Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Continuity of Care Issues
VA Greater Los Angeles
Healthcare System
Los Angeles, California

Redacted

Report No. 11-00910-118

March 4, 2011

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding continuity of care at the VA Greater Los Angeles Healthcare System (the system). The Los Angeles City Attorney's office alleged that the system's staff discharged a homeless veteran (the patient) to a shelter without the ability and appropriate supplies to care for himself, and against his will.

We did not substantiate the allegations. At the time of discharge, system staff appropriately determined that the patient had capacity to make decisions, was medically stable, and was able to care for himself. Discharge planners explored and offered appropriate disposition options, which included [redacted] However, the patient refused all available options because each required behavioral agreements and/or Social Security contributions. (b)(6)

Throughout the discharge planning process, the patient often told system staff he intended to return to being homeless. Therefore, system staff negotiated plans for him to go to a homeless shelter, and he agreed. The system provided the patient with instructions on self-care, medication that did not require refrigeration, medical supplies, follow up appointments, and transportation to the shelter. While we found [redacted] there was no indication he went to the shelter against his will and no law that required VA to continue to provide him with inpatient hospitalization that was not medically necessary.

We found that system staff made multiple and reasonable efforts to negotiate acceptable and safe disposition plans with the patient while also respecting his right to make his own decisions. We made no recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Desert Pacific Healthcare Network (10N22)

SUBJECT: Healthcare Inspection – Alleged Continuity of Care Issues, VA Greater Los Angeles Healthcare System, Los Angeles, California

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed allegations that VA Greater Los Angeles Healthcare System (the system) staff discharged a homeless veteran (the patient) to a winter shelter without the ability and appropriate supplies to care for himself, and against his will. The purpose of the inspection was to determine if the allegations had merit.

Background

A VA Regional Counsel attorney notified OIG that the Los Angeles (LA) City Attorney's office alleged that the system's staff forced a veteran (the patient) to leave the system and stay at a winter shelter (Shelter B), and of their intention to investigate the case for elder abuse and "patient dumping."[1]

The system is a 1A complexity level,[2] tertiary care medical center that treats approximately 80,000 veterans per year. It operates 13 comprehensive outpatient programs throughout Kern, Los Angeles, San Luis Obispo, Santa Barbara, and Ventura counties. The system has 242 acute care beds and 203 community living center (CLC) beds. It discharges approximately 8,039 acute care patients per year and has a 92 percent acute-care bed occupancy rate. The system also operates a 321 bed domiciliary that provides residential rehabilitation care to veterans with psychosocial, medical, and mental health (MH) needs, including homelessness. The system provides a range of additional services and programs to veterans who are homeless or at-risk for homelessness.

[1] Los Angeles city ordinance number 179913 prohibits a hospital from transporting a patient to a location other than the residence of the patient without the written consent of the patient, and to do so is considered "dumping."
[2] A 1A complexity designation indicates the system has the infrastructure and staff to treat high-risk patients with complex medical and surgical needs.

According to the U.S. Department of Housing and Urban Development (HUD), homelessness includes a person without a fixed, regular, and adequate nighttime residence; it includes those who live in emergency shelters. Homelessness results from a complex and varied set of circumstances. Factors that contribute to homelessness may include poverty, lack of affordable housing, physical disability, mental illness and addiction disorders, re-entry from incarceration, eroding work opportunities, and foreclosure.[3]

VA estimated there were approximately 107,000 homeless veterans in 2008, which accounted for nearly 20 percent of the homeless population in the United States.[4] A range of preventive treatment and housing options aimed towards at-risk and homeless veterans are currently available at local VA facilities, and VA Homeless Coordinators are appointed to assist veterans with accessing services and navigating the system. A National Call Center for Homeless Veterans is answered 24-hours daily by trained counselors to assist veterans, families, and professionals with referrals to VA, as well as community resources.

Preventive services for at-risk veterans include Veterans Justice Outreach, Healthcare for Re-entry (from incarceration), and more recently, Supportive Services for Veterans Families Program. VA offers a range of transitional and permanent housing options in addition to vocational and supported employment programming. Services include programs such as Grant & Per Diem (G&PD)[5] and HUD-VA Supported Housing (HUD-VASH)[6]. Compensated Work Therapy/Transitional Residences offer veterans temporary housing and provide vocational skills. Homeless veterans with medical, dental, MH, or psychosocial needs may benefit from programs such as Domiciliary Care for Homeless Veterans, Healthcare for Homeless Veterans, Homeless Veteran Dental Assistance, Drop-in Centers, and Veteran Stand Downs.[7]

HUD estimated that there were 8,197 homeless veterans in the system's service area in 2009.[8] The system reported that, in fiscal year (FY) 2010, VA awarded the system, and its partner community agencies, approximately $12.5 million to house homeless veterans and hire staff to oversee programs. The Comprehensive Homeless Center (CHC) is a screening intake unit on the system's campus that serves as a centralized hub

[3] National Coalition for the Homeless (July 2009) Why Are People Homeless? http://www.nationalhomeless.org/factsheets/why.html, accessed January 10, 2010.
[4] Community Homeless Assessment Local Education and Networking Groups (CHALENG), *The Sixteenth Annual Progress Report*, March 17, 2010, accessed January 12, 2011.
[5] G&PD programs help homeless veterans achieve residential stability by providing supportive housing for up to 24 months, in addition to services that include case management, education, crisis intervention, and counseling.
[6] The HUD-VASH Program is designed to transition veterans from homelessness to independent housing by providing rent subsidy vouchers to chronically homeless veterans with substance abuse and/or MH issues.
[7] During a stand down, homeless veterans assemble in one place for a few days and receive access to community resources that can help them address problems and get a new start.
[8] Estimate obtained from a HUD point-in-time count; a one-night count of sheltered and unsheltered homeless persons. CHALENG, *The Sixteenth Annual Progress Report*, accessed January 12, 2011.

for veterans in need of services. The system also provides outreach services to homeless women veterans, veterans in the county jail, and sheltered and unsheltered veterans in the community. In 2010, the outreach program served 2,700 homeless veterans in the LA community.

The system has approximately 1,300 G&PD transitional housing beds for homeless veterans through partnerships with community agencies. Healthcare for Homeless Veterans provides 10 beds for a community-based residential dual diagnosis[9] treatment program for veterans. The system's HUD-VASH program provided 1,295 housing vouchers to homeless veterans in FY 2009.

Scope and Methodology

We conducted a site visit on December 14–17, 2010. While on site, we interviewed the patient, the homeless shelter's director and staff; and system managers, clinicians, and other employees knowledgeable of this case. We reviewed relevant facility and VHA policies, the patient's medical record, and other documents related to this case.

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

Case Summary

(b)(6)

[redacted]

March 2000 to August 2009

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

(b)(6)

[redacted]

[redacted]

[redacted]

[redacted]

August to December 2010

[redacted] (b)(6)

[redacted]

(b)(6)

(b)(6)

[redacted]

[redacted]

Inspection Results

Issue 1: Discharge

We did not substantiate the allegation that the system discharged the patient without the ability or supplies to care for himself. We did not find that acts or omissions by VA personnel willfully, or by neglect, caused or permitted the personal health of the veteran to be injured. We did not find a violation of the Emergency Medical Treatment and Active Labor Act (42USA § 1395dd) because the veteran did not have an emergency medical condition that required stabilization.

VA requires that, before discharge, patients must no longer require services that are only available to inpatients.[17] [redacted]

The patient also had access to adequate medical supplies. [redacted]

[17] M-1, Part 1, Chapter 13.44, *Medical Considerations – Hospital and Nursing Home Patients*, April 8, 1993.

[redacted]

VA also requires that staff suitably arrange patient outpatient needs and services in advance of their discharge.[18] We found that system staff arranged for the patient's outpatient needs prior to his discharge. [redacted] (b)(6)

We found the patient did not require inpatient care on the day of discharge. He was medically stable, could provide self-care, and had adequate medical supplies and medication. We also found the system suitably arranged his outpatient needs in advance of his discharge.

Issue 2: Disposition

We did not substantiate the allegation that the patient was forced to go to Shelter B against his will.

Patients with decision-making capacity have the right to self-determination, and discharge planners must consider those rights when planning hospital discharges. The system's medical team determined that the patient had the capacity to make decisions. System discharge staff made multiple and reasonable efforts to negotiate acceptable and safe discharge plans with the patient while also respecting his right to make his own decisions.

[redacted] discharge planners offered appropriate placement options, and that–despite these efforts–the patient refused all discharge options other than an emergency shelter because the options required his behavioral or financial commitments. [redacted]

[redacted]

[18] M-1, Part 1, Chapter 13.44.

Conclusions

We did not substantiate that the system staff sent the patient to Shelter B without the ability and supplies to care for himself, and against his will.

At the time of discharge, system staff appropriately determined the patient had the capacity to make decisions, was medically stable, and was able to care for himself. Discharge planners offered appropriate placement options, but the patient refused all options because they required either behavioral or financial commitments. System staff then negotiated the shelter plans with the patient, obtained his agreement, and he willingly left the system to go to Shelter B. Providers ordered medications for him that did not require refrigeration and appropriate outpatient supplies and services.

Social workers made adequate attempts to offer safe plans for this patient, taking into account his autonomy and limited options (b)(6)

[redacted]

[redacted]

We found from our interview with the patient, and staff documentation, that the [redacted] VHA must ensure veterans have access to inpatient resources and monitor and manage the utilization of care based upon established standards.[20] Issues related to patients refusing discharge have become a dilemma and cost burden for many hospitals. (b)(6)

The system providers appropriately consulted bio-ethics staff and the PACT team. We found that the medical team ensured the patient was medically stable and had decision-making capacity prior to his discharge. We also found that the medical team made reasonable efforts to make this challenging and difficult disposition as safe as possible, and the record documents this well.

Patients with decision-making capacity ultimately have the right to make their own decisions, even unwise ones. We made no recommendation.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

[20] VHA Directive 2010-021, *Utilization Management*, May 14, 2010.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 2, 2011

From: Director, Desert Pacific Healthcare Network (10N22)

Subject: **Healthcare Inspection – Alleged Continuity of Care Issues, VA Greater Los Angeles Healthcare System, Los Angeles, California**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

Thru: Director, Management Review Service (10B5)

1. VA Desert Pacific Healthcare Network concurs with the findings.

(original signed by:)
Barbara Fallen,
Acting Network Director

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 1, 2011

From: Director, VA Greater Los Angeles Healthcare System (691/00)

Subject: **Healthcare Inspection – Alleged Continuity of Care Issues, VA Greater Los Angeles Healthcare System, Los Angeles, California**

To: Director, Desert Pacific Healthcare Network (10N22)

1. VA Greater Los Angeles Healthcare System concurs with the findings.

(original signed by:)

Donna M. Beiter, RN, MSN
Director, VA Greater Los Angeles Healthcare System (691/00)

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Melanie Cool Deputy Director, Baltimore Office of Healthcare Inspections
Acknowledgments	Melanie Cool, Team Leader Douglas Henao Stephanie Hensel Nelson Miranda Michael Shepherd Laura Tovar

Appendix D

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