coordination is a major culprit in adverse drug events. The problem in so many flawed handoffs is the inability to identify which practitioner was accountable for a resident's care during that fateful and error-prone discharge interval, the group asserts.

Such coordination mishaps are frustrating for pharmacists who serve senior living communities. As one recently noted in a leading trade publication, "From an operations standpoint, navigating all the communication methods to the pharmacy is complex and, at times, more information, more data equates to more room for error."

Even inside the walls of highly controlled environments like hospitals, medication records can often be rife with incomplete information, observers say.

Compounding matters is so many assisted living residents get their medications from multiple pharmacies, as many as five in some cases, which leads to even greater confusion and opportunity for adverse drug events. The situation can lead to over-dosing and drug interactions, most of which go undetected until it's too late.

In sum, by the time an assisted living resident as endured hospital and short-term nursing home rehab stays, it's challenging to reconcile where one medication ended and another began.

Another cause of poorly managed transitions is staffing. Today's senior living workforce can best be described as one in transition itself, as owners and operators grapple with unprecedented wage pressures and stressful work conditions. It's easy to see how a workforce that is constantly turning over lends a destabilizing influence that creates opportunities for error.

Moreover, assisted living providers often find themselves short on competently trained clinicians needed to manage critical handoffs from hospitals or skilled facilities. Many assisted living facilities also have held off investing in electronic medical record systems, which experts say are sorely needed to avoid many of the problems transitions cause.

Of all the culprits experts have identified to poor transitions, communication leads the pack. The Risk Management Foundation of the Harvard Medical Institutions recently conducted a survey that found almost a third of all malpractice claims that led to 1,744 deaths and $1.7 billion in costs were the direct result of communication failures.

Working toward better transitions

As the assisted living market matures, most say caregiving staff will eventually catch up with the rising acuity of their residents.

Government regulators are providing some incentives.

For example, the recent so-called "IMPACT ACT" (aka, "Improving Medicare Post-Acute Care Transformation") forces the issue of ADEs by new rules aimed at more timely handling of medication-related problems at admission. And the so-called pharmacy "Mega Rule requires long-term care facilities to produce a discharge summary that includes reconciliation of pre- and post-discharge medications, both prescribed and over-the-counter.

Some say working closer with assisted living residents' family and loved ones can go far in closing those vital communication gaps. Thoroughly querying them about an incoming resident's health habits and medication use can go far. Newly admitted residents need them to be their voice, their advocate.

Organizations like the AMDA easily argue that efforts to improve care continuity during transitions leads to better outcomes. As the group notes in its recent document, Transitions of Care in the Long-Term Care

Continuum “By improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management; the rate of avoidable rehospitalization can be reduced.”

When researchers at a randomized controlled trial conducted at an urban academic medical center implemented a package of discharge services (which included follow-up appointments, medication reconciliation and patient education), they documented a 30% decrease in emergency department visits and readmissions within 30 days of discharge, according to the AMDA. Moreover, when a “transition coach” encouraged patients and caregivers to take a more active role during transitions, rehospitalizations among people 65 and older dropped as much as six months, the AMDA reported.

On a higher level, some experts believe the more lines are blurred across the continuum of care, between various long-term care settings, the closer the industry can get to riding itself of silos and turfs that keep one group of caregivers from sharing with the other. Electronic health records is one example of the kind of universal, joint communication effort aimed at delivering the right information at the right time and place.

Many factors lead to medication errors during transition of care. ValueMed can be part of the solution to help ensure continuity of medication with integrated eMAR and MyValueMed.com to make family participation and communication easier. Contact us at ***ValueMed@PharMerica.com*** *or* ***866-628-2583*** *to learn more.*