



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT

Drug Interactions Related to a Patient Death at the Marion VA Medical Center in Illinois

June 2021

INTRODUCTION

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Valerie Lumm:

This is Valerie Lumm, Associate Director within the VA Office of Inspector General. I'm here with Hanna Lin, Healthcare Inspector and we are going to discuss the report, *Drug Interactions Related to a Patient Death at the Marion VA Medical Center in Illinois*, that was published in May 2021. This report looked at the care provided to a patient with multiple medical and mental health diagnoses including high cholesterol, PTSD, and major depression who died at the Marion VA Medical Center.

Hanna, how did the OIG first become involved?

Hanna Lin:

Thank you, Valerie. Like with many of our healthcare inspections, the OIG received an allegation through its hotline division that this patient had died because of complications from poor treatment of high cholesterol. During the inspection, we found additional concerns related to the care provided to this patient for his mental health diagnoses. The OIG looked at several different factors that may have contributed to the patient's death.

Valerie Lumm:

So, this hotline inspection actually looked into several different topics beyond the cholesterol concerns. Can you take us through the original allegation first?

Hanna Lin:

Certainly. The original allegations stated that the patient died because of complications from poor treatment of high cholesterol. High cholesterol is a real concern because it can lead to cardiovascular

disease including heart attacks, stroke, or other damage to the heart and brain, especially when there are other health factors involved like obesity, which was the case with this patient. However, in this case, the primary care team routinely monitored the patient's cholesterol level and blood pressure and worked to address the patient's high cholesterol and obesity through diet and exercise. We found that the patient's medical care was appropriate.

Valerie Lumm:

It doesn't sound like the patient died because of poor treatment. What was the cause of death?

Hanna Lin:

The patient's death certificate stated that the primary cause of death was accidental acute multi-drug intoxication and lists hypertensive cardiovascular disease and obesity as significant conditions contributing to the patient's death.

Valerie Lumm:

Can you explain more about the drugs that were found in the patient's system at the time of death and why they were prescribed?

Hanna Lin:

The patient was also being treated in the behavioral health clinic for PTSD, ADHD, generalized anxiety disorder, and major depressive disorder. Each of these diagnoses can be treated with different medications. Each medication comes with their own complications and interactions that need to be monitored closely by a psychiatrist. The patient was being prescribed an amphetamine medication, which can be addictive, to address the ADHD. The patient was also prescribed benzodiazepines, which are the most common medication used to treat anxiety for short periods of time. These medications alone can be dangerous if they are not used correctly by the patient or monitored closely by the psychiatrist.

Valerie Lumm:

It sounds like that may have been a factor in this case. Is this one of the concerns the OIG found?

Hanna Lin:

It definitely was. This patient had been working with the behavioral health team, including the psychiatrist, psychologist, and psychiatric nurse, for almost three years. In that time, the team did work with the patient on his symptoms but when it came to the medications, there were some problems. First,

treating patients with benzodiazepines for long periods of time is not recommended because of risk of addiction and tolerance to the medication. Second, the psychiatrist is required to discuss with the patient how these medications can interact with other medications and other substances like marijuana and alcohol. The discussion should be clearly documented in the medical record. Third, if the psychiatrist was monitoring the patient closely, any changes in the medication or lab work that is abnormal should be addressed right away.

Valerie Lumm

How long had this patient been taking benzodiazepines?

Hanna Lim

The patient had been on benzodiazepines for most of the three years, which is a long time, and in most cases is not the safest choice to manage chronic anxiety. However, we recognize that ultimately the management of any disorder should be based on the clinical judgement of the provider and the needs and expectations of the patient. That said, such reasoning should be documented in the medical record. In this case, we found no such documentation. The psychiatrist admitted to missing a red flag when the patient's lab work showed that the patient was not taking the ADHD medication as prescribed. In such situations, it is very important that a provider discuss those results with the patient to understand the patient's use or misuse of a prescribed medications, and again, to document those discussions. Adding to the complex management of this patient, the patient had a history of missing many appointments. We found that the clinic staff did not consistently send follow-up letters, as required, to remind the patient to reschedule those missed appointments.

Valerie Lumm:

If these medications are supposed to be watched that closely, it is just the psychiatrist that is responsible? Shouldn't there be another way to make sure the patients are safe?

Hanna Lin:

There is, actually. In 2013, the VA began the Psychotropic Drug Safety Initiative. The initiative has four phases and is geared towards improving the use of psychiatric medications. The fourth phase was focused on reducing the use of benzodiazepines and was launched in 2019 about one month before the patient died. The facility identified and developed a plan to address the phase four metrics, but implementation was delayed because of COVID-19. Of course, we could not say whether earlier implementation would have impacted the outcome in this case.

Valerie Lumm:

It sounds like there were some missed opportunities with this patient's care, especially related to the patient's medications.

Hanna Lin:

Unfortunately, yes. Medications can be dangerous, and providers are responsible for making sure they address any medication interactions and abnormal medication monitoring results with patients at every opportunity. Each phone call and face-to-face visit is an opportunity to ensure the patient is taking the medications as prescribed and is educated on the potential of dangerous drug interactions.

Valerie Lumm:

What were the final recommendations to the facility?

Hanna Lin:

Ultimately, the OIG recommended that the director ensure the behavior health staff are more thorough and consistent in their documentation and communication with patients, that follow-up appointments are entered as required, and to complete implementation of phase four of the drug safety initiative.

Valerie Lumm:

Hanna, thank you for your time today. I encourage those listening to visit the VA OIG's website and read the full report. There you will also find all of OIG's published reports, including the recently published Semiannual Report to Congress, which covers the VA OIG's work over the past six months.

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