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Case Reports

Barriers Beyond Clinical Control Affecting Timely Hospital Discharge for a Patient Requiring Guardianship

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Introduction

Psychiatrists are commonly asked to provide expertise regarding a patient's decision-making capacity, done specifically for the precise question at hand.[1] Although psychiatrists are not the only specialists capable of completing capacity evaluations, they are frequently asked to assist primary teams to determine capacity to accept or refuse specific treatments, including disposition.[2] Guardianship cases occur within a multidisciplinary setting, which includes the admitting hospital service and social services.[3]

A judge appoints a guardian based on evidence provided by clinicians, social workers, physical therapists, occupational therapists, psychiatrists, and family members.[4] In-hospital guardianship processes are state-specific, highly variable, and lengthy.[5] The entire guardianship process is complex and is well described in the literature.[2–7] Procedural delays in guardianship appointment contribute to the needless occupation of hospital beds and unnecessary costs. However, delays in hospital discharges due to nonclinical reasons beyond clinicians' control are seldom publicized.

We therefore present a case where psychiatry consultation for a capacity evaluation occurred early, but subsequent guardianship appointment leading to hospital discharge was delayed by myriad nonclinical factors. We aim to highlight the extent of delays for patients requiring in-hospital guardianship and argue that for delays to become preventable, social and legislative advocacy may be required.

Case Report

Ms. A, a 57-year-old-woman with a medical history of alcohol abuse, hypertension, and stroke, was admitted for sepsis with a pre-existing stage IV sacral decubitus ulcer and left heel osteomyelitis. She received surgical debridement and 6 weeks of intravenous antibiotic therapy. She was found at home covered in her own urine and feces for as long as 2 days and was initially admitted to an outside hospital. She had stopped eating a week before admission, and her parents brought her alcohol to incentivize her to eat.

Four days following admission, completion of an Advance Directive was attempted. Ms. A had initially expressed interest in having her sister become her medical proxy if needed. She had no insurance and had not applied for Medicaid, although she was eligible. She had refused her parents' assistance to apply for

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Social Security Disability Insurance. She had lost her job manufacturing labels about 5 years earlier when her company downsized.

Ms. A's prehospital living situation included bouts of self-destructive behavior, passive suicidal ideation, and willful self-neglect. The circumstances of her admission showed that she may benefit from urgent psychiatric consultation. She had actually been cared for by her parents, e.g., her father carrying her to the bathroom as necessary, but this could not be sustained owing to his having cardiac issues and being frail.

Psychiatry was consulted on hospital day 5. The initial interview was markedly limited because of severe dysarthria, noncooperation, and disorientation to time, place, and day. Collateral data and information confirmed initial reports that she was a heavy alcohol user, often having a glass of vodka in her hand whenever a sister or family member visited. The circumstances surrounding Ms. A's stroke approximately 4 years earlier were first learned, and it appeared that she had had a stroke causing her to be found in a similar physical condition as at the time of the present admission. She had not undergone rehabilitation following the stroke, which left residual dysarthria and right lower extremity weakness.

Ms. A was administered mirtazapine for assistance with appetite and for dysregulated sleep and mood. On the following day (hospital day 6), she refused to see a psychiatrist, to eat, to work with physical therapists, and to undergo a J-tube placement. A week later (hospital day 13), she was still eating very little, although she was receiving total parenteral nutrition. Psychiatric re-evaluation determined that Ms. A—due to dementia from alcohol and possibly superimposed delirium—did not have the capacity to refuse percutaneous endoscopic gastrostomy or to leave the hospital against medical advice.

Ms. A's durable power of attorney (DPOA) was then contacted for consent for the percutaneous endoscopic gastrostomy. However, she would not approve the placement of percutaneous endoscopic gastrostomy tube because she said "that would be against my sister's wishes." Risk Management notification and Ethics Committee consultation occurred 5 days later (hospital day 18), and it was found that the sister was well-suited to pursue guardianship because of the court offering guidance as to how Ms. A wanted to live her remaining life (e.g., placement of percutaneous endoscopic gastrostomy tube, which would likely be a long-term decision, vs not doing so), and as guardianship was necessary for skilled nursing facility (SNF) placement purposes.

On hospital day 15, financial information and documentation were needed for Medicaid application purposes. A plan was created to pursue a guardianship petition. The remainder of involvement by a psychiatrist was peripheral once family meetings and social services became more involved. Supplementary Table E1 provides the complete details and Supplementary Figure E1 offers the highlights.

Discussion

We are unaware of any reports publicizing the extent of delays in hospital discharges beyond the clinicians' control faced by patients requiring guardianship. Although a dedicated team charged with improving in-hospital guardianship processes potentially decreases their average number of medically unnecessary days,[7] factors beyond clinicians' control—specifically including the significant waiting times of patients applying for Long-Term Care (LTC) Medicaid—cannot be ameliorated without advocacy for specific administrative and rule changes. Table depicts the fact that more than three-quarters of our patient's hospital stay was coded by our data utilization team as medically unnecessary.

Of these medically unnecessary days, 26.4% were because of awaiting guardianship and 57.9% were because of awaiting LTC Medicaid approval. Thus, the significant driver of discharge delay was Ms. A's awaiting LTC Medicaid approval and not specifically because of routine guardianship processes. Using Dartmouth-Hitchcock Medical Center's cost-accounting methodology, the additional revenue opportunity if the medically unnecessary days of this patient were instead utilized by individuals with acute care needs exceeds half a million dollars. This is very costly for academic medical centers and costly for individuals requiring acute care. Unnecessary discharge delays are particularly unforgiveable if the patient's medical care has been completed and the patient could be cared for at a facility that is less geared for acute care (e.g., a dedicated rehabilitation center).

It is morally untenable and clinically unconscionable for any patient to wait excessively in an acute medical center while facing nonclinical barriers to