DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inadequate Discharge Coordination for a Vulnerable Patient at the Portland VA Medical Center in Oregon

HEALTHCARE INSPECTION | REPORT 21-02209-147 | MAY 4, 2022

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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to evaluate allegations that Portland VA Medical Center (facility) staff "inappropriately discharged" a patient with "severe cognitive impairment," then "turned away" the patient from the Emergency Department, and failed to provide the patient's medical records to Adult Protective Services (APS) staff for pursuit of public guardianship.[1] The OIG identified an additional concern related to facility staffs' failure to coordinate the patient's final discharge plan with family members including the lack of notification when the patient was discharged.

Synopsis of the Patient's Care

The patient, in their early 60s, has a history of chronic low back pain, peripheral neuropathy, alcohol use, cognitive impairment, and homelessness.[2] The patient was voluntarily homeless until April 2014 when facility Healthcare for Homeless Veterans (homeless services) staff provided housing assistance and case management. In late 2016, the patient completed a neuropsychological evaluation to address homeless services staff and patient concerns about the patient's memory. The neuropsychologist diagnosed the patient with neurocognitive disorder, and noted that the patient likely "suffered irreversible damage secondary to alcohol dependence," that impaired the patient's medical decision-making ability.

In December 2018, the patient was evicted from housing due to noncompliance and the facility's homeless services staff discharged the patient from the program. Between April 2019 and November 2020, the patient presented twelve times to the Emergency Department with conditions such as lice and scabies.

In early 2021, the patient presented to the facility's Emergency Department with concerns of gangrene of both feet and a skin rash "for months," and reported being homeless, sleeping outside "under a tarp or in a vehicle," and not removing their socks for three weeks. A resident physician admitted the patient to the inpatient unit with a diagnosis of cellulitis.

Throughout the patient's 33-day inpatient unit admission, facility staff evaluated the patient's cognitive functioning and decision-making capacity; communicated with the patient's family members, the public guardianship office, and APS staff; and pursued multiple placement options for the patient. Staff discharged the patient to a non-VA homeless shelter with arranged

[1] Multnomah County, "Adult Protective Services," accessed April 28, 2021, https://www.multco.us/ads/adult-protective-services. APS is a county government office that investigates abuse of adults aged 60 and older including mistreatment that results in physical, verbal, and emotional harm, and self-neglect "when an individual lacks the ability to understand consequences leading to harm." The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] The OIG uses the singular form of they (their) in this instance for the purpose of patient privacy.

transportation by cab. An inpatient social worker left a voicemail on the APS "screening line" to report the patient's discharge.

Approximately an hour after the patient's discharge, the patient presented to the facility's Emergency Department. The Emergency Department social worker documented that the patient reported being "dropped off here at the VA by a taxi."[3] The Emergency Department social worker provided the patient with a bus ticket and advised the patient "to return to the shelter." Within an hour, the patient returned to the Emergency Department and the Emergency Department social worker documented that the patient did not board the bus "as [the patient] had been instructed to do both verbally and with a printed trip plan." The Emergency Department social worker reprinted the instructions and again advised the patient to board the bus.

The day after discharge (day 34), a supervisory social worker documented that a social worker reported an APS staff member's concern that the patient "reportedly never presented to the shelter." The next day, a facility patient representative documented that a family member reported filing a missing person report. On day 37, facility staff located the patient at the non-VA shelter and the patient "vehemently declined the suggestion of relocating" to a Veterans Health Administration (VHA) community living center.

In correspondence with the OIG, a leader at the non-VA homeless shelter reported that the patient arrived at the shelter on day 34 and left approximately seven months later. As of November 22, 2021, the patient continued to receive case management and Emergency Department care for medical reasons.

OIG Findings

The OIG substantiated that facility staff discharged a patient with "severe cognitive impairment" to a non-VA homeless shelter by cab, but did not substantiate that facility staff "inappropriately discharged" the patient. The OIG found that facility staff assessed the patient's cognitive functioning and decision-making capacity, consulted the Complex Discharge Team and Integrated Ethics Council, pursued several discharge plan options, and ultimately determined the non-VA homeless shelter was the most appropriate placement option at the time the patient was deemed medically stable for discharge.[4]

The OIG substantiated that upon discharge, the patient was transported by cab to the non-VA homeless shelter where the patient did not present as planned on the day of discharge. However, the OIG determined that facility staff considered transportation options and determined that

[3] The OIG team based the time of the patient's discharge on the nurse's discharge note.

[4] Facility Memorandum No. 11-11, "*Discharge Planning*," August 4, 2018. The "Complex Discharge Team is a multidisciplinary consult team that reviews and makes recommendations of appropriate discharge options for complicated or difficult discharges from inpatient or CLC [community living center]."

direct transport via cab was preferable to the more complicated route of a bus or shuttle given the patient's cognitive impairment.

The OIG found that facility staff had regular communication with family members days 8 through 30 of the patient's inpatient unit admission. However, the OIG was unable to determine whether staff discussed the patient's final discharge plan and discharge date with the family, or notified family members of the patient's actual discharge, due to an absence of electronic health record (EHR) documentation and conflicting reports from staff and family members.[5]

Facility policy instructs social work staff to "Work toward cooperative, supportive discharge planning" with patients and their families in collaboration with community resources and other agencies.[6] Additionally, facility policy states "No plan will be implemented without the patient's and/or family's consent."[7] The treatment team is expected to update discharge plans as needed, and explain continuing care needs to the patient and family members.[8] Although the policy does not directly require documentation of communication with family, the Chief of Staff told the OIG that staff are expected to document family notification and discussion regarding the patient's discharge in the patient's EHR.

The OIG would expect facility staff to notify the patient's family of the patient's discharge and document family discussions in the patient's EHR to accurately record provided services and ensure the information is available to other clinicians. Failure to communicate the patient's discharge plan with family members and accurately document family communications may have resulted in the patient not receiving support during the discharge process, which may have contributed to the patient's failure to present to the non-VA homeless shelter and instead, return to the facility's Emergency Department.

The OIG substantiated that staff did not establish a safe transportation plan for the patient after the patient returned to the Emergency Department twice on the day of discharge. The Emergency Department social worker advised the patient to take the city bus to the non-VA homeless shelter. Emergency Department social workers facilitate patient access to benefits and referrals to services.[9] Facility travel guidance indicates that travel resources "Must always focus on the most economical and medically appropriate mode of travel that can meet the Veteran's needs."[10] A February 2019 facility Memorandum of Understanding between the Voluntary Service, Social Work Service, and Administrative Officer of the Day outlines procedures for the use of Uber gift

[5] The OIG team did not speak with one of the three family members since the one family member had minimal involvement in the patient's care.

[6] Facility Memorandum No. 11-11.

[7] Facility Memorandum No. 11-11.

[8] Facility Memorandum No. 11-11.

[9] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016.

[10] The facility Chief of Veterans Transportation Program provided a document entitled "Travel Resources."

cards to assist in patient travel from the facility's Emergency Department or inpatient treatment.[11]

The Emergency Department social worker advised the patient to return to the homeless shelter, provided the patient with "a bus ticket" and "a trip plan for the local transit system," and notified other social workers through the patient's EHR. Within an hour, however, the patient returned to the Emergency Department and reported that the bus driver told the patient "it was the wrong bus." The Emergency Department social worker documented re-printing "step-by-step trip plan instructions," and advising the patient to "board the [bus] and follow the instructions."

During interviews, the Emergency Department social worker told the OIG that most shelters do not accept admissions after 5:00 p.m.; however, because the patient had a reservation, the patient could arrive as late as 8:00 p.m.[12] The Emergency Department social worker explained that the trip to the shelter required the patient to transfer buses and that the patient "presented at almost 7 p.m. so I need to get [the patient] on the bus right away" to get to the shelter for admission.

In an interview with the OIG, the Emergency Department social worker reported not being aware of the Uber gift card option, nor having cab vouchers, and stated that taking the bus was the only transportation option.[13] When asked by the OIG, the Emergency Department social worker explained not considering contact with the patient's family because the patient's family was not involved in the past. The Emergency Department social worker acknowledged not reviewing the patient's EHR in depth because of concern about getting the patient to the shelter on time, and explained not contacting the non-VA homeless shelter regarding the patient's potential late arrival time because it was not "typical" for staff to ensure a patient's arrival. Further, the Emergency Department social worker reported an understanding that the patient had "an open adult protective services case…APS would have intervened if it was that severe," and that "I can't overstep APS."

The OIG would have expected the Emergency Department social worker to have attempted contact with the patient's family and the non-VA homeless shelter to enhance the likelihood of the patient's successful transition. Given the patient's cognitive impairment and the complexity of the bus route, utilization of Uber may have increased the likelihood of the patient arriving at the homeless shelter that day. Facility staff's lack of awareness of transportation resources could contribute to patients not receiving the safest transportation plans.

[11] VA Portland Health Care System Memorandum of Understanding, *Use of Uber Gift Cards*, February 21, 2019.

[12] A non-VA homeless shelter leader told the OIG that admissions typically end at 5:00 p.m. although later admissions may be accommodated.

[13] Facility guidelines did not address use of cabs for patient transport, and ten staff members, when asked by the OIG, reported lack of knowledge about discharge transportation by cab or which inpatient unit nursing staff member arranged for a cab for this patient.

The OIG did not substantiate that facility staff failed to provide the patient's medical records to APS staff for the purpose of pursuing public guardianship.[14] The Privacy Officer reported providing APS staff information regarding VHA requirements for the release of medical records—including the need for a written request—in May 2020, approximately eight months before this patient's inpatient admission.[15]

Two days after the patient's discharge, the Privacy Officer emailed guidance on how to request the patient's medical records to an APS supervisor. The APS Program Manager submitted a request for the patient's medical records and the APS supervisor received the patient's medical records two days later.[16]

However, the OIG found that Privacy Office staff returned other release of information requests without providing information regarding the specific missing elements and did not confirm the authority of the APS Program Manager as the head of the agency. The Privacy Officer told the OIG that the alternate Privacy Officer reported that when an APS request came in that did not meet release of information requirements, it was returned by fax to APS with "what was needed" for completion. In the two release of information requests reviewed by the OIG, the alternate Privacy Officer returned the requests with a list of required elements and did not specify the element missing from the request.[17] Although not a VHA requirement, the OIG recommends that facility leaders consider Privacy Office staff communicating the specific missing element(s) when returning a release of information request.[18]

The alternate Privacy Officer reported returning release of information requests submitted by the APS Program Manager due to incorrectly assuming that the Program Manager did not qualify as a head of agency and believing that APS had an "Executive Director" who would be considered the head of agency. However, the Privacy Officer told the OIG that a release of information request "needs to be signed by…someone in a leadership role that acknowledges there is a need for them for the investigation." As such, the OIG determined that the APS Program Manager had the authority to submit the request. The OIG concluded that the failure of facility staff to confirm the authority of the agency staff who submit release of information requests might contribute to delays in release of patients' medical records needed for APS investigations.

The OIG made three recommendations to the System Director related to consideration of requiring staff documentation of family contacts in patients' EHRs, a review of the Emergency Department social worker's care coordination of the patient, and consideration of Privacy Office

[14] VHA Directive 1605.01, *Privacy and Release of Information*, August 31, 2016.

[15] VHA Directive 1605.01; 5 U.S.C. § 552a(b)(7).

[16] In August 2021 a program supervisor in the public guardianship office told the OIG that the patient's guardianship application remained pending.

[17] The OIG reviewed two returned requests identified by APS staff.

[18] VHA Directive 1605.01.

staff communicating the specific missing element(s) when returning a release of information request.[19]

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes B and C). The OIG will follow up on the planned actions until they are completed.

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[19] The recommendations are directed to the VA Portland Health Care System Director as the individual responsible for oversight of the care provided at the Portland VA Medical Center in Oregon.

Contents

Abbreviations

APS	Adult Protective Services
CLC	community living center
CRRC	Community Resource and Referral Center
EHR	electronic health record
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection to evaluate allegations that staff at the Portland VA Medical Center (facility) in Oregon "inappropriately discharged" a patient with "severe cognitive impairment," then "turned away" the patient from the Emergency Department, and failed to provide the patient's medical records to Adult Protective Services (APS) staff for pursuit of public guardianship.[1]

Background

The VA Portland Health Care System, part of Veterans Integrated Service Network (VISN) 20, provides a range of inpatient, outpatient, long-term, and emergent care services across the facility; a Vancouver, Washington, campus; and 10 community-based outpatient clinics in Central and Northwest Oregon.[2] The facility, the main and largest site of VA Portland Health Care System, provided healthcare services to approximately 84,000 patients from October 1, 2019, through September 30, 2020.

Allegations and Related Concern

On February 23, 2021, the OIG received allegations that facility staff

1. "inappropriately discharged" a patient with "severe cognitive impairment" to a non-VA homeless shelter by cab,
2. did not ensure the patient's safe transportation to the non-VA homeless shelter after the patient returned to the Emergency Department twice on the same day as discharge, and
3. failed to provide the patient's medical records to the APS employee pursuing public guardianship.

During the healthcare inspection, the OIG identified an additional concern related to facility staffs' failure to coordinate the patient's final discharge plan with family members including the lack of notification when the patient was discharged.

[1] Multnomah County, "Adult Protective Services," accessed April 28, 2021, https://www.multco.us/ads/adult-protective-services. APS is a county government office that investigates abuse of adults aged 60 and older including mistreatment that results in physical, verbal, and emotional harm, and self-neglect "when an individual lacks the ability to understand consequences leading to harm." The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] The VA Portland Health Care System Director is responsible for oversight of the care provided at the Portland VA Medical Center.

Scope and Methodology

The OIG initiated the inspection on April 20, 2021, and conducted a virtual site visit from June 14–17, 2021.[3]

The OIG team interviewed facility staff familiar with the patient's care and relevant processes, the patient's family members, APS staff, county public guardianship office staff, and confirmed information with a leader at the non-VA homeless shelter. Additionally, the OIG team interviewed a VA Office of General Counsel attorney regarding public guardianship and release of information processes.

The OIG team reviewed relevant VHA directives, handbooks, and memoranda; facility policies and standard operating procedures; and facility organizational charts. The OIG team also reviewed the patient's electronic health record (EHR) and APS records, and a facility internal review document related to the patient's care.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

[3] The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," World Health Organization (WHO), accessed November 10, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.; *Merriam-Webster.com Dictionary*, "pandemic," accessed November 10, 2020, https://www.merriam-webster.com/dictionary/pandemic. A pandemic is "an outbreak of a disease that occurs over a wide geographic area (such as multiple countries or continents) and typically affects a significant proportion of the population."; "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," The World Health Organization, accessed November 10, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Patient Case Summary

The patient, in their early 60s, had a history of chronic low back pain, peripheral neuropathy, alcohol use, cognitive impairment, and homelessness.[4] In 2011, the patient met with Healthcare for Homeless Veterans (homeless services) staff and was placed on a housing waitlist.[5] In 2013, the patient began receiving care at the facility including two admissions to the inpatient medicine unit (inpatient unit) that year. The patient was voluntarily homeless until April 2014 when homeless services staff provided housing assistance and case management.

In late 2016, the patient completed a neuropsychological evaluation to address homeless services staff and patient concerns about the patient's memory. The neuropsychologist diagnosed the patient with neurocognitive disorder, and noted that the patient likely "suffered irreversible damage secondary to alcohol dependence," that impaired the patient's medical decision-making ability. In December 2018, the patient was evicted from housing due to noncompliance and the facility's homeless services staff discharged the patient from the program. Between April 2019 and November 2020, the patient presented twelve times to the Emergency Department with conditions such as lice and scabies.

In early 2021, the patient presented to the facility's Emergency Department with concerns of gangrene of both feet and a skin rash "for months," and reported being homeless, sleeping outside "under a tarp or in a vehicle," and not removing their socks for three weeks. A resident physician admitted the patient to the inpatient unit with a diagnosis of cellulitis.

Throughout the patient's 33-day inpatient unit admission, facility staff evaluated the patient's cognitive functioning and decision-making capacity; communicated with the patient's family members, the public guardianship office, and APS staff; and pursued multiple placement options for the patient. (See Appendix A for select EHR documentation that highlights the patient's inpatient unit care and family involvement.)

On the first day of the patient's admission (day 1), providers documented plans to complete a cognitive evaluation of the patient and consult with social work staff to assist the patient with financial and housing needs. On day 3, a resident physician (resident physician 1) documented that the cognitive screenings "strongly favor dementia," and planned to consult Psychiatry Service to assess the patient's capacity for medical decision-making. The next day, a psychiatrist

[4] The OIG uses the singular form of they (their) for the purpose of patient privacy. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[5] EHR documentation includes notes authored by two homeless service staff for visits on the same day. No further documentation is present in the EHR until 2013.

(psychiatrist 1) documented that the patient's cognitive disorder was "likely to interfere with [the patient's] capacity to make many decisions."

During days 8 and 9, a social worker (social worker 1) telephoned an APS staff member who reported that the patient's health care agent financially "exploited" the patient in the past, communicated with the patient's family members, and contacted the county public guardianship office.

From days 11 through 16, with ongoing consultation from psychiatric providers, inpatient unit staff placed the patient on a hospital hold due to the patient's "Lack of capacity for medical decision making, exit-seeking."[6] On day 12, a psychiatrist (psychiatrist 2) documented that the patient "is markedly cognitively impaired," unable to plan for [the patient's] health and safety, and "is at risk of immediate harm if [the patient] discharges without safe placement."

In a consult request to the facility's Complex Discharge Team on day 20, a social worker (social worker 2) indicated that the patient "lacks capacity to make decisions," did not have an identified surrogate decision maker, "is homeless, and cognitive deficits severe such that [the patient] will be lost to follow up as [an outpatient]."[7] The next day, the Complex Discharge Team physician documented that the patient could not be kept "indefinitely," must be discharged for the county to pursue guardianship, and that the patient should be discharged if it would not result in "immenent [*sic*] harm upon discharge (ie [*sic*] death highly likely 24-48 [hours] after [discharge]) and without other clear and timely path forward."

On day 22, a physician (physician 1) documented that the patient was at "very high risk of harm, further comorbidities, and loss to follow up if current discharge plan to the streets is the only option." Another resident physician (resident physician 2) documented that the patient "Does not want to go to the streets" and placed an Integrated Ethics Council consult. On day 27, the Integrated Ethics Council consultant responded that "When medically stable, patient can be d/c [discharged] to" the Community Resource and Referral Center (CRRC) for wound care.[8] The next day, a supervisory social worker (supervisory social worker 1) consulted with APS staff regarding the patient's public guardianship referral and release of information process.

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[6] Facility Memorandum No. 11-23, "*Involuntary Treated Patients with Psychiatric Disorders*," August 8, 2017. A hospital hold is an involuntary admission at the facility's "main hospital setting" for patients with psychiatric disorders who are a danger to themselves or others. When a patient is placed on a hospital hold, the State of Oregon requires a physician to complete a "notification of mental illness" that administrative staff then transmit to county court.

[7] Facility Memorandum No. 11-11, "*Discharge Planning*," August 4, 2018. The "Complex Discharge Team is a multidisciplinary consult team that reviews and makes recommendations of appropriate discharge options for complicated or difficult discharges from inpatient or CLC [community living center]."

[8] VA, "Portland VA Clinic," accessed March 8, 2022, https://www.va.gov/portland-health-care/locations/portland-va-clinic/. The CRRC is a community-based program that offers services and resources to homeless or potentially homeless veterans.

On day 30, another physician (physician 2) documented that the patient declined discharge to a shelter and if discharged the patient "would return to the street where it is clear [the patient] cannot safely" provide self-care. On day 33, staff discharged the patient to a non-VA homeless shelter with arranged transportation by cab. Social worker 2 left a voicemail on the APS "screening line" to report the patient's discharge.

Approximately an hour after the patient's discharge, the patient presented to the facility's Emergency Department. The Emergency Department social worker (social worker 3) documented that the patient reported being "'dropped off' here at the VA by a taxi."[9] Social worker 3 provided the patient with a bus ticket and advised the patient "to return to the shelter." Within an hour, the patient returned to the Emergency Department and social worker 3 documented that the patient did not board the bus "as [the patient] had been instructed to do both verbally and with a printed trip plan." Social worker 3 reprinted the instructions and again advised the patient to board the bus.

On day 33, social worker 2 documented speaking to an APS supervisor and an inability to clearly explain the EHR request process for purpose of the public guardianship referral. On day 34, a supervisory social worker (supervisory social worker 2) documented that social worker 2 reported an APS staff member's concern that the patient "reportedly never presented to the shelter." The next day, a facility patient representative documented that a family member (family member 1) reported filing a missing person report. On day 37, facility staff located the patient at the shelter and the patient "vehemently declined the suggestion of relocating" to another VHA facility community living center (CLC).

In correspondence with the OIG, a non-VA homeless shelter leader reported that the patient arrived at the shelter on day 34 and left approximately seven months later. As of November 22, 2021, the patient continued to receive case management and Emergency Department care for medical reasons.

Inspection Results

1. Discharge and Care Coordination

The OIG substantiated that facility staff discharged a patient with "severe cognitive impairment" to a non-VA homeless shelter by cab but did not substantiate that facility staff "inappropriately discharged" the patient. The OIG found that facility staff assessed the patient's cognitive functioning and decision-making capacity, consulted the Complex Discharge Team and Integrated Ethics Council, pursued several discharge plan options, and ultimately determined that

[9] The OIG team based the time of the patient's discharge on the nurse's discharge note.

the non-VA homeless shelter was the most appropriate placement option at the time the patient was deemed medically stable for discharge.

Assessment of Cognitive Functioning and Decision-Making Capacity

The OIG found that facility providers assessed the patient's cognitive functioning and decision-making capacity and pursued a surrogate decision-maker consistent with VHA policy.[10]

Decision-making capacity is a provider's "clinical judgment about a patient's ability to make a particular type of health care decision at a particular time."[11] Patients are generally presumed to have decision-making capacity and when uncertain, a provider must make an "explicit determination" of decision-making capacity based on an assessment of the patient's ability to understand the benefits, risks, and alternative options to the treatment recommendations and communicate a decision.[12] For a patient determined to be unlikely to regain decision-making capacity, a surrogate decision-maker must be pursued.[13]

If the patient has designated a health care agent, the responsible provider must first attempt to contact that individual.[14] If the designated health care agent is unavailable, the provider "must make a reasonable inquiry" regarding other available surrogate decision-makers.[15] Once identified, staff must attempt to contact the surrogate decision-maker within 24 hours of determining the patient lacks decision-making capacity.[16] The provider must document the surrogate identification process in the patient's EHR and decision-making must be a collaborative process between the surrogate decision-maker and the clinical team.[17]

Approximately four years prior to the patient's inpatient admission, the patient was diagnosed with a neurocognitive disorder and likely "irreversible damage" that was determined to impair the patient's medical decision-making ability. On the first day of the patient's inpatient unit admission (day 1), a physician noted concerns about cognitive functioning and requested an occupational therapy evaluation. On day 2, an occupational therapist noted that "significant

[10] VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives, December 24, 2013.

[11] VHA Handbook 1004.02.

[12] VHA Handbook 1004.02.

[13] VHA Handbook 1004.01(4), *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009, amended January 4, 2021.

[14] VHA Handbook 1004.01(4); VHA Handbook 1004.02.

[15] VHA Handbook 1004.01(4); Facility Memorandum No. 11-40, *Informed Consent and Refusal,* January 31, 2017. Surrogate decision-makers can be (1) a legal guardian who is court-appointed and can make health care decisions for a person who is legally incompetent; (2) next of kin; or (3) or a close friend who has shown care for the patient's welfare and is familiar with the patient's health, beliefs, and values.

[16] Facility Memorandum No. 11-40.

[17] VHA Handbook 1004.01(4).; VHA Handbook 1004.02.

cognitive impairments" would impede the patient's ability to live independently, and resident physician 1 documented a plan to assess the patient's decision-making capacity.

On day 4, psychiatrist 1 documented that the patient's cognitive disorder was "likely to interfere with [the patient's] capacity to make many decisions." Social worker 1 subsequently made two attempts to reach the health care agent the patient identified in a 2016 advance directive. Upon learning on day 8 that the identified health care agent had financially exploited the patient, social worker 1 contacted family member 1 who agreed to be the patient's surrogate decision-maker.[18] In an interview with the OIG, psychiatrist 2 confirmed that on day 30, the patient had the capacity to designate a family member to assist with the patient's application for Medicaid.[19] That same day, social worker 2 contacted family member 1 who "verbally agreed" to assist the patient with filing for Medicaid.

Patient Discharge

The OIG did not substantiate that facility staff inappropriately discharged the patient. Facility staff initiated discharge planning on day 1, pursued several placement options, and prior to the patient's discharge consulted with psychiatric, complex discharge, and ethics resources, as well as APS staff. The OIG determined that facility staff considered several options before concluding that the non-VA homeless shelter was the most appropriate option at the time the patient was deemed medically stable for discharge. The OIG was unable to determine whether staff discussed the patient's final discharge plan and discharge date with the family, or notified family members of the patient's actual discharge, due to an absence of EHR documentation and conflicting reports between staff and family members.

Discharge Planning

Facility policy outlines a discharge planning process that includes collaborating with the patient to identify the patient's goal, providing continuity of care, ensuring the appropriate level of care, and improving the quality of care through interdisciplinary team communication and accountability. Social work staff are responsible for coordinating discharge planning for patients who require placement in a community setting, such as in a CLC or a non-VA nursing home. The facility policy also requires that discharge planning begin "at or before" the patient's admission and includes the

- earliest possible discharge date based on the patient's readiness;

[18] VHA Handbook 1004.01(4).

[19] Caregiverlist, "Oregon Medicaid Eligibility Requirements For Seniors," accessed February 7, 2022, https://www.caregiverlist.com/oregon/medicaid.aspx. Medicaid would provide long-term care placement option coverage for the patient.

- assessment of "patient, family and/or caregiver, medical, nursing, rehabilitative, psychosocial, and financial needs;"
- identification of discharge problems;
- patient, caregiver, and provider agreement on the plan; and
- evaluation of implemented plans.[20]

The OIG found that facility staff initiated the patient's discharge planning on day 1 and engaged in discharge planning throughout the patient's admission as required.[21] Social workers pursued two CLC and three non-VA skilled nursing facility placement options that were declined with reasons such as lack of bed availability, absence of a long-term placement plan, and the patient's impulsivity.

Inpatient unit staff consulted with Psychiatry Service throughout the patient's admission and obtained consultation from the complex discharge and ethics committees to inform the patient's discharge planning. On day 21, the Complex Discharge Team physician noted that the patient could not be kept "indefinitely," must be discharged for the county to pursue guardianship, and that the patient should be discharged if it would not result in "immenent [*sic*] harm upon discharge (ie [*sic*]death highly likely 24-48 [hours] after [discharge]) and without other clear and timely path forward." Six days later, the ethics committee consultant emphasized that it is the family's responsibility to follow up with Medicaid and "When medically stable, patient can be [discharged] to CRRC" for wound care. On day 33, the patient was deemed medically stable and discharged to the non-VA homeless shelter by cab.

In an interview with the OIG, social worker 2 reported that they had considered dementia care facility options; however, the dementia facility did not have bed availability. Physician 2 told the OIG that the patient's placement at the non-VA homeless shelter and APS involvement was the only option given the limited placement options, and had documented that staff had "extensively exhausted all our resources." Social worker 2 told the OIG that a bed was reserved at the non-VA homeless shelter when physician 2 and "other hospital administrators" determined the patient's readiness for discharge. Social worker 2 also reported calling APS on day 33 to inform them of the patient's discharge.

Discharge Transportation

The OIG substantiated that upon discharge, the patient was transported by cab to the non-VA homeless shelter where the patient did not present as planned on the day of discharge. However, the OIG determined that facility staff considered transportation options and determined that

[20] Facility Memorandum No. 11-11.

[21] Facility Memorandum No. 11-11.

direct transport via cab was preferable to the more complicated route of a bus or shuttle given the patient's cognitive impairment.

Family Communication

The OIG found that facility staff had regular communication with family members days 8 through 30 of the patient's inpatient unit admission. However, the OIG was unable to determine whether staff discussed the patient's final discharge plan and discharge date with the family, or notified family members of the patient's actual discharge, due to an absence of EHR documentation and conflicting reports between staff and family members.[22]

Facility policy instructs social work staff to "Work toward cooperative, supportive discharge planning" with patients and their families in collaboration with community resources and other agencies.[23] Additionally, facility policy states "No plan will be implemented without the patient's and/or family's consent."[24] The treatment team was expected to update discharge plans, as needed, and explain continuing care needs to the patient and family members.[25] Although the policy did not directly require documentation of communication with family, the Chief of Staff told the OIG that staff were expected to document family notification and discussion regarding the patient's discharge in the patient's EHR.

Staff documented 12 contacts with family members from days 8 to 30.[26] On day 8, social worker 1 established contact with family member 1 and another family member (family member 2) and provided family member 2 with public guardianship office contact information the next day. On day 10, resident physician 2 listed family member 2 as the patient's medical decision-maker.[27] The next day, another resident physician attempted to reach family member 2 regarding the patient's attempt to leave the hospital against medical advice. Physician 1 documented "prolonged phone conversations" with family member 2 and another family member (family member 3) and established that the patient's discharge to their homes was not feasible. From days 13 to 30, social worker 2 spoke to family members seven times including discussion of the "limitations of holding veteran at the hospital," long-term care placement referral options, and the Medicaid application." Social worker 2 documented talking with family member 1 on day 30 and informing family member 1 that the patient would not be discharged that day. The patient's

[22] The OIG team spoke with family members 1 and 2 and did not speak with family member 3 given family member 3's minimal involvement in the patient's care.

[23] Facility Memorandum No. 11-11.

[24] Facility Memorandum No. 11-11.

[25] Facility Memorandum No. 11-11.

[26] A total of 12 family contacts were made by four providers from days 8 to 30.

[27] VHA Handbook 1004.01(4). A medical decision-maker is an individual who is authorized to make health care decisions for a patient.

EHR did not include documentation that reflected communication with the patient's family from days 31 through 33, the day of the patient's discharge.

In interviews with the OIG, social worker 1 reported that early in the patient's admission, the focus was on making contact with the patient's family to discuss pursuing guardianship and long-term planning.[28] Social worker 2 did not recall contacting the patient's family on the day of discharge, but stated that family would typically be notified of a patient discharge. Supervisory social worker 2 reported that a physician would notify a patient's family of discharge and said "I did not see that a family member was notified" that the patient was going to be discharged.

In an interview with the OIG, physician 2 reported speaking to family member 2 the day before and the day of discharge (days 32 and 33) and stated that family member 2 was aware of the patient's discharge. However, physician 2 did not document the contact in the patient's EHR and told the OIG that it was not a routine practice to document contact with family. The Chief of Staff acknowledged that physician 2 failed to document the discharge notification conversation with family member 2 and that the Chief of Hospital Medicine subsequently provided education to facility physicians about the significance of documenting family contact in patients' EHRs.

Family members 1 and 2 told the OIG that facility staff did not contact any family member to inform them about the discharge plan or date. Family member 1 expressed understanding that the facility could not keep the patient in the hospital indefinitely and noted that, with notification, an escort likely could have been arranged to accompany the patient to the non-VA homeless shelter.

Due to conflicting recollections, the OIG was unable to determine whether facility staff discussed the patient's final discharge plan and discharge date, or notified family members of the patient's discharge. The OIG would expect facility staff to notify the patient's family of the patient's discharge and document family discussions in the patient's EHR to accurately record provided services and ensure the information was available to other clinicians.[29] Failure to communicate the patient's discharge plan with family members and accurately document family communications may have resulted in the patient not receiving support during the discharge process, which may have contributed to the patient's failure to present at the non-VA homeless shelter and return to the facility's Emergency Department.

2. Staff Response to the Patient's Return to the Facility

The OIG substantiated that staff did not establish a safe transportation plan for the patient after the patient returned to the Emergency Department twice on the day of discharge. Social worker 3 advised the patient to take the city bus to the non-VA homeless shelter.

[28] Social worker 2 assumed responsibility for the patient's care on day 13.

[29] Facility Memorandum No. 11-11.

Emergency Department social workers facilitate patient access to benefits and referrals to services.[30] Facility travel guidance indicates that travel resources "Must always focus on the most economical and medically appropriate mode of travel that can meet the Veteran's needs."[31] A February 2019 facility Memorandum of Understanding between the Voluntary Service, Social Work Service, and Administrative Officer of the Day outlined procedures for the use of Uber gift cards to assist in patient travel from the facility Emergency Department or inpatient treatment.[32]

On day 33, at approximately 5:30 p.m., an inpatient unit nurse reviewed the discharge instructions with the patient. About an hour later, the patient presented to the facility Emergency Department and reported being dropped off by a cab. In an interview with the OIG, social worker 3 explained that the Emergency Department medical support assistant referred the patient to social work since the patient did not have a medical concern. Social worker 3 reported being familiar with the patient from prior contacts. Social worker 3 advised the patient to return to the homeless shelter, provided the patient with "a bus ticket" and "a trip plan for the local transit system," and notified social worker 2 and supervisory social worker 1 through the patient's EHR. Within an hour, the patient returned to the Emergency Department and reported that the bus driver told the patient "it was the wrong bus." Social worker 3 documented re-printing "step-by-step trip plan instructions," and advising the patient to "board the [bus] and follow the instructions."

During interviews, social worker 3 told the OIG that most shelters do not accept admissions after 5:00 p.m.; however, because the patient had a reservation, the patient could arrive as late as 8:00 p.m.[33] Social worker 3 explained that the trip to the shelter required the patient to transfer buses and that the patient "presented at almost 7 p.m. so I need to get [the patient] on the bus right away" to get to the shelter for admission.

In an interview with the OIG, social worker 3 reported not being aware of the Uber gift card option, nor having cab vouchers, and stated that taking the bus was the only transportation option.[34] When asked by the OIG, social worker 3 explained not considering contact with the patient's family because the patient's family was not involved in the past. Social worker 3 acknowledged not reviewing the patient's EHR in depth because of concern about getting the patient to the shelter on time. Social worker 3 also explained not contacting the non-VA homeless shelter regarding the patient's potential late arrival time because it was not "typical"

[30] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016.

[31] The facility's Chief of Veterans Transportation Program provided a document entitled "Travel Resources."

[32] VA Portland Health Care System Memorandum of Understanding, *Use of Uber Gift Cards*, February 21, 2019.

[33] A non-VA homeless shelter leader told the OIG that admissions typically end at 5:00 p.m. although later admissions may be accommodated.

[34] Facility guidelines did not address use of a cab for patient transport, and 10 staff members, when asked by the OIG, reported lack of knowledge about discharge transportation by cab or which inpatient unit nursing staff member arranged for a cab for this patient.

for staff to ensure a patient's arrival. Further, social worker 3 reported an understanding that the patient had "an open adult protective services case…APS would have intervened if it was that severe," and that "I can't overstep APS." The OIG would have expected social worker 3 to have attempted contact with the patient's family and the non-VA homeless shelter to enhance the likelihood of the patient's successful transition.

The OIG found that social worker 3 was not aware of the Uber gift card option to transport the patient. Given the patient's cognitive impairment and the complexity of the bus route, utilization of Uber may have increased the likelihood of the patient arriving at the homeless shelter that day. Facility staff's lack of awareness of transportation resources could contribute to patients not receiving the safest transportation plans.

3. EHR Documentation Request Process to Pursue Guardianship

The OIG did not substantiate that facility staff failed to provide the patient's medical records to APS staff for the purpose of pursuing public guardianship.[35] Facility staff provided the patient's EHR documentation to APS on day 37, two days after APS staff submitted a written release of information request. However, the OIG found that Privacy Office staff returned other release of information requests without providing information regarding the specific missing elements and did not confirm the authority of the APS Program Manager as the head of the agency.

VHA requires compliance with "all applicable privacy and confidentiality statutes and regulations," including "The Privacy Act of 1974" (The Privacy Act).[36] The Privacy Act prohibits disclosure of an individual's records unless the individual provides a written consent to release the information or certain exceptions apply to the disclosure. Section B7 of The Privacy Act allows a governmental agency, such as VA, to disclose individually-identifiable information if the head of another agency, such as APS, submits a written request to conduct a focused activity by law.[37]

In interviews with the OIG, the Privacy Officer and an Office of General Counsel attorney confirmed that APS staff, for purposes of their investigation or involvement, could request medical records through the Privacy Office for public guardianship.[38] The Privacy Officer reported that the "most common issue" for denial was that the head of the agency did not submit the request, as required.[39] The Privacy Officer reported providing APS staff information

[35] VHA Directive 1605.01, *Privacy and Release of Information*, August 31, 2016.
[36] VHA Directive 1605.01; *The Privacy Act of 1974,* 5 U.S.C. § 552a(b).
[37] VHA Directive 1605.01; 5 U.S.C. § 552a(b)(7).
[38] VHA Directive 1605.01; 5 U.S.C. § 552a(b)(7).
[39] VHA Directive 1605.01; 5 U.S.C. § 552a(b)(7).

regarding VHA requirements for the release of medical records including the need for a written request in May 2020, approximately eight months before this patient's inpatient admission.[40]

Release of Patient's EHR Documentation

The OIG found that facility staff complied with VHA requirements regarding the release of the patient's EHR documentation when requested by an APS supervisor following the patient's discharge from the facility. As discussed above, the patient lacked decision-making capacity and therefore was not able to provide informed consent to a release of protected information.

On day 14, the public guardianship program supervisor "shared [public guardianship] referral and intake worksheet" with social worker 2. Based on consultation with supervisory social worker 2, social worker 2 documented that that "initial referral is appropriate" but further medical record requests would need to be sent to the Privacy Office. On day 15, supervisory social worker 2 advised social worker 2 to contact APS "to report that [the patient] will [discharge] to street, lacks capacity, unable to care for [themself], and is vulnerable to exploitation by [the patient's significant other] again." Supervisory social worker 2 "enforced that [public guardianship] referral cannot be made" by the medical team due to the "Privacy Act" and that facility staff would need to work with APS to initiate the public guardianship referral.[41] Between days 16 and 27, social worker 2 and physicians continued to pursue placements for the patient, spoke with family members, communicated with a Medicaid screener, and requested Integrated Ethics Council and Complex Discharge Team consults. On day 28, supervisory social worker 1 documented explaining to APS staff that "VA staff are unable to release records to the public guardianship office [due to] federal privacy laws," and "Discussed option for the head of the APS to request records and then submit the referral on Veteran's behalf."

Two days after the patient's discharge, the Privacy Officer again emailed the APS supervisor guidance on how to request the patient's medical records. Subsequently, the APS Program Manager submitted a request and two days later the APS supervisor received the patient's medical records.[42]

Privacy Office Release of Information Process

An APS supervisor reported to the OIG that although the Privacy Officer had previously provided a template for the written request, when submitted accordingly, VHA had "rejected" the request. The APS supervisor described following the "specific language" and using the template provided by the Privacy Officer and "it gets rejected." The Privacy Officer reported no

[40] VHA Directive 1605.01; 5 U.S.C. § 552a(b)(7).

[41] VHA Directive 1605.01. The Privacy Act, 5 U.S.C. 552a, implemented by VA at 38 CFR 1.575-1.582. The Privacy Act requires VHA to ensure the confidentiality of individually identifiable information of living individuals.

[42] In August 2021 a program supervisor in the public guardianship office told the OIG that the patient's guardianship application remained pending.

APS release of information requests were denied since the Privacy Officer's presentation in May 2020. The Privacy Officer told the OIG that the alternate Privacy Officer reported that when an APS request came in that did not meet release of information requirements, it was returned by fax to APS with "what was needed" for completion. In the two release of information requests reviewed by the OIG, the alternate Privacy Officer returned the requests with a list of required elements and did not specify the element missing from the APS Program Manager's request.[43] Although not a VHA requirement, the OIG suggests that facility leaders consider communication of the specific missing element(s) when returning a release of information request.[44]

The alternate Privacy Officer reported returning the release of information requests submitted by the APS Program Manager due to the alternate Privacy Officer's understanding that APS had an "Executive Director" who would be considered the head of agency. However, the Privacy Officer told the OIG that a request "needs to be signed by…by someone in a leadership role that acknowledges that there is a need for them for the investigation." As such, the OIG determined that the APS Program Manager would have the authority to submit a request. The OIG concluded that the failure of facility staff to confirm the authority of agency staff who submit requests might contribute to delays in release of patients' medical records needed for APS investigations.

Conclusion

The OIG substantiated that facility staff discharged a patient with "severe cognitive impairment" to a non-VA homeless shelter by cab, but did not substantiate that facility staff "inappropriately discharged" the patient. The OIG found that facility staff assessed the patient's cognitive functioning and decision-making capacity, consulted the Complex Discharge Team and Integrated Ethics Council, pursued several discharge plan options, and ultimately determined that the non-VA homeless shelter was the most appropriate placement option at the time the patient was deemed medically stable for discharge.[45]

The OIG substantiated that upon discharge, the patient was transported by cab to the non-VA homeless shelter where the patient did not present as planned on the day of discharge. However, the OIG determined that facility staff considered transportation options and concluded that direct transport via cab was preferable to the more complicated route of a bus or shuttle given the patient's cognitive impairment.

[43] The OIG reviewed two returned requests identified by APS staff.

[44] VHA Directive 1605.01.

[45] Facility Memorandum No. 11-11. The "Complex Discharge Team is a multidisciplinary consult team that reviews and make recommendations of appropriate discharge options for complicated or difficult discharges from inpatient or community living center.

The OIG found that facility staff had regular communication with family members days 8 through 30 of the patient's inpatient unit admission. However, the OIG was unable to determine whether staff discussed the patient's final discharge plan and discharge date with the family, or notified family members of the patient's actual discharge, due to an absence of EHR documentation and conflicting reports between staff and family members.

Facility policy instructs social work staff to "Work toward cooperative, supportive discharge planning" with patients and their families in collaboration with community resources and other agencies.[46] Additionally, facility policy states "No plan will be implemented without the patient's and/or family's consent."[47] The treatment team was expected to update discharge plans, as needed, and explain continuing care needs to the patient and family members.[48] Although the policy did not directly require documentation of communication with family, the Chief of Staff told the OIG that staff were expected to document family notification and discussion regarding the patient's discharge in the patient's EHR.

The OIG would expect facility staff to notify the patient's family of the patient's discharge and document family discussions in the patient's EHR to accurately record provided services and ensure the information was available to other clinicians. Failure to communicate the patient's discharge plan with family members and accurately document communications with family may have resulted in the patient not receiving support during the discharge process, which may have contributed to the patient's failure to present at the non-VA homeless shelter and instead, return to the facility's Emergency Department.

The OIG substantiated that staff did not establish a safe transportation plan for the patient after the patient returned to the Emergency Department twice on the day of discharge. Social worker 3 advised the patient to take the city bus to the non-VA homeless shelter. Emergency Department social workers facilitate patient access to benefits and referrals to services.[49] Facility travel guidance indicates that travel resources "Must always focus on the most economical and medically appropriate mode of travel that can meet the Veteran's needs."[50] A February 2019 facility Memorandum of Understanding between the Voluntary Service, Social Work Service, and Administrative Officer of the Day outlined procedures for the use of Uber gift cards to assist in patient travel from the facility Emergency Department or inpatient treatment.[51]

Social worker 3 advised the patient to return to the homeless shelter, provided the patient with "a bus ticket" and "a trip plan for the local transit system," and notified social worker 2 and

[46] Facility Memorandum No. 11-11.

[47] Facility Memorandum No. 11-11.

[48] Facility Memorandum No. 11-11.

[49] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016.

[50] The facility Chief of Veterans Transportation Program provided a document entitled "Travel Resources."

[51] VA Portland Health Care System Memorandum of Understanding, *Use of Uber Gift Cards*, February 21, 2019.

supervisory social worker 1 through the patient's EHR. Within an hour, the patient returned to the Emergency Department and reported that the bus driver told the patient "it was the wrong bus." Social worker 3 documented re-printing "step-by-step trip plan instructions," and advising the patient to "board the [bus] and follow the instructions."

In an interview with the OIG, social worker 3 reported not being aware of the Uber gift card option, not considering contacting the patient's family, not reviewing the patient's EHR in depth, and not contacting the non-VA homeless shelter to ensure the patient's safe arrival. The OIG would have expected social worker 3 to have attempted contact with the patient's family and the non-VA homeless shelter to enhance the likelihood of the patient's successful transition.

The OIG found that social worker 3 was not aware of the Uber gift card option to transport the patient. Given the patient's cognitive impairment and the complexity of the bus route, utilization of Uber may have increased the likelihood of the patient arriving at the homeless shelter that day. Facility staff's lack of awareness of transportation resources could contribute to patients not receiving the safest transportation plans.

The OIG did not substantiate that facility staff failed to provide the patient's medical records to APS staff for the purpose of pursuing public guardianship. However, the OIG found that Privacy Office staff returned release of information requests without providing information regarding the specific missing elements and did not confirm the authority of the APS Program Manager as the head of the agency. Although not a VHA requirement, the OIG suggests that facility leaders consider communication of the specific missing element(s) when returning a release of information request. The OIG determined that the APS Program Manager would have the authority to submit a request and concluded that the failure of facility staff to confirm the authority of agency staff who submit requests might contribute to delays in release of patients' medical records needed for APS investigations.

Recommendations 1–3

1. The VA Portland Health Care System Director considers adding the requirement to document family contacts in patients' electronic health records in Portland VA Medical Center Policy 11-11, *Discharge Planning,* and ensures that staff document contact with family members, including notification of discharge, when applicable.
2. The VA Portland Health Care System Director ensures a review of the Emergency Department social worker's care coordination of the patient and takes action as warranted.
3. The VA Portland Health Care System Director considers requiring Privacy Office staff to communicate the specific missing element(s) when returning a release of information request.

Appendix A: Select Inpatient Unit Admission EHR Documentation

Day	Select EHR Documentation
1	A physician documented "Will try to perform a cognitive evaluation this admission." A resident physician documented a plan to consult with social work to assist the patient with financial and housing needs. A social worker documented that based on the patient's preferences, the patient would be discharged to an emergency shelter and referred to the CRRC. A podiatrist recommended wound care and compression dressings. A physical therapist documented that the patient • was at high risk for falls, oriented to person, place, and situation, and that the patient's "Short-term recall appears to be grossly impaired;" • agreed to be discharged to a skilled nursing facility for rehabilitation; and • should be transported by a wheelchair van.
2	Resident physician 1 planned to evaluate "suspected cognitive impairment [versus] dementia" and "will also assess for medical decision-making capacity today." The physical therapist documented that the patient would benefit "living in a supervised setting as [the patient] is unable to manage [their] own care." An occupational therapist was unable to complete a cognitive exam because the patient refused to continue and noted that the patient's "significant cognitive impairments" would impede the patient's ability to live independently and the patient would benefit from admission to a skilled rehabilitation program.
3	Resident physician 1 documented that the cognitive screenings "strongly favor dementia," and planned to consult Psychiatry Service to assess the patient's capacity for medical decision-making. A psychiatry resident physician (psychiatry resident physician 1) documented that • the patient was "agreeable to additional supports to help manage [the patient's] finances and medical decision making," and • a 2017 neuropsychological evaluation assessed the patient as lacking capacity to make decisions about [the patient's] health and recommended "initiating process for conservatorship and guardianship."
4	Psychiatrist 1 documented that the patient's cognitive disorder was "likely to interfere with [the patient's] capacity to make many decisions."
5	Social worker 1 • confirmed with a physician that the patient "does not have decisional making capacity at this time," • referred the patient to the facility's CLC, • planned to request "VA Contract to community [skilled nursing facility]" if CLC admission was not approved,

Day	Select EHR Documentation
	• documented that the patient had identified a [health care power of attorney] in a 2016 advance directive. Resident physician 1 documented a "Work-up of suspected cognitive impairment [versus] dementia with initial reversible causes of dementia" indicated a low vitamin D level and ordered replacement dosing for the patient.
8	Social worker 1 • telephoned an APS staff member who reported that the patient's health care agent financially "exploited" the patient in the past, • contacted family member 1 who reported being unable to house the patient and unwilling to seek guardianship but willing to "act as a [surrogate decision-maker] and be involved in medical care" of the patient, and • received a telephone call from family member 2 who explained their current life demands and a desire "to be involved in [the patient's] life but that pursuing public guardianship is the family's wish at this time." Resident physician 1 documented that the team would "likely need complex discahrge [*sic*] planning given patient needs [skilled nursing facility] and then is homeless but needs assistance for daily activities, +guardianship."
9	Social worker 1 • spoke with a staff member at the county's public guardianship program who advised that the family would need an attorney to pursue guardianship of the patient, and • provided family member 2 with the contact information for the public guardianship program and a program that might assist with associated legal fees.
10	Resident physician 2 listed family member 2 as the patient's medical decision-maker.
11	Another resident physician documented that nursing staff reported that the patient wanted to leave against medical advice. A physician placed the patient on a hospital hold due to the patient's "Lack of capacity for medical decision making, exit-seeking." A psychiatry resident physician (psychiatry resident physician 2) documented that the patient "appears to lack capacity to make the decision whether [the patient] can discharge from the hospital," may not be able to provide self-care "in the community due to [the patient's] neurocognitive disorder," and noted that the "[Notification of Mental Illness] is appropriate."
12	The patient remained on the hospital hold. Psychiatrist 2 documented

Day	Select EHR Documentation
	• the patient "is markedly cognitively impaired," unable to plan for [the patient's] health and safety, and "is at risk or immediate harm if [the patient] discharges without safe placement;" and • the recommendation that the patient's medical team continue pursuit of guardianship for "medical decision making and for placement decisions" because the patient was "unable to make these decisions…" Family member 2 requested the social worker contact a public guardianship program staff member.
13	A psychiatry resident physician (psychiatry resident physician 3) documented agreement with a continued hospital hold. Resident physician 2 documented that the hospital hold would be reviewed by the county that day. Social worker 2 • spoke with family member 2 who recommended contacting family member 3 who may be able to assist in becoming the patient's guardian, and • contacted family member 3 who reported caring for "multiple family members" and being unable to serve as the patient's guardian.
14	Psychiatry resident physician 3 documented that the patient continues with "marked memory impairments" and that the patient's "ability to engage in capacity-related assessment is limited due to [their] limited ability to track and [their] uncooperation [*sic*] with attempts at more- directed interview." A county public guardianship program supervisor told social worker 2 that they had "a hold on intakes for months, so referral list is lengthy, and would not serve [patient's] immediate needs" and "ultimately [their] vulnerabilities could move [them] up the priority list." Social worker 2 consulted with a supervisor and documented that initial referral completion was appropriate but that additional medical record requests would need to go through the facility's Privacy Office.
15	A psychiatry fellow physician documented that the patient's "ability to engage in capacity-related assessment is limited." Social worker 2 documented that a CRRC outreach coordinator reported that the patient was eligible for wound care post-discharge and provided a "list of shelter services across the town" for the patient's "emergency housing needs." Supervisory social worker 2 • advised social worker 2 to contact APS "to report that [the patient] will [discharge] to street, lacks capacity, unable to care for [themself], and is vulnerable to exploitation by [the patient's significant other] again;" and • "enforced that [public guardianship] referral cannot be made by" the medical team due to the "Privacy Act" and that facility staff would need to work with APS to initiate the public guardianship referral.

Day	Select EHR Documentation
16	Psychiatry resident physician 3 documented that the hospital hold would expire that day and multiple unsuccessful daily attempts to contact or get a response from the county office that monitors patients on a hospital hold.
17	Resident physician 2 documented that the hospital hold "appears to be dropped by the county on 2/5/21" and that "if [the patient] were to attempt to leave over this weekend [they] would need another" hospital hold placed.
18	A physician documented that the patient is "not on psychiatric/medical hold at this time, but does not have capacity and likely never will."
19	Social worker 2 documented • that two non-VA nursing homes declined the patient's admission due to concerns about the patient's unstable housing after the skilled nursing facility discharge; and • a discussion with family member 2 about the patient's "possible [discharge] in the next few days" and family member 2 reported that the family was unable to finance the legal fees to pursue guardianship. Resident physician 2 documented a plan that included "establishing guardianship" and then placement in a skilled nursing facility for approximately three weeks.
20	In a consult request to the facility's Complex Discharge Team, social worker 2 indicated that the patient "lacks capacity to make decisions," did not have an identified surrogate decision-maker, "is homeless, and cognitive deficits severe such that [the patient] will be lost to follow up as [an outpatient]." Resident physician 2 documented that the patient "is aware that if [the patient] is discharged to the streets there is a high likelihood that [the patient] will have further infections of [their] feet."
21	The Complex Discharge Team physician recommended determining if the patient "might have capacity to be able to designate/sign paperwork for [family members 2 and 3] to act on [the patient's] behalf to pursue Medicaid." The Complex Discharge Team physician also noted that the patient could not be kept "indefinitely," must be discharged for the county to pursue guardianship, and that the patient should be discharged if it would not result in "immenent [*sic*] harm upon discharge (ie [*sic*] death highly likely 24-48 [hours] after [discharge]) and without other clear and timely path forward." A physical therapist assistant documented that the patient was making "good and steady progress" with a "decreased need of assist" and recommended discharge to a "Higher level of care."
22	Physician 1 documented that the patient was • "again unable to demonstrate even limited capacity to assign someone consistently to apply for medicaid [*sic*] on [the patient's] behalf," and • "at very high risk of harm, further comorbidities, and loss to follow up if current discharge plan to the streets is the only option." Resident physician 2 documented that the patient "does not want to go to the streets" and placed an Integrated Ethics Council consult.

Day	Select EHR Documentation
	Social worker 2 noted a plan to notify CRRC staff of the patient's expected discharge and left a voicemail for a county "Medicaid Screening Line" staff member.
23	Social worker 2 • attempted to contact the family member 2 to provide information about the family's responsibility "to manage [the patient's] Medicaid referral for potential [long-term care] placement," and • noted that the discharge plan included a shelter referral and follow up with CRRC.
27	Social worker 2 • explained the need for family to assist the patient with a Medicaid application to family member 2, and • contacted a Medicaid screener who reported being familiar with the patient and agreed to contact the patient for the screening the next day. Family member 3 told the social worker about willingness to assist with the Medicaid application if other family members declined. Supervisory social worker 1 discussed the patient's case with physician 2 and the social worker and documented a plan to contact APS to discuss "any options for intervention" while the patient was an inpatient. The Integrated Ethics Council consultant emphasized that it is the family's responsibility to follow up with Medicaid and "When medically stable, patient can be [discharged] to CRRC" for wound care. Imaging tests of the patient's brain indicated no changes from imaging done approximately 17 months prior that included loss of brain volume.
28	Supervisory social worker 1 • documented a call from an APS staff member who recommended that facility staff complete a public guardianship referral for the patient, and • informed the APS staff that facility staff could not release the patient's EHR to the public guardianship office due to privacy laws and advised APS to request the medical records and complete the public guardianship referral.
29	Social worker 2 • attempted to contact the family member 1 regarding follow up to the Medicaid application, • received a message from an APS staff member regarding the potential records request to begin a public guardianship referral pending the patient's discharge, and • secured a bed for the patient at a non-VA homeless shelter for the next day pending the patient's discharge.
30	Psychiatrist 2 determined that the patient "does have the capacity to designate" family member 1 as a Medicaid authorized representative. Social worker 2

Day	Select EHR Documentation
	• documented that family member 1 agreed to assist with the Medicaid application and attempted to contact the Medicaid staff member, • informed family member 1 that the patient would not be discharged that day, • referred the patient for placement at another VHA facility's CLC, and • attempted to contact an APS supervisor regarding "referral/records request." Physician 2 documented that the patient declined discharge to a shelter and if discharged the patient "would return to the street where it is clear [the patient] cannot safely" provide self-care.
31	A resident physician documented that family member 1 was unable to access the patient's financial information for the Medicaid application due to not being the patient's health care agent or guardian.
33	The patient "adamantly declines referral to shelter." Staff discharged the patient to a homeless shelter with arranged transportation by cab. Social worker 2 left a voicemail on the APS "screening line" to report the patient's discharge.

Source: OIG review of the patient's EHR documentation.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 1, 2022

From: Director, VA Northwest Network (10N20)

Subj: Healthcare Inspection—Inadequate Discharge Coordination for a Vulnerable Patient at the Portland VA Medical Center in Oregon

To: Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review the report Healthcare Inspection – Inadequate Discharge Coordination for a Vulnerable Patient at the Portland VA Medical Center in Oregon.

2. VISN 20 concurs with all the recommendations and will ensure all corrective actions to the recommendations are fully implemented.

(*Original signed by*:)

Teresa D. Boyd, DO
Director VA Northwest Network

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: 3/24/22

From: Director, VA Portland Health Care System (648/00)

Subj: Healthcare Inspection—Inadequate Discharge Coordination for a Vulnerable Patient at the Portland VA Medical Center in Oregon

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the Healthcare Inspection — Inadequate Discharge Coordination for a Vulnerable Patient at the Portland VA Medical Center in Oregon.

2. Portland VA Healthcare System concurs with the findings and have attached implementation plans towards corrections.

(*Original signed by*:)

Darwin G. Goodspeed, FACHE
Director, VA Portland Health Care System

Facility Director Response

Recommendation 1

The VA Portland Health Care System Director considers adding the requirement to document family contacts in patients' electronic health records in Portland VA Medical Center Policy 11-11, *Discharge Planning,* and ensures that staff document contact with family members, including notification of discharge, when applicable.

Concur.

Target date for completion: July 1, 2022

Director Comments

The VA Portland Health Care System will revise the Discharge Planning policy to include documentation of contact with family members, including notification of discharge for Veteran's with severe cognitive impairment. The policy changes will be communicated to applicable staff members via customary posting of the policy to the facility intranet and an email notification to the applicable staff.

Recommendation 2

The VA Portland Health Care System Director ensures a review of the Emergency Department social worker's care coordination of the patient and takes action as warranted.

Concur.

Target date for completion: August 1, 2022

Director Comments

Social Work Service leadership will review the Emergency Department social worker's care coordination of the patient and if action is warranted, perform a root cause analysis. A non-punitive Protected Peer Review (PR) will be completed. Follow up action will be implemented accordingly.

Recommendation 3

The VA Portland Health Care System Director considers requiring Privacy Office staff to communicate the specific missing element(s) when returning a release of information request.

Concur.

Target date for completion: July 1, 2022

Director Comments

The VA Portland Health Care System Privacy office will create standard work on how to process a release of information. This will include direction on how to communicate the specific missing element(s) when returning a request. The new process will be communicated to all Privacy Office staff members via customary process through email or in person communication.

Glossary

To go back, press "alt" and "left arrow" keys.

advance directive. A legal document of a person's health care preferences used to guide health care decisions in the event the person is unable to make such decisions.[1]

against medical advice. Term used to describe when a voluntarily admitted patient chooses to leave the hospital without the treating provider recommending discharge.[2]

cellulitis. A skin condition caused by bacteria entering through a break in the skin that commonly affects the lower legs.[3]

dementia. A group of symptoms that affects cognitive and psychological functioning including memory and personality changes.[4]

gangrene. A type of body tissue death caused by lack of blood flow that commonly affects the feet.[5]

health care agent. An appointed person who can make health care decisions for an individual determined to be unable to make those decisions.[6]

lice. Parasitic insects that feed on a person's blood, are easily spread through close contact with other people or their belongings and can infect the scalp and other parts of the body.[7]

neurocognitive disorder. An acquired disorder characterized by a decline in cognition functioning.[8]

neuropathy. Damage or disease of one or more nerves typically marked by pain, numbness, tingling or muscle weakness.[9]

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[1] VA Form 10-0137, "VA Advance Directive: Durable Power of Attorney For Health Care and Living Will."

[2] Alfandre, David J. MD, "'I'm Going Home': Discharges Against Medical Advice," Mayo Clinic Proceedings, 2009 Mar; 84(3): 255-260, accessed October 9, 2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2664598/.

[3] Mayo Clinic, "cellulitis," accessed August 26, 2021, https://www.mayoclinic.org/diseases-conditions/cellulitis/symptoms-causes/syc-20370762.

[4] Mayo Clinic, "dementia," accessed April 28, 2021, https://www.mayoclinic.org/diseases-conditions/dementia/symptoms-causes/syc-20352013/.

[5] Mayo Clinic, "gangrene," accessed April 28, 2021, https://www.mayoclinic.org/diseases-conditions/gangrene/symptoms-causes/syc-20352567.

[6] VHA Handbook 1004.01(4).

[7] Mayo Clinic, "lice," accessed October 5, 2021, https://www.mayoclinic.org/diseases-conditions/lice/symptoms-causes/syc-20374399.

[8] Diagnostic and Statistical Manual of Mental Disorders, "Neurocognitive Disorders," accessed April 28, 2021, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm17.

[9] *Merriam-Webster.com Dictionary*, "neuropathy," accessed September 21, 2021, https://www.merriam-webster.com/dictionary/neuropathy."

neuropsychological evaluation. A series of assessments used to determine how well the brain is functioning and can also identify the cause of a patient's cognitive changes such as aging, a neurological illness, or other mental health diagnosis.[10]

occupational therapist. A rehabilitation therapist who evaluates and provides treatment related to a person's ability occupational performance and daily self-care activities.[11]

physical therapist. A rehabilitation therapist who evaluates and provides treatment related to a person's muscle strength, balance and coordination, endurance, and mobility.[12]

podiatrist. A physician who treats the foot, ankle, and related leg structures.[13]

public guardianship. A legal process by which a government employee is appointed to make decisions on behalf of a person who can no longer make sound decisions or is susceptible to fraud or undue influence and does not have family members or friends able to assume the role.[14]

scabies. A skin condition that can result in severe itching and is often contagious.[15]

surrogate decision-maker. An individual authorized under VHA policy to make decisions on behalf of a patient who lacks decision-making capacity[16]

[10] "Neuropsychological Testing and Assessment," Cleveland Clinic, accessed April 29, 2021, https://my.clevelandclinic.org/health/diagnostics/4893-neuropsychological-evaluation.

[11] VHA Directive 1170.03, Physical Medicine and Rehabilitation Service, November 5, 2019.

[12] VHA Directive 1170.03.

[13] "What is a Podiatrist," American Podiatric Medical Association, accessed October 7, 2021, https://www.apma.org/podiatristsFAQ.

[14] "What is Guardianship," National Guardianship Association, accessed November 29, 2021, https://www.guardianship.org/what-is-guardianship/.; "Bill Brief: SB 1553, Oregon Public Guardian and Conservator," Oregon Department of Human Services, accessed November 29, 2021, https://www.oregon.gov/DHS/SENIORS-DISABILITIES/ADVISORY/GCSS/CommissionMeetingsFull/02-2014/SB%201553%20Public%20Guardian.pdf.

[15] Mayo Clinic, "scabies," accessed April 30, 2021, https://www.mayoclinic.org/diseases-conditions/scabies/symptoms-causes/syc-20377378.

[16] VHA Handbook 1004.01 (4), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended January 4, 2021.

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