AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 31, 2023

Dr. Stephen Leffler, CEO
University Of Vermont Medical Center
111 Colchester Ave
Burlington, VT 05401

Provider ID #: 470003

Dear Dr. Leffler:

The Division of Licensing and Protection completed a survey at your facility on **February 22, 2023**. The purpose of the survey was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **March 30, 2023**.

Sincerely,

Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Director, Division of Licensing & Protection

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470003	A. BUILDING _____ B. WING _____	C 02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF VERMONT MEDICAL CENTER	111 COLCHESTER AVE BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An unannounced on-site complaint investigation #21565 & #21575 was conducted at the University of Vermont Medical Center by the Division of Licensing and Protection on 2/21/2023 and2/22/2023 as authorized by The Centers for Medicare and Medicaid Services to determine the Acute Care Hospital's compliance with the Conditions of Participation for Patient Rights, Medical Staff, Nursing Services, ED Services, Rehab Services, and Discharge Planning. Regulatory violations were identified regarding Discharge Planning.	A 000		
A 799	DISCHARGE PLANNING CFR(s): 482.43 The hospital must have in effect a discharge planning process that focuses on the patient goals and treatment preferences and includes the patient and his or her caregivers support person(s) in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to a preventable hospital readmissions This CONDITION is not met as evidenced by: Based upon observation, interview and record review, the facility failed to ensure an effective transition of one patient [Patient #8] of 10 sampled patients from hospital to post-discharge care, leading to a same day hospital readmission. Findings include: Per record review, a Hospitalist discharge summary dated 2/12/2022 noted that Patient #8	A 799	See attached plan of correction See attached plan of correction POC accepted 3.30.23	5/3/23 5/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 3/30/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 799	Continued From page 1 entered the Emergency Department [ED] with "Mild Alzheimer's dementia admitted after presenting on 2/3/23 to the ED after an altercation with [his/her] daughter in the setting of years of erratic behavior with verbal and sometimes physical family altercations. Family reported being unable to care for [him/her] at home, declined discharge from the ED, and [he/she] was ultimately admitted for custodial care and placement." Case Manager #1 [CM#1] notes dated 2/4/23, the day after Patient #8 was left at the ED, state "Patient repeatedly moving to live with various family and friends, all which have been unsuccessful ...There are no family or friend options available at this time due to this challenging dynamic". Case Manager #2 [CM#2] notes dated the next day, 2/5/23, reveal "RN assessment is that patient is certainly unable to manage on her own - even with the support of home health services - would require 24/7 support or Assisted Living level of care due to memory impairment. Physician Notes dated 2/5/23 note "I spoke again with [CM#2] this afternoon, and unfortunately, after contact with the son, the impression is that he lacks feelings of any moral obligation to bring his mother home and is likely aware that there is no "legal" obligation to care for his mother. Case management has worked extensively on placement over the weekend, but placement will likely take weeks to secure Long Term Care Medicaid financing ...custodial admission unfortunately appears inevitable at this point." An Initial Case Management/Social Work Assessment and Discharge Plan was conducted	A 799	See attached plan of correction POC accepted 3-30-23 [signature]	5/3/23

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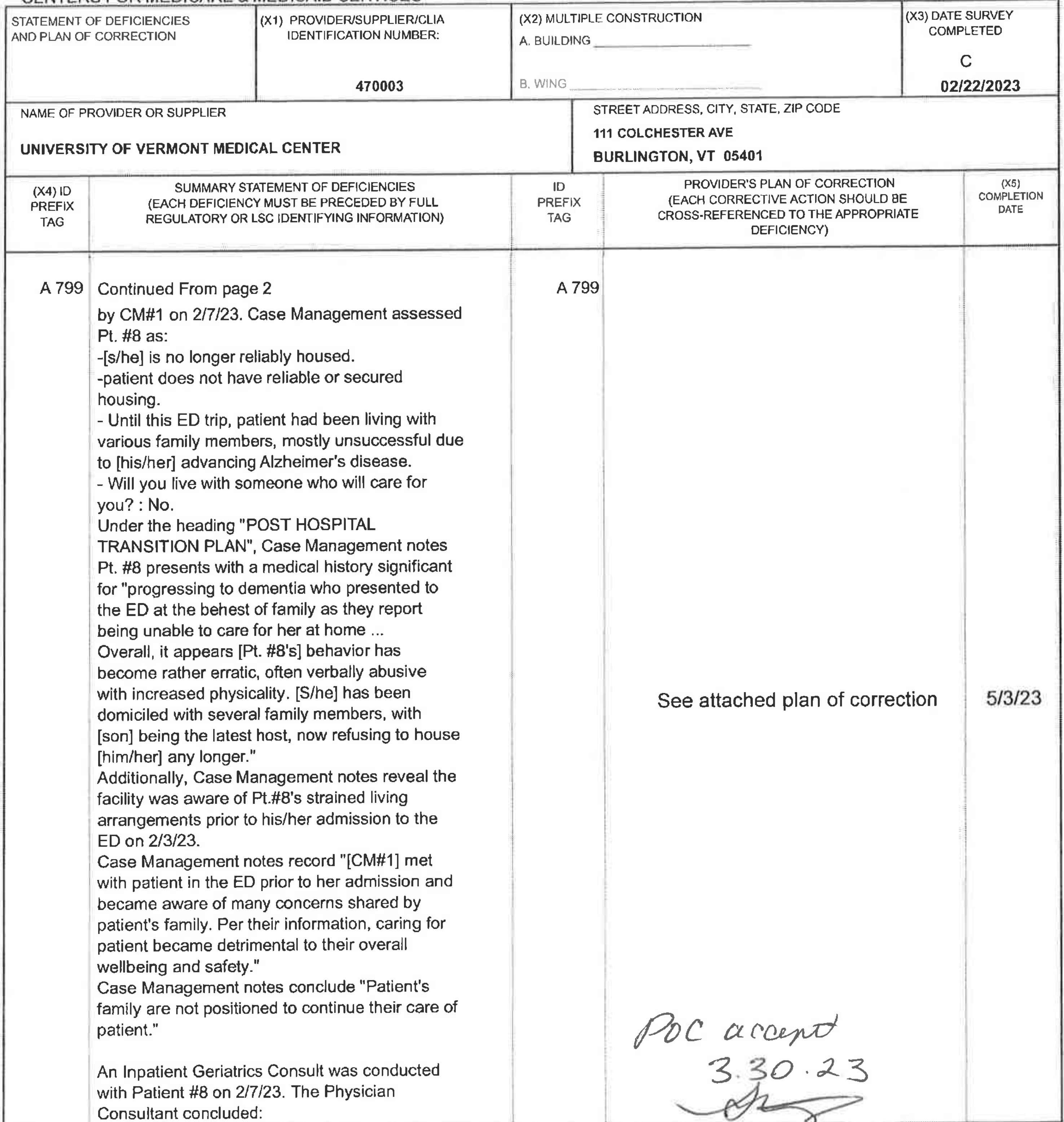

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A 799	Continued From page 2 by CM#1 on 2/7/23. Case Management assessed Pt. #8 as: -[s/he] is no longer reliably housed. -patient does not have reliable or secured housing. - Until this ED trip, patient had been living with various family members, mostly unsuccessful due to [his/her] advancing Alzheimer's disease. - Will you live with someone who will care for you? : No. Under the heading "POST HOSPITAL TRANSITION PLAN", Case Management notes Pt. #8 presents with a medical history significant for "progressing to dementia who presented to the ED at the behest of family as they report being unable to care for her at home ... Overall, it appears [Pt. #8's] behavior has become rather erratic, often verbally abusive with increased physicality. [S/he] has been domiciled with several family members, with [son] being the latest host, now refusing to house [him/her] any longer." Additionally, Case Management notes reveal the facility was aware of Pt.#8's strained living arrangements prior to his/her admission to the ED on 2/3/23. Case Management notes record "[CM#1] met with patient in the ED prior to her admission and became aware of many concerns shared by patient's family. Per their information, caring for patient became detrimental to their overall wellbeing and safety." Case Management notes conclude "Patient's family are not positioned to continue their care of patient." An Inpatient Geriatrics Consult was conducted with Patient #8 on 2/7/23. The Physician Consultant concluded:	A 799	See attached plan of correction POC accept 3.30.23 [signature]	5/3/23

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A 799	Continued From page 3 - [Patient #8] "is not able to describe potential adverse events related to inadequate care." - [s/he] "admits that [s/he] does not always remember communications from the treatment team." - [s/he] "is not able to compare options since [s/he] has no real sense of what the options are." - After prompting, [s/he] is able to articulate the choices that [s/he] does not have; [s/he] is able to recall that the house [sold to the Grandson] is no longer [his/hers]. - [s/he] "wants to leave the hospital and "have some freedom". However, [s/he] admits that [s/he] does not know where [s/he] would go" - "When I ask where [s/he] would go, [s/he] tells me "I have no idea"." Geriatric Consultant follow up notes the next day, 2/8/23, reveal "Alzheimer's disease, unable to live independently. Per my note from yesterday, the patient does not have capacity to make a decision to leave the hospital as [s/he] has nowhere to go and no plan. Long discussion with case management. Unfortunately, [Case Management] does not feel that the situation with family can be resolved...At this point, the patient will have to stay in the hospital for a prolonged period of time." A third visit from the Geriatric Consultant on 2/9/23 again states "the patient does not have capacity to make a decision to leave the hospital as [s/he] has nowhere to go and no plan. CM#1 notes dated 2/8/23 document "[Pt. #8] appears to have fleeting recognition that [s/he] is not able to return to [his/her] former home in Highgate". CM#1 notes dated 2/13/23 record "[CM#1] reviewed chart notes which indicate a difficult	A 799	See attached plan of correction PC accept 3-30-23 [signature]	5/3/23

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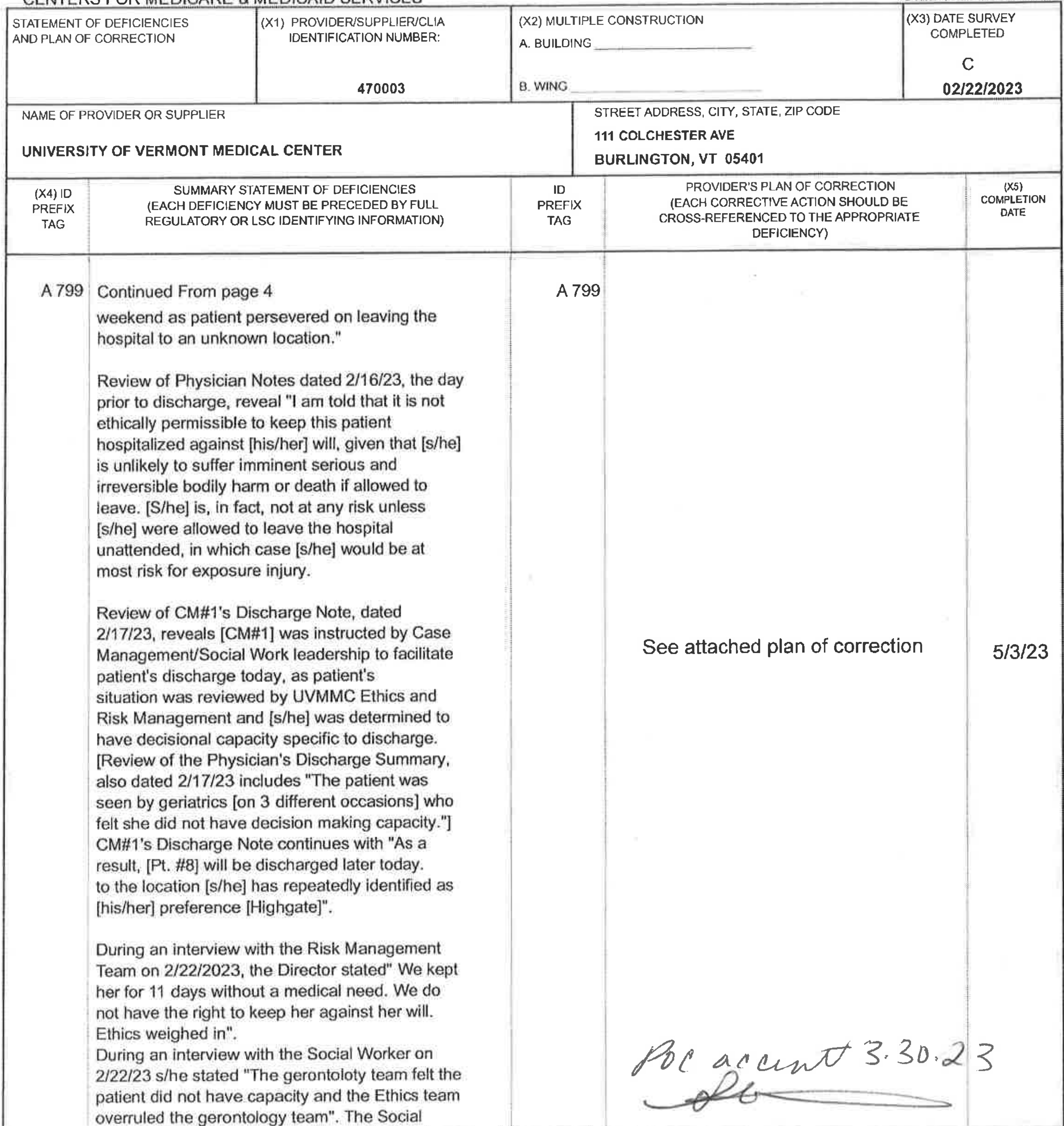

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A 799	Continued From page 4	A 799	See attached plan of correction	5/3/23

weekend as patient persevered on leaving the hospital to an unknown location."

Review of Physician Notes dated 2/16/23, the day prior to discharge, reveal "I am told that it is not ethically permissible to keep this patient hospitalized against [his/her] will, given that [s/he] is unlikely to suffer imminent serious and irreversible bodily harm or death if allowed to leave. [S/he] is, in fact, not at any risk unless [s/he] were allowed to leave the hospital unattended, in which case [s/he] would be at most risk for exposure injury.

Review of CM#1's Discharge Note, dated 2/17/23, reveals [CM#1] was instructed by Case Management/Social Work leadership to facilitate patient's discharge today, as patient's situation was reviewed by UVMMC Ethics and Risk Management and [s/he] was determined to have decisional capacity specific to discharge. [Review of the Physician's Discharge Summary, also dated 2/17/23 includes "The patient was seen by geriatrics [on 3 different occasions] who felt she did not have decision making capacity."] CM#1's Discharge Note continues with "As a result, [Pt. #8] will be discharged later today. to the location [s/he] has repeatedly identified as [his/her] preference [Highgate]".

During an interview with the Risk Management Team on 2/22/2023, the Director stated" We kept her for 11 days without a medical need. We do not have the right to keep her against her will. Ethics weighed in".
During an interview with the Social Worker on 2/22/23 s/he stated "The gerontoloty team felt the patient did not have capacity and the Ethics team overruled the gerontology team". The Social

POC accept 3.30.23

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A 799	Continued From page 5 Worker furthur stated that s/he uses Supervisors and Leadership as to which provider's direction to follow and that s/he looks to the last provider's directions to follow, and Ethics was the last provider involved with this patient. An interview was conducted with Patient #8's Physician on 2/22/23. The Physician stated that "Geriatrics did an assessment- they did not feel [s/he] had decision making capacity to go home- specific to regarding the decision to go home. I contacted the Ethicist to discuss. The Ethicist said we can't keep [him/her] against [his/her] will. I saw the patient again. I felt [s/he] was straightforward. I called the Legal Team. They said to trust the Ethicist but create the safest possible situation. The legal team then advised me to say [s/he] was being discharged to family. The following day, I spoke to [Chief Medical Officer for Case Management] and the Legal Team- everyone said arrange for a ride to [his/her] location of choice ...I told Ethics and the Legal Team about the discrepancy ..." Patient #8's Physician concluded with "there is greater pressure to get people out". Further review of CM#1's Discharge Note, dated 2/17/23, reveal "Call to patient's son, updating him on the plan to discharge patient today to the address in Highgate [s/he] has repeatedly identified ...[Son] indicated 'I'm not coming to get her. [S/he] can't go to that location, [s/he] doesn't live there.'" Per interview with CM#1 on 2/22/23, the CM stated that s/he was not told by Age Well staff that there were no keys to the Highgate residence and that there was no way for Pt. #8 to get in.	A 799	See attached plan of correction POC accepted 3.30.23 [signature]	5/3/23

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A 799	Continued From page 6 The CM furthur reiterated that "I called Age Well, I wanted them to be aware that they would have to engage the patient. I left a message that we were proceeding. Age Well called me back and we spoke at length. They did not confirm they would be there to meet the patient and when I called the family, the family hung up on me". Regardless, Pt. #8 was sent unaccompanied by cab to the address on 2/17/23. Upon notification that client had been discharged, reporter asked [former Age Well CM] to drive to the address in Highgate to meet client ... When [Age Well CM] arrived at the address in Highgate, the client was sitting in the snowbank and stating that the home was hers and that she would just sit there until someone let her in. The cab driver was still on site and expressed relief when Age Well CM arrived and concern that he had been told to leave client at this address that was evidently not hers." [Per review of weather data for Burlington, VT for 2/17/23, 12:00 pm - 6:00 pm: Light snow, temperatures 21-19 degrees F. Winds at 14 mph.] (https://www.timeanddate.com/weather/usa/burlington-vt/historic) Further review of Patient #8's Medical Record reveals on 2/17/23, the same day of his/her discharge, the patient was returned to the Emergency Department [ED]. Per ED Physician notes: "79-year-old with a history of Alzheimer's dementia who presents to the ED after being picked up by [his/her] age well case manager who found [him/her] upon	A 799	See attached plan of correction 	5/3/23

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A 799	Continued From page 7 discharge outside unaccompanied reportedly in a snowbank ...there is concern that [s/he] does not have adequate capacity to discharge safely independently ... presents to the ED for concerns for safety related to inability to care for self upon [his/her] requested discharge to an address that [s/he] was unable to access ... I had conversations ... with Case Management ...Hospitalist service ...ethics consult ..., I have requested hospitalization after these discussions as there is not a safe discharge plan anticipated tonight or tomorrow." Case Management notes dated 2/17/23, after Patient #8 was returned to the Emergency Department, record "[Pt.#8] was recently discharged and arrives after being found out in the cold. [S/he] is undomiciled and has dementia ... Per interview on 2/22/23 a registered nurse on the Risk Management team stated that "In retrospect its easy to say this patient should not have been discharged. She said she had access. The phyusician knew there were risks but assumed the financial DPOA would take some responsibility". An interview was conducted with Pt. #8 on 2/22/23 at UVMMC. The patient was observed to be confused about the facts of his/her hospitalization and unable to recall if [s/he] owned a home or not. [S/he] stated that [s/he] had Alzheimer's Disease and sometimes forgets this. The patient was unable to state how long [s/he] had been in the hospital or how many times.	A 799	See attached plan of correction POC accept 3.30.23	5/3/23

A 000 ***INITIAL COMMENTS***

An unannounced on-site complaint investigation #21565 & #21575 was conducted at the University of Vermont Medical Center by the Division of Licensing and Protection on 2/21/2023 and2/22/2023 as authorized by The Centers for Medicare and Medicaid Services to determine the Acute Care Hospital's compliance with the Conditions of Participation for Patient Rights, Medical Staff, Nursing Services, ED Services, Rehab Services, and Discharge Planning. Regulatory violations were identified regarding Discharge Planning.

A 799 ***DISCHARGE PLANNING CFR(S): 482.43***

The hospital must have in effect a discharge planning process that focuses on the patient goals and treatment preferences and includes the patient and his or her caregivers support person(s) in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to a preventable hospital readmissions

This CONDITION is not met as evidenced by:
Based upon observation, interview and record review, the facility failed to ensure an effective transition of one patient [Patient #8] of 10 sampled patients from hospital to post-discharge care, leading to a same day hospital readmission.

Action Plan

- ***The Condition Level response is addressed at the standard level findings below.***

Findings include:

Per record review, a Hospitalist discharge summary dated 2/12/2022 noted that Patient #8 entered the Emergency Department [ED] with "Mild Alzheimer's dementia admitted after presenting on 2/3/23 to the ED after an altercation with [his/her] daughter in the setting of years of erratic behavior with verbal and sometimes physical family altercations. Family reported being unable to care for [him/her] at home, declined discharge from the ED, and [he/she] was ultimately admitted for custodial care and placement"

Case Manager #1 [CM#1] notes dated 2/4/23, the day after Patient #8 was left at the ED, state "Patient repeatedly moving to live with various family and friends, all which have been unsuccessful ...There are no family or friend options available at this time due to this challenging dynamic".

Case Manager #2 [CM#2] notes dated the next day, 2/5/23, reveal "RN assessment is that patient is certainly unable to manage on her own - even with the support of home health services - would require 24/7 support or Assisted Living level of care due to memory impairment.

Physician Notes dated 2/5/23 note "I spoke again with [CM#2] this afternoon, and unfortunately, after contact with the son, the impression is that he lacks feelings of any moral obligation to bring his mother home and is likely aware that there is no "legal" obligation to care for his mother. Case management has worked extensively on placement over the weekend, but placement will likely take weeks to secure Long Term Care Medicaid financing ...custodial admission unfortunately appears inevitable at this point."

An Initial Case Management/Social Work Assessment and Discharge Plan was conducted by CM#1 on 2/7/23. Case Management assessed Pt. #8 as:

- *[s/he] is no longer reliably housed.*
- *patient does not have reliable or secured housing.*
- *Until this ED trip, patient had been living with various family members, mostly unsuccessful due to [his/her] advancing Alzheimer's disease.*
- *Will you live with someone who will care for you? : No*

Under the heading "POST HOSPITAL TRANSITION PLAN", Case Management notes Pt. #8 presents with a medical history significant for "progressing to dementia who presented to the ED at the behest of family as they report being unable to care for her at home ...Overall, it appears [Pt. #8's] behavior has become rather erratic, often verbally abusive with increased physicality. [S/he] has been domiciled with several family members, with [son] being the latest host, now refusing to house [him/her] any longer."

Additionally, Case Management notes reveal the facility was aware of Pt.#8's strained living arrangements prior to his/her admission to the ED on 2/3/23.

Case Management notes record "[CM#1] met with patient in the ED prior to her admission and became aware of many concerns shared by patient's family. Per their information, caring for patient became detrimental to their overall wellbeing and safety."

Case Management notes conclude, "Patient's family are not positioned to continue their care of patient."

An Inpatient Geriatrics Consult was conducted with Patient #8 on 2/7/23. The Physician Consultant concluded:

- *[Patient #8] "is not able to describe potential adverse events related to inadequate care."*
- *[s/he] "admits that [s/he] does not always remember communications from the treatment team."*
- *[s/he] "is not able to compare options since [s/he] has no real sense of what the options are."*
- *After prompting, [s/he] is able to articulate the choices that [s/he] does not have; [s/he] is able to recall that the house [sold to the Grandson] is no longer [his/hers].*
- *[s/he] "wants to leave the hospital and "have some freedom". However, [s/he] admits that [s/he] does not know where [s/he] would go"*
- *"When I ask where [s/he] would go, [s/he] tells me "I have no idea"*

"Geriatric Consultant follow up notes the next day, 2/8/23, reveal "Alzheimer's disease, unable to live independently. Per my note from yesterday, the patient does not have capacity to make a decision to leave the hospital as [s/he] has nowhere to go and no plan. Long discussion with case management. Unfortunately, [Case Management] does not feel that the situation with family can be resolved...At this point, the patient will have to stay in the hospital for a prolonged period of time."A third visit from the Geriatric Consultant on 2/9/23 again states "the patient does not have capacity to make a decision to leave the hospital as [s/he] has nowhere to go and no plan.

CM#1 notes dated 2/8/23 document "[Pt. #8] appears to have fleeting recognition that [s/he] is not able to return to [his/her] former home in Highgate".

CM#1 notes dated 2/13/23 record "[CM#1] reviewed chart notes which indicate a difficult weekend as patient persevered on leaving the hospital to an unknown location."

Review of Physician Notes dated 2/16/23, the day prior to discharge, reveal "I am told that it is not ethically permissible to keep this patient hospitalized against [his/her] will, given that [s/he] is unlikely to suffer imminent serious and irreversible bodily harm or death if allowed to leave. [S/he] is, in fact, not at any risk unless [s/he] were allowed to leave the hospital unattended, in which case [s/he] would be at most risk for exposure injury.

Review of CM#1's Discharge Note, dated 2/17/23, reveals [CM#1] was instructed by Case Management/Social Work leadership to facilitate patient's discharge today, as patient's situation was reviewed by UVMMC Ethics and Risk Management and [s/he] was determined to have decisional capacity specific to discharge. [Review of the Physician's Discharge Summary, also dated 2/17/23 includes "The patient was seen by geriatrics [on 3 different occasions] who felt she did not have decision making capacity."] CM#1's Discharge Note continues with "As a result, [Pt. #8] will be discharged later today. To the location [s/he] has repeatedly identified as [his/her] preference [Highgate]".

During an interview with the Risk Management Team on 2/22/2023, the Director stated" We kept her for 11 days without a medical need. We do not have the right to keep her against her will. Ethics weighed in".

During an interview with the Social Worker on 2/22/23, s/he stated, "The gerontoloty team felt the patient did not have capacity and the Ethics team overruled the gerontology team". The Social

Worker further stated that s/he uses Supervisors and Leadership as to which provider's direction to follow and that s/he looks to the last provider's directions to follow, and Ethics was the last provider involved with this patient.

An interview was conducted with Patient #8's Physician on 2/22/23. The Physician stated, "Geriatrics did an assessment- they did not feel [s/he] had decision making capacity to go home specific to regarding the decision to go home. I contacted the Ethicist to discuss. The Ethicist said we can't keep [him/her] against [his/her] will. I saw the patient again. I felt [s/he] was straightforward. I called the Legal Team. They said to trust the Ethicist but create the safest possible situation. The legal team then advised me to say [s/he] was being discharged to family. The following day, I spoke to [Chief Medical Officer for Case Management] and the Legal Team- everyone said arrange for a ride to [his/her] location of choice ...I told Ethics and the Legal Team about the discrepancy ..."Patient #8's Physician concluded with "there is greater pressure to get people out".

Further review of CM#1's Discharge Note, dated 2/17/23, reveal "Call to patient's son, updating him on the plan to discharge patient today to the address in Highgate [s/he] has repeatedly identified ...[Son] indicated 'I'm not coming to get her. [S/he] can't go to that location; [s/he] doesn't live there.'

"Per interview with CM#1 on 2/22/23, the CM stated that s/he was not told by Age Well staff that there were no keys to the Highgate residence and that there was no way for Pt. #8 to get in

The CM furthur reiterated that "I called Age Well; I wanted them to be aware that they would have to engage the patient. I left a message that we were proceeding. Age well called me back and we spoke at length. They did not confirm they would be there to meet the patient and when I called the family, the family hung up on me". Regardless, Pt. #8 was sent unaccompanied by cab to the address on 2/17/23.

Upon notification that client had been discharged, reporter asked [former Age Well CM] to drive to the address in Highgate to meet client ... When [Age Well CM] arrived at the address in Highgate, the client was sitting in the snowbank and stating that the home was hers and that she would just sit there until someone let her in. The cab driver was still on site and expressed relief when Age Well CM arrived and concern that he had been told to leave client at this address that was evidently not hers."

[Per review of weather data for Burlington, VT for 2/17/23, 12:00 pm - 6:00 pm: Light snow, temperatures 21-19 degrees F. Winds at 14 mph.] (https://www.timeanddate.com/weather/usa/burlington-vt/historic)

Further review of Patient #8's Medical Record reveals on 2/17/23, the same day of his/her discharge, the patient was returned to the Emergency Department [ED]. Per ED Physician notes: "79-year-old with a history of Alzheimer's dementia who presents to the ED after being picked up by [his/her] age well case manager who found [him/her] upon discharge outside unaccompanied reportedly in a snowbank ...there is concern that [s/he] does not have adequate capacity to discharge safely independently ... presents to the ED for concerns for safety related to inability to care for self upon [his/her] requested discharge to an address that [s/he] was unable to access ... I had conversations ... with Case Management ...Hospitalist service ...ethics consult ..., I have requested hospitalization after these discussions as there is not a safe discharge plan anticipated tonight or tomorrow."

Case Management notes dated 2/17/23, after Patient #8 was returned to the Emergency Department, record "[Pt.#8] was recently discharged and arrives after being found out in the cold. [S/he] is undomiciled and has dementia

Per interview on 2/22/23 a registered nurse on the Risk Management team stated, "In retrospect it's easy to say this patient should not have been discharged. She said she had access. The physician knew there were risks but assumed the financial DPOA would take some responsibility".

An interview was conducted with Pt. #8 on 2/22/23 at UVMMC. The patient was observed to be confused about the facts of his/her hospitalization and unable to recall if [s/he] owned a home or not. [S/he] stated that [s/he] had Alzheimer's Disease and sometimes forgets this. The patient was unable to state how long [s/he] had been in the hospital or how many times

Action Plan

Under the direction of the Senior Collaborative Leadership Team comprised of Chief Medical Officer, Chief Quality Officer and Chief Nursing Officer, a formal Multidisciplinary Quality Review was performed. In accordance with DISCHARGE PLANNING CFR(S): 482.43, please find below plan for addressing system improvements and performance monitoring. The action plan and all components will be completed by May 3, 2023.

I. New Policy and Process

- Under the direction of the Network AVP Care Management, the Director of Care Coordination & Patient Transitions, and the UVM Medical Center's Associate Chief Medical Officer, the Discharge Escalation Policy was created and new process adopted and approved.

- The referenced policy includes the use of an Inpatient Case Manager using a standardized Discharge Barrier Screening Tool and accompanying escalation process. Inpatient Case Managers will use the Discharge Barrier Screening Tool and escalate any concerns through their Supervisor or covering Supervisor, as well as our Throughput Lead Case Manager, who will review the case and either advise on next steps or widen the escalation process/team for further analysis.

- The referenced policy includes a Destination Confirmation procedure. This procedure articulates the requirement for direct communication and documentation of discharge plan and destination with receiving caregiver when two or more out of the four patient criteria are met:
  1. Patients with cognitive concerns
  2. Patients deemed not to have decision making capacity
  3. Patients being transported via private transportation service (example taxi cab transportation or any other similar modality of transportation) outside of being personally picked up by their support person at the hospital
  4. Any other similar patient scenario, where concern exists around safe discharge, and confirming discharge destination details with patient's support person would be beneficial.

- The UVMMC Discharge Escalation Policy will be presented by Chief Medical Officer/ designee at the April 6, 2022 Medical Executive Committee for approval, education and awareness within the Medical Staff at large.

II. Dedicated Staff to Support Improved Process

- Under the direction of Network AVP Care Management, a full time position description entitled "Throughput Lead" was posted for recruitment in March 2023 to support transitions of care to include the UVMMC Discharge Escalation Policy and process.

III. New Patient Transportation Contract

- Under the direction of the Network Chief Supply Chain Officer, UVMMC and Roundtrip have agreed upon contractual terms and are currently conducting an information technology/cyber security review of the Roundtrip system. The Roundtrip system is a dispatch platform that allows for a centralized transportation hub, the ability to communicate specific driver instructions and traceability.

IV. Education Plan

- An online education module for staff involved in discharge planning of vulnerable patients with impaired decision-making capacity has been developed By UVMMC Director of Medical Ethics, Risk Management, Network AVP Care Management and Director of Care Coordination & Patient Transitions. Contents will include: (1) familiarization with the new UVMMC Discharge Escalation Policy, (2) clarification of ethical and legal limits of hospitalization over refusal for patients with impaired decision-making capacity, (3) a guide to internal institutional resources to use when patients with impaired decision-making capacity refuse hospitalization, and (4) components of a safe handoff to outpatient care for patients with impaired decision-making capacity who refuse hospitalization.

V. Ongoing Monitoring of Performance

- Performance will be monitored by the Director of Care Coordination & Patient Transitions and an RN Clinical Analyst through monthly sampling of documentation review for compliance with the Discharge Escalation Policy. Feedback will be provided as required at the local level.

- Aggregate data will be shared at the Standards of Operation monthly meeting, chaired by the Chief Medical Officer and Chief Quality Officer and at the monthly Transitions of Care Meeting chaired by the Medical Director of Case Management.

This Plan of Correction (POC) constitutes written allegation of compliance for the deficiencies cited. However, submission of this POC is not admission that the deficiencies exist or that one was cited correctly, nor is it an admission that the facts listed on the 2567 are accurate. The POC is submitted to meet the requirements established by federal and state law.