PODCAST TRANSCRIPT

DEFICIENCIES IN DISCHARGE PLANNING FOR A MENTAL HEALTH INPATIENT WHO TRANSITIONED TO THE JUDICIAL SYSTEM FROM A VETERANS INTEGRATED SERVICE NETWORK 4 MEDICAL FACILITY

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Dr. Terri Julian:

This is Dr. Terri Julian, Director of Mental Health Programs within the VA Office of Inspector General. I'm here with Dr. Elizabeth Winter, Senior Physician.

Dr. Winter, we are here to discuss the report, *Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility*. This report relates to a patient with chronic, severe mental illness and how the multiple failures of VA staff to address the patient's needs, including the discharge process from the medical facility, may have contributed to the patient's subsequent death at a federal detention center. How did the OIG got involved?

Dr. Elizabeth Winter:

The OIG received allegations that resulted in an inspection of how a VA medical facility provided care to a long-time residential patient in a VA inpatient mental health program. For privacy reasons, we cannot reveal the name of the facility to prevent identification of the patient.

Specifically, we examined how the facility staff discharged the patient to the VA police for transition to federal detention. The patient had assaulted a staff member and was formally arrested about a month after that event. The patient was discharged from the facility, moved to a federal detention center, and died while incarcerated, two days later. The cause of death was cardiovascular disease related to high blood pressure and the build-up of plaque in the arteries.

Dr. Terri Julian:

What were the major areas of concern the team examined and described in the report?

Dr. Elizabeth Winter:

The team was struck by the failure of VA medical facility staff and leaders to carry out their ethical responsibilities for the care of this patient. All VA employees must uphold the rights of all patients, even those who are challenging in terms of their needs and behaviors and ensure their well-being. Here, the facility staff consistently failed to appropriately obtain informed consent from the patient for all aspects of treatment including inpatient admission, and medication management. They did not consider accessing available resources for consultation, and then failed to support a safe transfer of care to the criminal justice system.

Dr. Terri Julian:

Let's take some time to discuss each of these issues in turn. What is informed consent?

Dr. Elizabeth Winter:

Informed consent involves educating a patient about the risks and benefits of any proposed treatment and allowing the patient to ask questions before making a decision about whether to accept the treatment. If a patient lacks the capacity to make a decision about his or her own medical care, the provider must identify a surrogate decision maker. Informed consent is one of the foundations of ethical medical care. VA has clear guidelines outlining the procedure for assessing who should make clinical decisions, including designation of a surrogate when appropriate, and then documenting the process.

Dr. Terri Julian:

And did that not happen in this case?

Dr. Elizabeth Winter:

No, the patient was a resident at the medical facility for over 10 years and in that time, the facility clinicians documented decision-making capacity inconsistently and sometimes inaccurately. Despite this, none of the treatment providers performed a clinical assessment for capacity, as required by the Veterans Health Administration (or VHA). Facility clinicians also failed to appropriately identify and consistently document a surrogate decision maker for the patient, even though the patient's family was available and involved in the patient's care. This led to the patient signing consent forms for treatment without any evidence of understanding for the risks and benefits.

Dr. Terri Julian:

Were there other ways in which this may have impacted the patient's care?

Dr. Elizabeth Winter:

It directly impacted the patient's discharge from the facility. VHA requires that patients or their surrogates be involved in the decision planning process. In this case, the facility knew that the patient was going to be arrested and discharged to VA police custody. However, they did not inform the patient of the impending arrest until police were on the unit and failed to inform the patient's mother until after the patient had already been removed from the facility. This is a clear violation of the patient's basic right to be involved in decision-making related to discharge planning, or to have someone else make those decisions who has the patient's best interests at heart.

Dr. Terri Julian:

This was clearly an extremely challenging case. You mentioned additional consultation resources earlier. What resources are available to the facility in situations like these?

Dr. Elizabeth Winter:

First, given the extensive issues with decision-making capacity and surrogacy in this case, the facility could have consulted their own Ethics Consultation Service, which specializes in these kinds of evaluations and helps with determinations of appropriate surrogates. Facility leaders confirmed that despite the numerous discussions surrounding this patient's care, they never considered an ethics consult. Second, given the severity of the patient's mental health issues, questionable decision-making capacity, and the pending legal charges, the facility could have consulted a forensic specialist. Forensic psychologists or psychiatrists specialize in evaluations of criminal responsibility and competency to stand trial. A specialist's input may have dramatically altered the outcome for this patient's discharge to the federal detention center if the patient was determined to not be criminally responsible. Again, facility leaders conceded that they had not considered such a consultation.

Dr. Terri Julian:

It sounds like there were multiple missed opportunities for the care providers to make sure they were providing optimal care to this patient. Let's talk about this patient's discharge from the facility. You mentioned that the transfer of care was mishandled; how so?

Dr. Elizabeth Winter:

A provider's primary responsibility to a patient is to promote well-being and prevent harm; this includes the obligation to ensure that any discharge plan or transfer of care is safe. In addition to making certain that a patient is medically (and in this case mentally) stable for discharge, it is imperative that the discharging provider to collaborate with the receiving care provider to afford appropriate continuity of care. Here, the OIG team found that facility staff made no efforts to contact the treatment providers at the federal detention center, despite the patient's extensive mental health and physical health issues, and a complicated medication regimen. The failure to provide this information meant that the federal detention center was unaware that the patient had a cardiac history including recent complaints of chest pain, which is significant given the patient's death from cardiovascular disease.

Dr. Terri Julian:

Dr. Winter, thank you for exploring the issues related to this patient's care and the inspection. The OIG team made several recommendations to VISN and facility leaders that are also useful lessons for other VA facilities across the nation. VA has already submitted actions plans to address each of the identified deficiencies for the facility that was the subject of the inspection.

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