



Choose **VA**

Post Sedation Anesthesia Care and Discharge Toolkit



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Executive Summary

The Office of Care Management and Social Work presents the Post Sedation Anesthesia Care and Discharge Toolkit. The toolkit was developed to support Veterans who receive outpatient or ambulatory procedures using sedation and/or anesthesia; and have no social supports or transportation to facilitate their recovery and transition from a VA medical facility to their desired destination post care. A Veterans Health Administration (VHA) commissioned interprofessional workgroup convened to discuss the relevant factors which affect a complex intersection of clinical needs and psychosocial barriers. The toolkit serves as a resource for development for outpatient procedures involving sedation and/or anesthesia for Veterans with no social support or transportation resources.

Significant shifts in clinical care delivery models over the past twenty years have resulted in significant increases in ambulatory procedures performed in outpatient settings, many of which require sedation and/or anesthesia. Despite these shifts, professional societies do not agree on medical requirements for patients leaving outpatient procedural and anesthesia areas. Furthermore, the recommendations, statutes, and business rules of accrediting organizations, regulatory agencies, and VHA create a complex policy landscape for VA medical facilities to provide Veteran care for ambulatory procedures.

Many community health care institutions adopt a ‘no-ride, no-procedure’ standard for patients who do not have transportation or an attendant to accompany them home following a procedure using sedation or anesthesia. Within VHA, the application of this same standard creates healthcare disparities, diagnostic and treatment delays, and inappropriate utilization of scarce or costly resources (i.e. inpatient observation beds). There is a need for a safe, pragmatic, and Veteran-centered approach for Veterans to receive the care they need and return to their desired discharge destination following outpatient procedures requiring sedation and/or anesthesia.

The interprofessional workgroup reviewed relevant federal regulations, VHA directives and handbooks, external accreditation standards, peer-reviewed literature, and professional society guidelines. This toolkit summarizes the current state of post-sedation and/or anesthesia transportation dispositions within VHA, defines “responsible adult” options, suggests guidelines for Veterans with no social support, and shares VHA best practices within existing standards. Additionally, this toolkit identifies opportunities to change existing VHA policy and identifies ethical considerations to mitigate Veteran care barriers.

Most Veteran discharge plans can be clearly and easily executed. Some Veterans have psychosocial barriers which may contribute to safety concerns upon



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discharge. VHA clinical teams collaborate to ensure safe discharges, though these mitigations can be challenging with limited Veteran and VHA resources. Veterans with limited or no support systems require additional attention and considerations when scheduling procedures and during discharge planning. These Veterans may be homeless, traveling with service animals, possess active Category I Behavioral Patient Record Flags, reside in rural/highly rural locations, and/or have experienced significant trauma.

VHA clinical teams must consider several factors when discharging Veterans following an outpatient procedure which involves sedation and/or anesthesia. These considerations include Veteran-specific health factors, the procedure performed, the type of sedation and/or anesthesia used, and the discharge disposition (e.g. transportation modality, discharge location). A safe discharge plan considers the need for an attendant after discharge, the mode of transport, and the duration of additional support at the discharge destination, if needed at all. VA paid transportation is based on VA travel benefit eligibility. VA medical facility resource availability and allocation impacts discharge planning.

It is essential to include administrative, clinical, and other support personnel when developing policy to meet the needs of Veterans when planning presents challenges. This toolkit describes considerations for a local framework of governance, policies, and procedures for discharge planning associated with outpatient procedures using sedation and/or anesthesia.

Conflict occurs as administrative, clinical, and support leaders work to find an acceptable balance of risk, safety, and resource expenditure while ensuring Veterans have medically necessary procedures. Resources including volunteer transportation services and temporary lodging, when available, focus on safety of the Veterans, staff, and drivers. Volunteer transportation drivers express concern about the lingering effects of sedation/anesthesia because drivers only drive; they do not help the Veteran in/out of the vehicle or into the discharge destination, and they do not perform care activities. Temporary lodging personnel are not medical personnel, and most lodging facilities are not staffed overnight. Support personnel need to trust that the discharging physician has accurately represented the Veteran's needs upon discharge. Support personnel must also understand that Veterans discharged following procedures using moderate sedation and/or anesthesia are expected to be at or near their baseline cognitive status and capable of self-care.

Further complicating the landscape is the belief the Joint Commission and the United States Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) strictly require a patient to be discharged in the company

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of a responsible adult. It is certainly prudent to discharge patients with a responsible adult following sedation and/or anesthesia whenever it is practically achievable. However, the attending physician can exempt patients from this requirement, when appropriate.

The American Society of Anesthesiologists (ASA) Task Force on Postanesthetic Care found insufficient evidence within the medical literature that a decrease in post-discharge complications or other adverse outcomes is associated with the requirement that patients are accompanied home by a responsible individual. This group of consultants and ASA members nonetheless assert “requiring patients to have a responsible individual to accompany them home after discharge reduces adverse outcomes, increases patient comfort and satisfaction, and should be mandatory.” The American Society for Gastrointestinal Endoscopy is decidedly agnostic on the issues surrounding discharge plans following invasive procedures. At least one large non-VA health care system, the Mayo Clinic, has adopted a Sedation Dismissal Process (SDP) for patients discharged alone and validated its safety using a retrospective case-control study involving over 7,300 patients.

Discharging a Veteran alone is possible for Veterans who are at lower clinical risk, who receive sedation and/or anesthesia regimens which mitigate the duration and extent of the impairment of their physiologic and functional state, and who are discharged via a transport modality which protects their personal privacy and safety across a spectrum of factors. Such factors include the release of personally identifiable information (PII) to a potentially non-VA contracted, non-VA employed driver; the qualifications of the driver; the identified discharge destination (i. e. whether this is pre-determined, or fixed, at the time the patient travels vs. dynamic and provided to the driver at the time of transport); the need to conduct a monetary transaction at the time of travel; and the type of transport service (i.e. curb-to-curb vs. door-to-door services).

The VHA Handbook 1140.6: Purchased Home Health Care Services Procedures allows the use of home health funding to purchase medical companion services for Veterans who require an attendant in the periprocedural period. For Veterans who have no support and need someone to accompany them, purchasing medical companion services is preferred over not providing medical care.

Based upon current standards of care and medication used, no Veteran under any circumstances should be cleared to drive following a procedure which involves sedation and/or anesthesia until at least 12 hours have elapsed since their time of discharge from the outpatient procedural area.

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The ultimate decision for the discharge disposition rests with the VHA proceduralist and/or anesthesia provider, using established clinical factors; input from support staff and clinical team members such as the referring provider, anesthesia team, social worker, and nursing staff; and policies and procedures as prescribed by Veterans Transportation Program (VTP) Board of Directors outlined in VHA Directive 1695 Veterans Transportation Services. Veterans are assessed for discharge according to their overall condition, according to standard discharge criteria, and with the kinetics of the sedation and/or anesthesia regimen in mind. Veterans discharged alone are generally healthy at baseline, physiologically and psychologically stable, capable of self-care, and outside the expected time course of sedating effects of agents used.

The toolkit identifies and discusses discharge factors and possible transportation options potentially available to VA medical facilities, detailed in a summary spreadsheet on the [National Social Work SharePoint](#).

The toolkit closes with a discussion on unresolved policy barriers and ethical considerations surrounding this complex issue of Veteran discharge planning following procedures involving sedation and/or anesthesia.

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Introduction

The Office of Care Management and Social Work is pleased to present the Post Sedation Anesthesia Care and Discharge Toolkit. This toolkit was developed in response to VA medical facility inquiries related to supporting Veterans who require sedation and/or anesthesia for outpatient or ambulatory procedures; and have no social supports or transportation to facilitate their recovery and transition from a VA medical facility to their desired destination post care.

VHA recognizes the complexities in managing care for Veterans following outpatient procedures involving sedation and/or anesthesia and sponsored a multidisciplinary workgroup to address relevant issues. The workgroup reviewed the relevant statutes, accreditation requirements, current VHA policies, and VHA operational landscape to develop this toolkit which is intended to inform local VA medical facility leadership as it develops local policies and procedures for outpatient procedures involving sedation and/or anesthesia.

The workgroup convened at VA Central Office in August 2018. The workgroup includes members from program offices at VACO and field-based leaders. VA disciplines and staff participating in the workgroup include Primary Care, Specialty Care, Anesthesia, Gastroenterology, Surgery, Mental Health, Nursing, Social Work, Clinical Integration, VA Voluntary Services, Veterans Transportation Program, the National Center for Patient Safety, the National Center for Ethics in Health Care, the Office of Healthcare Equity, the Office of Veterans Access to Care, the Office of Quality, Safety & Value, the Office of General Counsel, and Information Access & Privacy Office.

Reason for a Toolkit

The United States health care system and the Veterans Health Administration (VHA) have witnessed a shift from inpatient to outpatient care over the past 20 years. This shift has led to a significant increase in ambulatory procedures requiring anesthesia or moderate sedation in outpatient settings. Healthcare economics and advances in shorter-acting anesthetic agents (which limit cognitive impairment and allow patients to rapidly return to normal daily activities) are large drivers in this shift. However, despite these innovations, professional societies have been unable to reach consensus on medical requirements for patients leaving outpatient procedural and anesthesia areas safely. For example, there are no clear and consistent guidelines about transportation to a patient's discharge destination, the need for an attendant or companion upon discharge, who is an acceptable attendant, and the duration and responsibilities for companion observation after procedures using sedation and/or



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anesthesia. Furthermore, accrediting organizations and regulatory agencies such as The Joint Commission (TJC) and the Department of Health and Human Services (HHS) respectively are not overtly prescriptive in their standards and regulations.

Requiring attendants to transport and/or accompany patients following discharge from outpatient procedures using sedation and/or anesthesia has several financial, social, and logistical implications. Healthcare facilities, patients, and their potential attendants face significant potential costs, logistical challenges, and social burden due to these requirements. As the U.S. population in general ages, and more specifically the Veteran population, there are increasing numbers of older patients who lack family or friends who may be able to serve as attendants to accompany them to outpatient procedures. Therefore, health care organizations, including VHA, face increasing pressure to mitigate the complex transportation and attendant dilemmas of the patients they serve.

Some Veteran patients present unique challenges. These challenges include comorbid and complex physical, behavioral, and psychosocial conditions; previously established disruptive behavior; service animal needs, and/or a history of trauma.

VHA's Journey to High Reliability and commitment to zero harm engenders a high priority to develop policies and procedures which ensure patient safety. This emphasis on high reliability is purposefully broad in scope. Subsequently, VA medical facilities must develop post-procedure discharge plans consistent with Veteran safety within the context of facility and Veteran resources. Healthcare policy which emphasizes risk aversion may limit Veteran access to procedures involving anesthesia and/or sedation, resulting in unintended healthcare disparities, social inequity, and delays in diagnosing and treating potentially serious health conditions for some Veterans. Alternatively, healthcare policy which disproportionately prioritizes accessibility may unintentionally undermine overall safety after discharge as well as over-utilize inpatient resources, thereby driving up operational costs. Regrettably, the current policy landscape within VHA adds to the medical facility challenges in developing robust, reliable, safe, cost-effective, ethical, and pragmatic strategies associated with the discharge of Veterans following outpatient procedures involving sedation and/or anesthesia.

Some Veterans in need of outpatient procedures involving sedation and/or anesthesia lack support systems to transport and/or accompany them home post-sedation or anesthesia, or the resources to obtain such support. For such patients, many non-VA healthcare institutions have adopted a 'no-ride, no-procedure' standard. Within VHA, the application of this same standard creates healthcare disparities, diagnostic and treatment delays, and inappropriate utilization of scarce or costly

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resources (i.e. inpatient observation beds). There is a need for a safe, pragmatic, and Veteran-centered approach for Veterans to receive the care they need and return to their desired discharge destination following outpatient procedures requiring sedation and/or anesthesia.

There are competing VHA policies and demands which contribute to front-line barriers for Veterans who lack post-sedation and/or anesthesia support and care options. This toolkit summarizes the current state of post-sedation and/or anesthesia transportation options, identifies options when identifying a post-procedure “responsible adult”, suggests guidelines for patients with no social support, and shares VHA best practices within existing standards. Additionally, the toolkit identifies opportunities to change policy and ethical considerations to mitigate the current barriers to care.

United States Code and Code of Federal Regulations

The United States Code (U.S.C.) contains federal legislation governing VHA general functions, the Medical Benefits Package for VA enrollees, VA Beneficiary Travel (BT) eligibility and benefits, the Veterans Transportation Services (VTS) benefits, the types of transportation that may be provided by VA facilities through VTS, grants for transportation of patients in highly rural areas, the purchase of home care services, and Fisher House or other temporary lodging eligibility. Relevant U.S.C. statutes include, but are not limited to: 38 U.S.C. 7301, 38 U.S.C. 111, 38 U.S.C. 111A, 38 U.S.C. 1720, 38 U.S.C. 1708.

The Code of Federal Regulations (CFR) is a compilation of laws issued by federal agencies to comply with federal statutes. Relevant VA regulations that interpret the statutes above include: 38 CFR 17.38, 38 CFR 70.10, 38 CFR 70.30, 38 CFR 70.70-73, 38 CFR 17.72, 38 CFR 60.10.

The United States Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) Conditions for Coverage for Ambulatory Surgical Centers are found in the CFR. These HHS/CMS Conditions for Coverage which pertain to outpatient procedures and sedation and/or anesthesia do not strictly apply to Department of Veterans Affairs operations, though they nonetheless inform VHA providers and clinical leaders on relevant standards of care. Relevant HHS/CMS regulations include 42 CFR 416.42, 42 CFR 416.47, and 42 CFR 416.52. Of these, two noteworthy elements stipulate “The Ambulatory Surgical Center must ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and Ambulatory Surgical Center policy” and “The Ambulatory Surgical Center



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must ensure that all patients are discharged in the company of a responsible adult, except those patients exempted by the attending physician.”

Relevant VHA Directives and Handbooks

There are several relevant VHA policies which establish VHA standards for procedures and operational requirements. These impact discharge following outpatient procedures involving sedation and/or anesthesia. This complex topic involves a vast and diverse policy landscape which intersects multiple disciplines. The following were reviewed to develop toolkit recommendations:

1. VHA Directive 1036: Standards for Observation in VA Medical Facilities, appendix A 1.b.(9) page A-1 describes circumstances in which Veterans following sedation or anesthesia could be considered for admission to Observation Status
2. VHA Directive 1073: Moderate Sedation by Non-Anesthesia Providers discusses policy for post-sedation management of Veterans and discharge processes.
3. VHA Directive 1100.16: Accreditation of Medical Facility and Ambulatory Programs establishes policy and responsibilities in obtaining and retaining The Joint Commission (TJC) accreditation and continual readiness with TJC standards at all VHA medical facilities.
4. VHA Directive 1107: VA Fisher Houses and Other Temporary Lodging specifically cites the role of Temporary Lodging of Veterans following sedation or anesthesia.
5. VHA Directive 1188: Animals on Veterans Health Administration (VHA) Property, section 5.a.(3)(b) details policy barring service animals from invasive procedural and operative areas. The directive also outlines policy for alternate handler requirements and options.
6. VHA Directive 1220: Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting establishes infrastructure requirements for VA medical facilities performing invasive procedures in any clinical setting, and the complexity of the invasive procedures being performed, as well as the method for monitoring compliance.
7. VHA Directive 1605.01: Privacy and Release of Information details policy authorizing release information; for example, to entities involved in transportation or lodging of Veterans following sedation or anesthesia.
8. VHA Directive 1695: Veterans Transportation Services details policy regarding many transportation options for Veterans and the requirements for VA medical facilities to develop local Veterans Transportation Program (VTP) Boards of Directors.
9. VHA Directive 4721: VHA General Post Funds – Gifts and Donations details policy on the disbursement of monies within the VA’s General Post Fund trust fund



10. VHA Handbook 1123: Anesthesia Service, section 9.c.(1-5) page 6 details policy on post-anesthesia care including discharge.
11. VHA Handbook 1140.6: Purchased Home Health Care Services Procedures, section 7.a-b details eligibility and determinations of need for VA home health care services. Provisions allow for flexibility to use home health services one time for patients discharged from a procedure using sedation or anesthesia.
12. VHA Handbook 1163.06: Intensive Community Mental Health Recovery Services (ICMHR) outlines in section 6.c.(13) page 11 the policy for use of Federal vehicles by ICMHR Services staff whose services might include transportation of patients following anesthesia or sedation.
13. VHA Handbook 1620.01: Voluntary Service Procedures provides procedures for the operation of a structured volunteer program under the management of the Department of Veterans Affairs Voluntary Service (VAVS).
14. VHA Handbook 1620.02: Volunteer Transportation Network (VTN) details policy on volunteer drivers as without compensation (i.e. WOC) VA employees and authority to transport patients.

External Accreditation Standards

The accreditation of VHA's healthcare facilities is governed by VHA Directive 1100.16 Accreditation of Medical Facility and Ambulatory Programs. The Joint Commission (TJC) accreditation is nationally recognized and is one of VHA's major external quality reviews. TJC's accreditation standards and guides are available on the [VHA Office of External Accreditation Services and Program website](#).

The workgroup reviewed TJC accreditation standards and consulted with the External Accreditation Services and Programs director. It is important to remember external accreditation standards are not practice standards. Instead, the external accreditation organizations assess the facility's adherence to the established practice standards. Local practice and policy are based on best practices, research, and national directives.

The toolkit discusses research and national policy related to operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia upon which a local policy may be developed.

Peer Reviewed Literature and Professional Society Guidelines

The American Society of Anesthesiologists (ASA) Task Force on Postanesthetic Care published a practice guideline in February 2013, entitled "Practice Guidelines for



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Postanesthetic Care”. The task force found insufficient evidence within the medical literature that a decrease in post-discharge complications or other adverse outcomes is associated with the requirement that patients are accompanied home by a responsible individual. This group of consultants and ASA members nonetheless assert “requiring patients to have a responsible individual to accompany them home after discharge reduces adverse outcomes, increases patient comfort and satisfaction, and should be mandatory.”

The American Society for Gastrointestinal Endoscopy (ASGE) Standards of Practice Committee published “Guidelines for Sedation and Anesthesia in GI Endoscopy” in February 2018. This guideline minimally addresses discharge following sedation, only stating, “After the completion of endoscopic procedures, patients should be monitored for adverse effects from either instrumentation or sedation. Standardized discharge criteria should be used to assess recovery from sedation.” There are no statements in this guide discussing escorts or attendants upon discharge.

Hui Yun Vivian Ip and Frances Chung published an article in *Current Opinion in Anaesthesiology* in December 2009, “Escort Accompanying Discharge After Ambulatory Surgery: A Necessity or a Luxury?”. In this article, the authors review the previous evidence pertaining to the prevalence of no escorts in ambulatory surgical patients, the effects of general and regional anesthetics on cognitive and psychomotor performance, and the effects of surgery on cognitive and psychomotor performance. They discuss criteria for discharge, patient adherence to discharge instructions, and the role of escorts. Lastly, they discuss legal considerations of discharge plans and make recommendations. They define a “responsible adult” in this article as “a person who has the physical and mental ability to assist the patient, recognize when help is needed and to summon help should the patient be unable to do so.” They suggest the minimum attendant age be 16-18 years old. They reason there are no consensus guidelines on how frequently a patient should be checked post procedure, and how much supervision is required. They also recognize the quality of overnight supervision can be affected by whether the attendant sleeps in a different room as the patient as opposed to sharing the same bedroom. The authors conclude that “patient discharge without an escort after ambulatory surgery under general anesthesia, sedation or premedication can potentially be dangerous and is not recommended. The role of an escort should be more than merely providing the patient with ‘the ride home’...patients should certainly not be allowed to drive home after administration of any kind of hypnotic, sedative, or opioid. This should be a fundamental issue of patient safety and good standard of care in relation to ambulatory anesthesia.” This article is a clinical review of survey data and many small studies and represents the opinions of the authors and not the opinion of a larger professional medical society.

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David P. Martin MD et. al. published an article in The Mayo Clinic Proceedings in September 2018, “Outpatient Dismissal With a Responsible Adult Compared With Structured Solo Dismissal: A Retrospective Case-Control Comparison of Safety Outcomes”. In this article, the authors describe a Sedation Dismissal Process (SDP) used at the Mayo Clinic for solo patients undergoing sedation and/or anesthesia. This SDP allows the unaccompanied patient to have their procedure even if alone. This process is detailed in the patient’s pre-procedural educational materials. The patient has the option to stay at an SDP participating hotel which offers shuttle service to/from the medical center. The patient may stay at a different hotel but separately arrange medical transport services to the hotel post-procedure. Additionally, the patient can hire a non-licensed care provider such as a nurse’s aide or patient care assistant to transport and provide comfort/safety check measures at the hotel post-procedure. If a patient lives close to the Mayo Clinic, a friend or family member may take them home and “get them settled”. SDP patients were identified in the procedural area via specific wristband.

The authors do not describe any eligibility criteria for this SDP based on patient-specific clinical circumstances, such as co-morbid conditions, mental health issues, and/or social stressors. The SDP team at Mayo Clinic places a higher value on hotel shuttle services than taxis, as the destination is fixed in advance and a monetary transaction is not needed at the time of transport following sedation and/or anesthesia. Additionally, the SDP team at Mayo Clinic places a higher value on medical transport services over taxis and ride hailing programs (e. g. Uber, Lyft), because drivers of medical transport services vehicles can competently and safely help patients to their destination and have passed security background checks. Such services also provide the patient door-to-door services which ensures the patient’s safe arrival inside their residence, as opposed to sidewalk drop-off (a.k.a. curb-to-curb services) from a taxi or ride hailing service.

The authors found there was no difference in the risk of adverse events or unplanned readmission following a procedure involving sedation and/or anesthesia between 2703 patients who left with an escort who was familiar to them (i. e. family member or friend) and 2441 patients who were escorted through the SDP process. The discussion of these results focused on various sedation regimens emphasizing the benefits of using propofol and limiting midazolam use. This study was a retrospective case-control study likely with considerable heterogeneity between patient populations of the Mayo Clinic and of the VHA.



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General Decision-Making

VHA clinical team must consider several factors when planning discharge following an outpatient procedure which involves sedation and/or anesthesia. These considerations include the procedure performed, the type of sedation and/or anesthesia used, and the discharge disposition. If the Veteran discharges to home, VHA clinical team must determine if the Veteran needs an attendant or companion during transportation and/or at the desired discharge destination; and the length of time additional support is needed at the desired destination, if at all. Transportation depends on the Veteran's identified need and personal resources, or the Veteran's eligibility for VA travel benefits.

There are several considerations when assessing the Veteran's and the overall risk for complications following a procedure. These considerations may include the Veteran's age, presence of chronic co-morbid conditions (e. g. hypertension, diabetes mellitus, heart failure) and relative control, known or suspected cognitive impairment, active mental health disorder(s) requiring ongoing intervention, substance use, ambulatory status and overall functional independence, and social stressors such as housing stability, urban versus rural setting, family support, and recent major life events. Specific medical conditions and/or treatment plans may also merit consideration, such as Veteran weight/body mass index (BMI), Mallampati airway classification and associated serious respiratory pathology (obstructive sleep apnea, moderate/severe COPD, diaphragmatic paralysis), history of chronic renal or hepatic disease, chronic use of antithrombotic therapy, chronic use of injection therapy such as insulin, chronic use of antiepileptic therapy for seizure disorder, and a history of delayed reaction to anesthesia. Finally, there may be special considerations for peri-procedure and transportation management, such as an accompanying service animal, history of disruptive behavior substantiated in the Computerized Patient Record System (CPRS) as a Category I Behavioral Patient Record Flag (BPRF), or self-identified gender-based care considerations.

In general, the type of sedation or anesthesia used in association with a medical procedure has a significant impact on post procedure discharge disposition. Moderate sedation regimens typically involve the use of a benzodiazepine to minimize anxiety and a narcotic analgesic to minimize pain and discomfort. The exact drug used for each class of medication influences factors such as onset of action, duration of action, amnestic properties, and side effects such as nausea or thrombophlebitis. Specific antagonists for both classes of medications exist and are typically available in procedural areas, though the provider should be aware the effects of reversal agents may be shorter than the effects of the anxiolytic and analgesic drugs themselves. Additional pharmacologic adjuncts are sometimes used such as diphenhydramine,



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promethazine, and droperidol to potentiate the action of a typical benzodiazepine-narcotic combination, resulting in deeper levels of sedation and potentially longer recovery periods. Alternatively, propofol may be used as a single agent or with other adjunctive sedatives to achieve moderate sedation, deep sedation, or general anesthesia. Propofol is typically administered by an anesthesia provider. Propofol may be given in addition to a typical benzodiazepine-narcotic combination to achieve balanced propofol sedation, or BPS. Propofol has the advantage of providing shorter sedation and shorter recovery times but requires specialized training and patient selection to be administered safely. BPS more specifically has the advantage of providing propofol mediated-sedation, with its shorter recovery times and enhanced patient satisfaction, while reducing the risk of over-sedation. Historically, anesthesia or sedation was achieved with agents that had longer half-lives. Sodium thiopental, for example has a half-life of 24 or more hours; diazepam (valium) has a half-life of 24-40 hours; and morphine has a half-life of 4 hours. Modern sedation and anesthesia rely on fentanyl, with a redistribution half-life of 40 minutes; remifentanyl, with a half-life 5 minutes; propofol, with a half-life of 1 hour; and midazolam, with a half-life of 1-4 hours. The use of agents with shorter half-lives speed recovery and return patients to their preoperative cognitive state much faster than in the past. Patients have frequently returned to baseline cognitive function with these newer agents in 1-4 hours. Comparatively, with the historical use of older anesthesia regimens that relied on agents with longer half-lives, a 24-hour time span may be been required to regain baseline function.

Most outpatient sedation and/or anesthesia regimens are designed for patient recovery within 1-4 hours. Several factors influence individual patient recovery from sedation and/or anesthesia. Recovery times as little as 1 hour and as long as 24 hours are possible depending on the agents chosen for anesthesia and sedation. Many studies demonstrate significantly diminished patient cognitive and psychomotor performance following various types of anesthesia including both general anesthesia and monitored anesthesia care (MAC). The extent and duration of the impairment depend on the agents chosen and the patient's baseline cognitive state. It should be noted that these impairments are difficult to objectively predict. Nonetheless, these impairments likely affect a patient's ability to conduct normal daily activities like driving. In summary, providers must assess a patient's readiness for discharge using defined criteria following sedation and/or anesthesia. It should be recognized that a patient meeting discharge criterion may not have fully regained their baseline cognitive state upon discharge. Moreover, the choice of medications used for post-procedural pain management may also affect post-procedural cognitive function. Discharging a patient to a desired destination such as home does not necessarily equate to (nor require



necessarily) complete recovery of the physiologic state, or complete reinstatement of the pre-procedural functional cognitive state. Clinicians evaluate patients prior to discharge, review baseline medical conditions, changes resulting from the procedure performed, medications administered during the procedure, medications planned to be administered after the procedure both for post procedure pain management and medical conditions and make a corresponding decision on the appropriate level of care and supervision needed after the procedure.

In addition to baseline medical conditions of the patient, the type of sedation or anesthesia used, and the postoperative analgesics used, the specific procedure performed may impact post-procedure functional recovery and care planning. Some procedures (or the pain and discomfort they may cause) can affect reaction time and decrease psychomotor cognitive performance. These factors may further aggravate the effect of sedation and/or anesthesia on functional capabilities.

A Veteran recovering from an outpatient procedure involving sedation and/or anesthesia is not safe to drive immediately upon discharge. Alternate transportation is necessary. Veterans who have no alternate means for transport will need assistance. It is important to be aware that all patients eligible for VA health care may not be eligible for Beneficiary Travel benefits. Discussion about transportation options must occur when initially planning a procedure and in anticipation of discharge. Care teams must assess the need for transporting an attendant and/or service animal, the type of vehicle required to accommodate them, and any adaptive equipment needs of the Veteran, such as a wheelchair. There may be restrictions or special accommodations for patients with a demonstrated history of disruptive behavior.

The transportation service may need to consider the availability of vehicle communication equipment (e.g. cell phone, two-way radio) or safety equipment to ensure the safety of Veterans, attendants, service animals, and the driver. There are liability concerns leadership will need to consider for VA employed versus contracted or volunteer drivers. Safety and security confidence increase when routine background security checks, safety training, and assistance competencies are completed. Different types of transportation services authorize drivers to assist patients into their homes while other services are restricted to drop-off only. Other relevant transportation considerations include disclosure of Personally Identifiable Information (PII) to the driver, the need for financial transactions during the transportation process, the anticipated length of the trip (which may be particularly important for very rural discharge locations), the intended destination (i. e. predetermined before transportation versus determined by the Veteran during transit), and level of service (i. e. door-to-door services versus curb-to-curb services).



Social Work Role in Addressing Discharge Barriers

Most Veterans can actively participate in discharge planning. They support persons in their lives and have resources to execute a safe discharge plan. However, there are Veterans without support and resources. Early discussion about discharge planning is necessary. Discharge planning is best conducted at the time at which a procedure is scheduled. When the referring provider, proceduralist, or anesthesia provider identifies barriers in the discharge plan, they are recommended to consult social work.

Best practice for social work consults involves identifying specific discharge requirements, the barriers experienced by the Veteran, and the date the plan must be established. Specific discharge requirements may include the attendant task expectations and duration and may also include finding safe shelter for a specified duration for a Veteran with unstable housing.

Social workers assess social determinants of health including housing, access to care, social support, psychological and functional status, community and financial resources, and program eligibility. It is reasonable in a clinical setting to assess a Veteran's medical readiness including advance care planning. Many Veterans do not consider declining health or its impact on their independence as they age. Assessing Veterans for an outpatient procedure discharge plan can lead to planning for future medical considerations, potentially addressing barriers impacting future procedures.

Additionally, the social work assessment is a good time to review next-of-kin and emergency contacts, and the Advance Directives if available, to ensure the record is accurate and reflects the Veteran's preferences. The discussion between the Veteran and social worker clarifies social supports who can reasonably assist the Veteran to and from an outpatient procedure. Veterans are encouraged to explore their personal support system before securing alternative solutions, such as a medical companion. Medical companion services are not included in the Veteran's benefits package. Medical companion services may be available to the most vulnerable Veterans who lack social support.

After assessing the Veteran's current psychosocial status, the social worker discusses discharge planning needs with the Veteran as identified by the referring provider, proceduralist, or anesthesia provider. Social workers are skilled at creative problem-solving. Where there initially seems to be no solution, creative discussions may yield effective solutions which support the Veteran's access to care.

VA medical facilities with experience resolving the most challenging discharge barriers are encouraged to share best practices. VHA staff members who wish to



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implement these solutions may contact facilities already engaged in these practices for guidance and support.

Need for an Attendant or Companion

Occasionally, Veterans cannot identify anyone who can accompany them to the procedure and assist in transporting the Veteran following an outpatient procedure involving sedation and/or anesthesia. Additionally, Veterans may not have an attendant or companion at their desired location to observe them following the procedure, if such observation is deemed necessary by VA clinical staff. It is important the VHA proceduralist, anesthesia provider, and/or clinical support staff communicate any expected duration of incapacitating or sedating effects, any activities which are restricted, and any necessary tasks following a procedure to the patient and the attendant or companion, when applicable. Clearly defining this information with the Veteran and social worker identifies the necessary post-procedure treatment plan. Working together, the Veteran and social worker discuss available discharge options.

Some VA medical facilities secure short-term homemaker and/or home health aide (H/HHA) services as an alternate attendant or medical companion following an outpatient procedure involving sedation and/or anesthesia. H/HHAs cannot administer medications, as this is a skilled need they are not trained or certified to provide. H/HHAs cannot monitor a Veteran clinically but if a Veteran appears to be unwell or is having medical problems, the H/HHA can ensure the patient is transported to an Emergency Room (ER) or otherwise receives Emergency Medical Services (EMS) by calling 911. H/HHA may serve as the Veteran's post-procedure attendant or companion when the Veteran has a homebound partner or would otherwise be alone and requires nonskilled support at the discharge destination. The duration of post-discharge support is determined by the VHA proceduralist and/or anesthesia provider.

A medical companion consult flowchart and associated documents are available in the appendix. The flowchart and appendices are also available on the [National Social Work SharePoint](#).

Special Population Considerations

While it is the desire of the VA to ensure all Veterans have stable housing, it is not a reality for some Veterans. Sometimes Veterans reside in a shelter or other housing program. Larger communities may have shelters capable of managing individuals with medical needs short of requiring a home health aide. It is important for a VHA proceduralist, anesthesia provider, and/or clinical support staff to identify a



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specific duration a Veteran may be impaired from the procedure itself and/or the sedation regimen given, so that the social worker can find suitable short-term shelter. Such solutions may include VA and non-VA temporary lodging. This solution may be best for Veterans experiencing homelessness and who need special preparation for outpatient procedures, such as the pre-procedure preparation prescribed for a colonoscopy.

Transporting Veterans who have a service animal presents unique challenges while undergoing an outpatient procedure involving sedation and/or anesthesia. VHA Directive 1188(1) establishes policy on this topic. VHA staff members are not permitted to care for, supervise, or assume responsibility for a service animal while the service animal is on VHA property. Furthermore, a service animal is not permitted into operating rooms and surgical suites, areas where invasive procedures are being performed, and acute inpatient hospital settings when the presence of the service animal is not needed as part of the treatment plan. Given the above, Veterans who elect to bring a service animal to the procedure involving sedation and/or anesthesia will need to secure an alternate handler who cannot be a VHA staff member. The alternate handler may accompany the Veteran to the procedure and assume care and supervision of the service animal before, during, and after the Veteran's procedure. It is important to note some transportation services may not be amenable to accommodating an accompanying service animal and alternate handler.

Veterans with a Category I Behavioral Patient Record Flag (BPRF) in the Computerized Patient Record System (CPRS) may require special attention. Veterans with a Category I BPRF may need a transportation eligibility review to ensure safety. Considerations include vehicle type, seating configuration, and driver status (VA employed vs. contracted vs. volunteer driver, e.g.). Potentially aggressive Veterans receiving transportation services should not be seated behind the driver. Transportation services whose staff is trained in the Prevention and Management of Disruptive Behavior (PMDB) may be needed. Additionally, it is prudent to disclose the Veteran behavior risk, within confidentiality limitations, to any solicited H/HHA services at the time of referral, to ensure the safety of the Veteran and the H/HHA staff. The nature of the disruptive behavior also should be considered when a consult is submitted for temporary lodging (Hoptel) services. It is important to remember temporary lodging is not included in the Veteran's benefits package and not available at every VA campus. Temporary lodging staff need to be confident the Veteran will not disrupt the safety, security, and operations of temporary lodging. It may be necessary for VHA clinical staff to consult with the local Disruptive Behavior Committee who assessed the Veteran and request re-evaluation before the anticipated outpatient procedure using sedation and/or anesthesia.



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Veterans with behavioral flags require special attention to support their clinical needs. The H/HHA agency determines if agency staff can serve the prospective client. VHA staff and the agency collaborate to assess the nature of the flagged behavior, known strategies to address the behavior, and determine the best option to render the care the Veteran wants and clinically needs and maintain staff safety. If a medical companion service is not available for a Veteran with a behavioral flag, the facility should prioritize providing the care the Veteran wants and clinically needs within the risk analysis for the situation.

Veterans living in very rural locations who need VA health care services present challenges for VA medical facilities. Facility Mobility Managers are adept at providing transportation services to Veterans despite geographic challenges. VA Mobility Managers may explore availability of the Highly Rural Transportation Grant Program. This program provides grants to Veterans Service Organizations and State Veteran Service agencies to support highly innovative transportation services to/from VA medical facilities supporting the provision of VA health care. Approximately \$3 million is available each year under Grants for Transportation of Veterans in Highly Rural Areas. The maximum allowable grant is \$50,000. VA may award one grant per fiscal year per highly rural area, defined as a county having less than 7 persons per square mile.

Another special consideration includes Veterans with trauma histories (i. e. Military Sexual Trauma, PTSD, etc.). It may be important to assess the impact of trauma and specific accommodations requested by the Veteran. For example, some Veterans may express a specific gender preference of an assigned H/HHA medical companion or of an assigned transportation driver. This request should be considered and honored as often as it practically feasible, as Veteran preference and clinical judgment often guide plans to ensure Veteran and medical companion safety.

Cost Considerations

VA medical facilities can experience widely disparate financial burdens due to transportation, temporary lodging, medical companion, or observation needs for Veterans following outpatient procedures involving sedation and/or anesthesia. Some discharge plans result in no additional costs to the VA medical facility. Some Veterans are well-resourced, for example, and can be driven home by a friend or family member. Other Veterans may be able to utilize Volunteer Transportation Network (VTN) or Volunteer/Community Transportation Providers (non-VTN) for transportation to their desired discharge location.

Low cost discharge plans for VA medical facilities likely include Beneficiary Travel unit costs for eligible Veterans using Common Carrier or Special Mode

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Transportation vehicles, Veterans Transportation Services, VA to VA Transportation Services, and Hoptel/temporary lodging on VA campuses.

Medium cost discharge plans likely include contracted Hoptel/temporary lodging off-site, medical companion services, and VA Appointed Case Manager Transportation services via Intensive Community Mental Health Recovery (ICMHR) services.

High cost discharge plans likely include Beneficiary Travel unit costs for eligible Veterans utilizing ambulance services when clinically appropriate and necessary, and inpatient medical/surgical observation admissions following a procedure.

Recommendations

Discharge planning for an outpatient procedure using anesthesia and/or sedation is complex. Clinician teams must consider many factors including the Veteran's overall health status; the Veteran's social circumstances and relative availability of a support person or community support; the type of procedure performed; the sedation/anesthesia regimen used; and the availability and capability of transportation, temporary lodging, medical companion, and observation services at a given VA medical facility. Specific local capabilities impact discharge planning enormously. With the above in mind, both facility and clinical leadership input is critical when determining how to best meet the Veteran's needs using limited resources. The following recommendations describe a process by which local VA medical facility leadership and clinical staff can develop a framework for governance, and policies and procedures for discharge planning associated with outpatient procedures using sedation and/or anesthesia. Specific information about possible discharge dispositions and their relative feasibility within the current VHA policy is presented. Local governance, policies, and procedures should inform and guide local VA clinical staff with respect to outpatient procedure discharge dispositioning.

For the purposes of this toolkit, a procedure is defined as any medical procedure which requires written, signed informed consent, and typically involves the safe discharge of the patient from the VA medical facility procedural area after meeting defined discharge criteria. This toolkit is intended as a resource for treatment planning for procedures which require sedation or anesthesia and involve the planning for safe discharge of the patient from the VA medical facility procedural area after meeting defined discharge criteria. Procedures defined for this toolkit may include an invasive skin incision or puncture, endoscopy, imaging study, open or minimally invasive surgery, percutaneous aspiration, gynecologic surgery, oral surgery, selected injections, biopsy, percutaneous cardiac and vascular diagnostic and/or interventional procedures, laparoscopy, bronchoscopy, interventional cardiology procedures, neuroradiological



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procedures, CT-guided interventional procedures, MRI-guided interventional procedures, electroconvulsive therapy (ECT), ketamine infusion, transesophageal echocardiography (TEE), cardioversion procedures, and other procedures that require sedation or anesthesia.

Sedation and/or anesthesia is defined within the toolkit as any level of sedation on the sedation continuum beyond minimal sedation (anxiolysis) as defined by the American Society of Anesthesiologists (ASA) practice guidelines. Specifically, the levels of sedation include moderate (formerly known as conscious) sedation, deep sedation, and general anesthesia. Please see the table below as a reference. Please also note that procedures that exclusively utilize topical or local anesthesia are not a focus of this toolkit, and as such are not included in the toolkit’s definition of sedation and/or anesthesia.

Levels of Sedation and Anesthesia (from ASA Practice Guidelines)				
	Minimal Sedation (Anxiolysis)	Moderate Sedation/Analgesia (Conscious Sedation)	Deep Sedation/Analgesia	General Anesthesia
Responsiveness	Normal response to verbal stimulation	Purposeful response to verbal or tactile stimulation	Purposeful response after repeated or painful stimulation	Unarousable, even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular function	Unaffected	Usually maintained	Usually maintained	May be impaired

Outpatient or ambulatory procedures that involve sedation and/or anesthesia may occur in Outpatient Intermediate (moderate sedation), Ambulatory Procedure Center (APC) Basic, Inpatient Standard, and APC Advanced settings as defined by VHA’s Invasive Procedure Complexity Matrix (IPCM) which can be found in VHA Directive 1220, Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting.

For the purposes of this toolkit, a responsible adult is a person at least 16 years old who has the physical and mental ability to assist the Veteran, recognize when help is needed, and to summon help if the Veteran be unable to do so. An attendant or



companion is any responsible adult present with the Veteran in the periprocedural period and who helps Veteran with transportation to a desired location following discharge from the completed procedure. Additionally, when necessary and specified by VA clinical staff, an attendant or companion assists the Veteran at the discharge location for a specified period.

Characteristics associated with a lower clinical risk for adverse events associated with transportation to the discharge location include the following clinical circumstances: minimal/mild burden of chronic co-morbid conditions (hypertension, diabetes mellitus, chronic obstructive pulmonary disease, e.g.), and if present under reasonable clinical control; absence of home oxygen requirements; absence of known or suspected significant cognitive impairment; absence of significantly active and/or uncontrolled mental health disorder(s); absence of substance use disorder (or if present in durable/sustained remission); ambulatory and generally without strict need for adaptive equipment or assistive devices (cane, walker, etc.); and absence of significant and active social stressors (i.e. domiciled, good family support, no major recent/ongoing life events).

The following factors may increase the clinical risk for adverse events associated with transportation to the discharge location: moderate to severe burden of chronic co-morbid conditions, especially if any are uncontrolled clinically; home oxygen requirements; known or suspected significant cognitive impairment; significant burden of active mental health disorder(s) especially if uncontrolled clinically; active substance use disorder not in remission or in partial remission; limited ambulatory capability requiring the strict need for adaptive equipment or assistive devices; and significantly active social stressors.

Other factors influencing clinical risk for adverse events following an outpatient procedure involving sedation and/or anesthesia which merit consideration by the procedural team include the age of the Veteran; body mass index (BMI); Mallampati airway classification status; the presence of chronic renal or hepatic disease; the need for chronic antithrombotic therapy, chronic injection therapy (insulin, e.g.), or chronic antiepileptic drug therapy; a history of delayed reaction to anesthesia; obstructive sleep apnea; and post procedural pain requiring opiate analgesia.

Public transportation is defined as buses, trains, subways, ferries, and other forms of transportation which charge set fares, run on fixed routes and approximate time schedules, and are available to the general public.

Fundamental to local governance when developing policies and procedures for outpatient procedure discharge planning is having a Veterans Transportation Program



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(VTP) Board of Directors at each VA medical facility. Per VHA Directive 1695, Veterans Transportation Services, the VA medical facility Director is responsible establishing a VTP Board of Directors chaired by the Associate Director. The VTP Board of Directors is chartered in accordance with VTP Board of Directors Guidelines and meet regularly. Essential functions of the VTP Board of Directors include: promoting the integration of a Veterans Transportation Program with Beneficiary Travel (BT) and Highly Rural Transportation Grant (HRTG) programs; informing VA medical facility executive leadership of program status, business plan, accomplishments, best practices, and problems; developing local policy for all Veteran transportation activity to include VTS, BT Special Mode Transportation, HRTG, Office of Rural Health Transportation grants, local shuttles, and other transportation resources; and collaborating and coordinating between VTP and other services, to include fleet management, business office, fiscal, voluntary service, social work service, nursing service, and other transportation stakeholders.

It is important to note neither The Joint Commission (TJC) nor HHS/CMS strictly require a patient to be discharged in the company of a responsible adult. It is certainly optimal but may not be possible or essential to discharge Veterans with a responsible adult following sedation and/or anesthesia. Within VHA, it is estimated that between ten (10%) and twenty (20%) percent of Veterans do not have an adult to accompany them after a procedure requiring sedation. While it could be a goal recommendation whenever it is practically achievable by the Veteran and the VA medical facility, the absolute requirement for an accompanying adult to escort a Veteran after a procedure may not be either possible, or essential, and may prevent a significant number (10-20%) of Veterans from undergoing clinically necessary procedures that require sedation and/or anesthesia. Discharge with an accompanying adult is recommended by the American Society of Anesthesiologists (ASA). However, none of the ASA's discharge guidance statements specify how long the Veteran should have an accompanying adult, what the role of that accompanying adult should be after discharge, and how the choice of medications for sedation should affect those recommendations. If an attendant or companion is to be provided by VHA, the attendant or companion should if possible, meet the Veteran prior to undergoing the outpatient procedure involving sedation and/or anesthesia, to establish familiarity and rapport before sedative or other psychotropic medications are administered.

It is important however to acknowledge that many VA Veterans (10-20%) do not have companions, and many VA medical facilities that strictly require Veterans to be discharged with a responsible adult are not able to provide care for these Veterans. Access to a responsible adult may be more of a challenge for more socioeconomically disadvantaged Veterans. There is always risk in medical care. Denying access to

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medical care because the Veteran does not have an accompanying adult increases risk from delays in diagnosis, delays in treating disease, and the potential for significant risks from untreated medical problems. Providing care to Veterans who do not have an accompanying adult to escort them home also entails risk. The risks of both options must be balanced in treatment planning. The American Society for Gastrointestinal Endoscopy is decidedly agnostic on the issue of a requirement for an accompanying adult, and at least one large non-VA health care system, the Mayo Clinic, has adopted a Sedation Dismissal Process (SDP) for patients discharged alone which has been validated for safety using a retrospective case-control study involving over 7,300 Veterans.

Discharging patients alone has been shown to be safe for patients who are generally at lower clinical risk, who receive sedation and/or anesthesia regimens which mitigate the duration and extent of the impairment of their physiologic and functional state, and who are discharged via a transport modality which protects personal privacy and safety across a spectrum of factors. Such factors include the release of personally identifiable information (PII) to a potentially non-VA contracted, non-VA employed driver, the qualifications of the driver, the identified discharge destination (i. e. whether this is pre-determined, or fixed, at the time the Veteran travels versus dynamic and provided to the driver at the time of transport), the need to conduct a monetary transaction at the time of travel, and the type of transport service (i.e. curb-to-curb services vs. door-to-door).

The ultimate decision for the discharge disposition rests with the VHA proceduralist and/or anesthesia provider, using established clinical factors; input from support staff and collaborative clinical members such as the referring provider, anesthesia team, social worker, and nursing staff; and policies and procedures as prescribed by VTP Board of Directors. Veterans are assessed for discharge at the time of potential discharge according to their overall condition according to standard discharge criteria, and with the kinetics of the sedation and/or anesthesia regimen in mind. Veterans discharged alone are generally healthy at baseline, physiologically and psychologically stable, and outside the expected time course of sedating effects of agents used.

Based upon current standards of care, no Veteran under any circumstances should be cleared to drive following a procedure which involves sedation and/or anesthesia until at least 12 hours have elapsed since their time of discharge from the outpatient procedural area in accordance with attaining standard discharge criteria.

There are times when despite mindful discharge planning by VA clinical staff, Veterans may arrive to a procedural area without an effective discharge plan in place. It

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is incumbent upon VA clinical staff to determine if last minute feasibility exists with respect to developing a safe and effective procedural discharge plan on short notice. The ultimate decision on whether to continue with the procedure as planned rests with the VHA proceduralist, working in concert with Veteran, their support network, and clinical support staff. The emphasis should be on continuing with the planned procedure to achieve the stated clinical goals whenever possible.

The following paragraphs summarize discharge dispositions potentially available at VA medical facilities. A spreadsheet of the same information and feasibility within the current VHA policy is available at [National Social Work SharePoint](#).

1. Veteran-led Private Transportation

- a. Veterans can coordinate the use of a privately-owned vehicle for transport to the discharge destination following a procedure involving sedation and/or anesthesia. A friend or family member drives the private vehicle. In these situations, the Veteran and transporting agent assume responsibility for safe transport to the discharge destination. Door-to-door services by a driver known to the Veteran to a fixed destination and devoid of a monetary transaction are advantages of this mode.
- b. Veterans of any clinical risk are encouraged to use private transportation and attendant services. The attendant must meet the definition of responsible adult described in this toolkit.

2. Veteran Ambulates to Discharge Destination

- a. Veterans may elect to walk to the discharge destination. While this proposed discharge may not be unreasonable, discharging staff should consider the Veteran's overall health, ability to walk post-procedure, functional capacity, and exercise tolerance. Discharging staff should also consider the type of procedure performed and sedation and/or anesthesia regimen used, and magnitude and timing of potential gaps between the attainment of acceptable clinical criteria for discharge and the complete recovery of pre-procedural physiological and functional states.
- b. This option may be considered upon weighing clinical risk as assessed by the VHA proceduralist and/or anesthesia provider, with input from relevant support staff and collaborative clinical members and local policies and procedures. Prudence dictates this discharge plan is suitable for clinically lower risk Veterans with good functional capacity following a procedure and sedation and/or anesthesia. Furthermore, this modality may be considered when the patient is expected to travel relatively short distances



on stable and safe terrain to the discharge destination with an attendant or companion as defined in this toolkit.

3. Observation Admission

- a. Concerns about VA inpatient overcrowding and limited bed availability may result from more frequent use of observation status and observation beds as alternatives to inpatient admission. VHA recognizes the importance matching clinical need and setting. The goal of observation is to assess initial therapy response and/or to clarify diagnosis, ultimately improving quality of care.
- b. VHA directs all VA medical facilities with Emergency Departments (EDs), Urgent Care Centers (UCCs), and/or acute care inpatient beds to have a written policy for patients needing clinical observation.
- c. Routine post recovery from ambulatory procedures is not considered observation; these beds should not be used for this purpose. However, Veterans recovering from an elective ambulatory procedure who require greater than 6 hours, but no more than 47 hours and 59 minutes post-procedural management, or who require monitoring of co-morbid conditions may recover and receive care and treatment in a non-count observation unit/ward on a case-by-case basis. Additionally, Veterans admitted to non-count units or wards to facilitate treatment during the preprocedural, periprocedural, and postprocedural phases of an ambulatory procedure may be discharged and admitted to observation if the Veteran sustains a complication requiring an extended stay. The reason for admitting a Veteran to observation following an ambulatory procedure must be clearly documented in the medical record.
- d. Observation status and VA medical facility observation beds are suitable following ambulatory procedures involving sedation and/or anesthesia when Veterans meet admission criteria delineated above. Observation status and beds are not used for routine post recovery services, or when Veterans who are otherwise medically stable for discharge from the procedural area have social or logistical impediments to discharge to the discharge destination.

4. Beneficiary Travel Services (BT):

- a. Generally, service-connected Veterans are eligible for beneficiary travel benefits. The percentage of service connection, more specifically the



priority group, determines eligibility. Veterans receiving a VA pension or who are below an income threshold are eligible for travel.

- b. The BT program provides mileage reimbursement for common carrier modes of transportation (plane, train, bus, taxi, light rail, etc.) as well as special mode transport when medically indicated in the form of ADA wheelchair or stretcher vehicles (wheelchair vans, ambulances).
- c. Veterans using common carrier modes of transportation secure their own reservations, pay for these services, and request reimbursement from VHA.
- d. Common carrier driver qualifications vary based upon State regulations and the specific mode of transportation. Monetary transactions are expected with the transport. Destinations are not always pre-determined, or fixed, at the time the Veteran uses the service. Common carrier services are typically no more robust than curb-to-curb services.
- e. Special mode driver qualifications include background checks, Department of Transportation (DOT) physical examinations, and appropriate license and Basic Life Support (BLS) certifications. Ambulance transportation includes an Emergency Medical Technician (EMT) or paramedic trained staffing. Special mode services are often door-to-door services.
- f. An attendant can accompany the Veteran and receive BT benefits when the Veteran is medically determined to require the presence of the attendant because of a physical or mental condition.
- g. Generally, an attendant or companion should accompany the Veteran to their desired destination when common carrier services are used, given the variability in driver qualifications, monetary transaction risks, lack of fixed destination, and curb-to-curb services. This is especially true for eligible Veterans deemed to be at higher clinical risk for adverse events associated with transportation to the desired destination. However, common carrier services are satisfactory for eligible Veterans traveling alone who are assessed as clinically low risk for adverse events during transportation, and when an attendant or companion is otherwise not logistically feasible or strongly opposed by the Veteran. The proceduralist and/or anesthesia provider should counsel the Veteran on the risks of not having an attendant or companion. Best practice is to document the discussion in the medical record.
- h. Special mode services are considered for eligible Veterans traveling alone or with an attendant to the desired destination. Consistency in driver qualifications and training, no monetary transactions, having a fixed



destination, and the high likelihood of door-to-door services make this a suitable option for clinically lower and higher risk Veterans, with or without an attendant.

5. Veterans Transportation Services (VTS)

- a. VTS is VA partner which ensures transport of Veterans and attendants to/from VA or VA-authorized facilities for the purposes of examination, treatment, or care. VTS eligibility is broader than BT eligibility. Eligibility includes Veterans discharged from outpatient procedures involving sedation and/or anesthesia, as well as any attendant.
- b. VTS uses VA owned or leased vehicles. VTS selects and trains drivers and maintains the vehicles. Vehicles typically accommodate ambulatory Veterans and Veterans who use adaptive equipment, including a wheelchair.
- c. VTS driver qualifications include background checks, Department of Transportation (DOT) physical examinations, and appropriate license and Basic Life Support (BLS) certifications. VTS drivers also take several mandated Talent Management System (TMS) training modules which include Safe Patient Handling and Prevention and Management of Disruptive Behavior (PMDB). These requirements apply to paid or WOC VA employees.
- d. VTS generally provides door-to-door services to fixed destinations without monetary transactions with the Veteran.
- e. VTS Services are suitable for eligible Veterans traveling alone or with an attendant. Consistency in driver qualifications and training, the lack of monetary transaction, having a fixed destination, and door-to-door service make VTS Services an option for clinically lower and higher risk Veterans with or without an attendant. **However, this is not an option if a Veteran needs an attendant at the discharge destination to monitor the Veteran and lacks this level of support. This requirement is specifically delineated in VHA Directive 1695.**

6. Volunteer Transportation Network (VTN)

- a. VTN provides transportation to ambulatory Veterans seeking benefits at VA facilities, including Veterans Benefits Administration (VBA) offices, and who have no other means of transportation.
- b. VTN services include transportation in privately-owned vehicles by Disabled American Veterans (DAV) and by government-owned vehicles,



including VTS vans and Office of Rural Health vans, donated vehicles, and county vehicles.

- c. VA Voluntary Services (VAVS) is responsible for the VTN. VAVS oversee driver selection, background checks, physicals and health screenings, training, vehicle maintenance and safety procedures. Volunteer drivers are VA WOC employees.
- d. VTN drivers, unlike VTS drivers, are exempt from BLS certification and mandatory TMS training such as PMDB training.
- e. VTN destinations are fixed, there are no monetary transactions, and drop-off services may either be door-to-door or curb-to-curb depending on the unique circumstances of the trip.
- f. **It is unclear if ambulatory Veterans discharged following procedures that involve sedation and/or anesthesia can use VTN services. There may be two policy barriers. VHA Directive 1073 does not allow unaccompanied Veterans following moderate sedation to use public transportation, DAV or volunteer van drivers. It is unclear if this includes VTN drivers and vehicles. Beyond this issue, the VHA Handbook 1620.02 governing the VTN does not include policy about transporting an attendant or companion.**
 - i. If attendants are allowed under VTN business rules, VTN services can be considered for ambulatory Veterans of any clinical risk when traveling with an attendant or companion to the discharge destination.
 - ii. If VHA Directive 1073 does allow unaccompanied Veterans to use VTN services, VTN is acceptable for ambulatory Veterans traveling alone who are assessed as clinically lower risk for adverse events during transportation to the discharge destination. VTN transport of ambulatory Veterans assessed as higher clinical risk without an attendant is not recommended; however, this disposition may be appropriate in rare circumstances involving complex and mitigating factors.

7. Volunteer or Community Transportation Providers (non-VTN)

- a. Non-VTN community transportation providers are not overseen by VA Voluntary Services. Driver qualifications, vehicle types, destination and drop-off service, hours of availability, and operational processes vary significantly across VA medical facilities.
- b. Due to the variability across the VA Enterprise, the use of this modality cannot be strongly endorsed by the workgroup.



- i. This service can likely be used for Veterans of any clinical risk when traveling with an attendant or companion to the discharge destination.
 - ii. **It is unclear if VHA Directive 1073 allows this option for Veterans discharged alone.** If allowed, this may be an option for Veterans traveling alone who are assessed as clinically lower risk for adverse events during transportation to the discharge destination. Risk/benefit analysis should account for the specific local non-VTN community transportation provider (i. e. driver qualifications, type of vehicle, destination/drop-off status, etc.). The proceduralist and/or anesthesia provider should counsel the Veteran on the risks to forego an attendant and document the discussion in the medical record.
 - iii. Veterans assessed as higher clinical risk who travel alone are not suited for this transport mode; however, this mode may be appropriate in rare settings involving complex and mitigating factors.
- c. It is not necessary to obtain a signed, written authorization to release information in this context because the call for the non-VTN transport service would be with the consent and knowledge of person needing the ride because the Veteran coordinates the transportation.

8. Taxi Services:

- a. Taxi services provide a vehicle and driver for hire. A taxi conveys passengers between locations of their choice.
- b. Vehicle types vary and many may not accommodate a wheelchair.
- c. Driver qualifications vary from State to State, destinations may not be fixed, monetary transactions may occur, and drop-off services are usually curb-to-curb.
- d. There is no statutory or funding authority within VA which permits payments to contract taxi services for non-BT eligible Veterans. Non-BT eligible Veterans may solicit self-pay taxi services following an outpatient procedure involving sedation and/or anesthesia. Additionally, there may be instances in which VA Voluntary Service (VAVS) can provide single use, on-demand taxi services using donated funds if these funds are available.
- e. If VAVS or other staff schedule taxi services on the patient's behalf, staff must secure a signed, written authorization from the patient using VA Form 10-5345 or other VA-approved form prior to disclosing personally



identifiable information to the taxi service. The authorization must occur PRIOR to the administration of any sedation and/or anesthesia to ensure the Veteran has full capacity for informed consent. Veterans may schedule the taxi prior to the procedures. In these circumstances, a release is not required.

- f. This option may be suitable for ambulatory Veterans assessed as lower clinical risk who are traveling alone, keeping in mind variation in driver qualifications, monetary transaction risks, and service variability. This option is not suitable for ambulatory Veterans assessed as higher clinical risk who travel alone; however, this option may be appropriate in rare settings involving many complex and mitigating factors. This option is suitable for ambulatory Veterans of any clinical risk when traveling with an attendant or companion to the discharge destination.
 - i. **When using VAVS donated funds for Veterans discharging alone, it's important the local VA VTP Board of Directors develop policy. VHA Directive 1073 may present a barrier discharging ambulatory Veterans alone using taxi services, as the directive may consider taxis "public transportation".**

9. Ride Hailing Services (i. e. Uber, Lyft)

- a. Ride hailing services are an unlicensed taxi service.
- b. Like taxi services, ride hailing services hire a vehicle and driver to convey passengers to requested locations.
- c. Vehicle types vary widely and may not accommodate wheelchairs.
- d. Driver qualifications vary by state, destinations are often not fixed, monetary transactions occur at transport usually through electronic payments, and drop-off services are usually curb-to-curb.
- e. Some ride hailing services advertise healthcare related services. These include services such as Uber Health, or Lyft/Allscripts, for example. Such services are designed to meet healthcare and privacy standards established in the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA), and offer centralized scheduling and billing administered by healthcare institutions instead of the Veteran.
- f. There is no VA statutory or funding authority to permit payments to contract ride hailing services for non-BT eligible Veterans. Non-BT eligible Veterans may solicit self-pay ride hailing services following an outpatient procedure involving sedation and/or anesthesia. Additionally, VAVS may provide single use, on-demand ride hailing services to Veterans using donated funds if these funds are available.



- g. If VAVS or other staff schedule ride hailing services on the patient's behalf, staff must secure a signed, written authorization from the patient using VA Form 10-5345 or other VA-approved form prior to disclosing personally identifiable information to the ride hailing service. The obtaining of authorization must occur PRIOR to the administration of any sedation and/or anesthesia to ensure the patient has full capacity for informed consent.
- h. Given the variation in driver qualifications, monetary transaction issues, and destination/drop-off status issues, the Workgroup recommends cautiously considering Ride Hailing Services for the transport of ambulatory Veterans of lower clinical risk that are traveling alone. The Workgroup does not recommend considering Ride Hailing Services for the transport of ambulatory Veterans of higher clinical risk that are traveling alone as a standard practice; however, this modality may still be appropriate in rare settings involving many complex and mitigating factors. Ride Hailing Services can be considered for ambulatory Veterans of any clinical risk when traveling with an attendant or companion to their desired destination, provided that this attendant or companion can accompany the Veteran during transportation.
 - i. **When using VAVS donated funds for Veterans discharging alone, it's important the local VA VTP Board of Directors develop policy. VHA Directive 1073 may present a barrier discharging ambulatory Veterans alone using ride hailing services, as the directive may consider ride hailing services as "public transportation".**

10. VA Medical Facility to VA Medical Facility Transportation Services

- a. Some VA medical facilities within reasonable geographic proximity to one another provide transportation between the facilities. VTS drivers use large capacity ambulatory shuttle buses. There are no monetary transactions and drop-off services are usually curb-to-curb at fixed locations on fixed routes according to approximate time schedules. They almost never deliver a Veteran to the discharge destination and require the Veteran to obtain other means of transportation to the discharge destination.
 - i. This service is suitable for ambulatory Veterans of any clinical risk when traveling with an attendant the discharge destination. The attendant or companion ensures the Veteran reaches the discharge location.



- ii. This service is not recommended for ambulatory Veterans assessed at higher clinical risk who travel alone due to their uncontrolled logistical nature.
- iii. This service is not recommended for ambulatory Veterans assessed as lower clinical risk who travel alone; however, it may be appropriate in rare settings involving complex and mitigating factors.

11. Public Transportation Services

- a. Public transportation is buses, trains, subways, ferries, and other forms of transportation which charge set fares, run on fixed routes and approximate time schedules, and are available to the general public.
- b. Vehicle types and capabilities vary based upon the mode of transportation. Driver/operator qualifications vary by State and involve monetary transactions unless a voucher or pre-paid fare card is used. Services are usually curb-to-curb, but not at the curb of the discharge destination, requiring the Veteran to use other means to reach the desired destination.
- c. Public transportation for Veterans discharged alone following outpatient procedures using sedation and/or anesthesia is prohibited by VHA Directive 1073. Setting aside this restriction for the sake of discussion, in rare circumstances, it may be suitable for patients assessed as low clinical risk.
- d. Public transportation is suitable for patients of any clinical risk when traveling with an attendant or companion to their discharge destination as long as the attendant/companion ensures the Veteran safely reaches the discharge destination. VAVS may provide a single-use on-demand fare passes purchased with donations. VAVS distributes fare passes to a Social Work office for distribution to Veterans.

12. Hoptel/Lodging Services (e.g., Hoptel, lodgtel, Fisher Houses)

- a. Temporary lodging is not available at every VA facility and is not included as part of the Veteran's benefits package. VA temporary lodging may include an inpatient room set aside for this purpose, may be in another campus building, or contracted with a local hotel/motel in accordance with 38 U.S.C 1708.
- b. Under 38 CFR 60.10(b)(1), and VHA Directive 1107, VA facilities with a Fisher House may lodge a Veteran only if there is an accompanying adult attendant or companion. When VA campuses have a Fisher House and a



Hoptel, the Fisher House may be used as Hoptel overflow only for Veterans with an adult attendant or companion. There is no cost to the Veteran or attendant/companion; however, food is not included.

Temporary lodging only offers a safe building, a bed, and bathroom.

- c. Temporary Lodging is granted as space-available with consideration of roommate compatibility. Room sharing of unrelated individuals of the same gender may be necessary.
- d. Veterans must be assessed as medically stable, capable of self-care or accompanied by an individual (i. e. family, friend, or H/HHA) able to provide such care, and able to stay in an unsupervised setting. VA does not provide nursing or other medical care in temporary lodging facilities.
- e. Temporary Lodging is available for Veterans who travel either 50 or more miles or at least 2 hours from home to the VA medical facility. Exceptions may be granted by the VA medical facility director in rare circumstances.
- f. When non-VA temporary lodging facilities are used, VA staff may schedule transportation to/from the medical facility for those patients without personal transportation. Transportation may be non-VA or VA sourced, and based on Veteran and mode eligibility. If VA staff schedule transport for the patient and need to disclose personally-identifiable information, a signed written authorization using VA Form 10-5345 or other VA-approved form is required. The obtaining of authorization must occur PRIOR to the administration of any sedation and/or anesthesia to ensure patient's full capacity for informed consent.
- g. Temporary lodging is suitable for Veterans of any clinical risk when accompanied by an attendant or companion during their stay in a temporary lodging facility.
- h. VHA Directive 1107: VA Fisher Houses and Other Temporary Lodging clarifies that Veterans receiving conscious sedation during a procedure may not receive overnight accommodations in temporary lodging post procedure unless supervised by an accompanying individual. This prohibition notably is only for sedation, as the Directive does not mention general anesthesia
- i. It is the workgroup's opinion that restrictions related to sedation and anesthesia in this policy should be reconsidered.

13. VA Paid Medical Companion Service

- a. Homemaker and/or home health aide (H/HHA) services help patients with activities of daily living (ADLs) or instrumental ADLs (IADLs) dependencies so the patient may live in the community as long as



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- possible. H/HHA are trained and employed by a home health agency. VA enrolled Veterans with medical necessity may receive H/HHA services.
- b. Authority for H/HHA services are codified at 38 U.S.C. 1720C and operational requirements are specified at VHA Handbook 1140.06, Purchased Home Health Care Services Procedures. Veterans eligible for H/HHA services are clinically assessed through an interdisciplinary assessment as having three or more ADL dependencies, or significant cognitive impairment, or ongoing community hospice services that require adjunct H/HHA services, or 2 or more ADL dependencies with other qualifying conditions. Every contingency cannot be foreseen, however. Veterans who do not strictly meet the above criteria may receive these services if a medically validated reason for the variance is documented in the Veteran's record.
 - c. VHA Community Care Programs leadership advises H/HHA services may be used to accompany Veterans during transport and at the discharge location for a time period when clinically indicated. **VHA Community Care Programs leadership supports this clinically indicated use and are amending the Community Care Guidebook to clearly delineate funding authority for time-limited VA paid medical companion services.**
 - d. Veterans using VA paid medical companion services upon post-procedure discharge must be assessed as medically stable by a qualified licensed independent practitioner or according to established discharge criteria. Veterans assessed as lacking social support are eligible for short-term, time-limited H/HHA services for medical companion services. There must be a clinically indicated and documented need post-discharge for either/or transport or assistance at the discharge location. It is incumbent upon VA medical and social work staff to make good faith efforts to identify pragmatic and cost-effective alternatives to safely transition the Veteran to a discharge location before using H/HHA for medical companion services. The use of H/HHA services for medical companion services is based on H/HHA resource availability as determined by VA medical facility leadership.
 - e. When using medical companion services, every effort should be made to introduce the Veteran and the medical companion before the outpatient procedure involving sedation and/or anesthesia. This increases Veteran rapport and decreases anxiety before administration of sedative or other psychotropic medications.

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14. VA Appointed Case Manager Transportation

- a. Intensive Community Mental Health Recovery Services (ICMHR) encompasses three VHA evidence-based clinical programs. Assertive Community Treatment (ACT) to individuals with serious mental illness (SMI) is shown to reduce inpatient mental health hospitalization, improve Veteran satisfaction with care, increase housing stability, and improve treatment retention.
- b. Within VHA, ICMHR is known as Mental Health Intensive Case Management (MHICM), Rural Access Network for Growth Enhancement (RANGE), and Enhanced Rural Access Network for Growth Enhancement (E-RANGE). Fundamental to the ICMHR service delivery is interdisciplinary clinical case management whereby all members of the team support the Veteran.
- c. Eligible Veterans are enrolled through referral and assessment for the specific service.
- d. ICMHR Services uses Federal vehicles for community-based service delivery which clinical staff may use to transport Veterans. Clinical staff are medically cleared and trained in accordance with VHA Directive 2008-020. Transportation of enrolled ICMHR Veterans provides door-to-door services to Veterans with SMI by staff who are well-known to the Veteran. The discharge destination is fixed and costs the Veteran nothing.
- e. ICMHR services are encouraged for transportation of Veterans of any clinical risk enrolled in ICMHR services.

Unresolved Ethical Considerations

Post Sedation and Anesthesia Care, which assures a safe transition from a VA medical facility to a post-care destination, is procedurally and ethically complex, especially for Veterans without suitable social supports or transportation. VA is unwaveringly committed to providing eligible Veterans with the clinically indicated care they need and desire. Providing such care is consistent with VA's mission, our I CARE values, and our ethical and legal obligations. Accordingly, from an ethics perspective, eligible Veterans should never be denied clinically indicated and desired care because they lack social supports or resources for post-sedation or anesthesia care.

Additionally, VA care must be provided within the existing regulatory and policy framework, and within resource constraints. In the face of these obligations, which at times are in conflict, the Post Sedation and Anesthesia Care workgroup strongly and consistently advocates for a Veteran-centered approach to individual treatment planning; that is, promoting individual treatment planning that is primarily guided by



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clinical standards, and Veteran values and preferences. Where regulatory or policy barriers exist, the workgroup advocates for resolving systematic conflicts by changing laws, regulations, or policies to remove the regulatory or policy barriers and that assure Veterans' clinical needs can be safely met regardless of their individual psychosocial circumstances.

Inevitably, ethics questions about post sedation and anesthesia care and/or discharge will continue to arise. Such questions should be referred to the IntegratedEthics® Ethics Consultation Service at the Veteran's local facility, or to the VA National Center for Ethics in Health Care (10E1E) at vhaethics@va.gov.

Unresolved Policy Barriers

Current regulations and VHA directive and handbooks are complex and at times present significant challenges to VA medical facilities attempting to develop policy and procedures to safely meet Veteran needs and ensure access to clinically necessary procedures or surgery requiring sedation and/or anesthesia. Specific challenges exist for Veterans who need help scheduling an attendant or companion, or transportation. The policy landscape became more difficult with directive revisions within the last five years of VHA Directives 1073 (Moderate Sedation) and 1107 (VA Fisher Houses and Other Temporary Lodging). Moreover, it has been confounded by transportation options and their limitations, imprecise language about Veterans undergoing sedation or anesthesia, and VHA's interpretation of relevant Joint Commission Standards and CMS Medicare requirements. The results contribute to angst and uncertainty in the field when local solutions are proposed which either violate a regulation or VHA directive or handbook business rule, result in high costs and/or disproportionate use of scarce resources (e.g. heavy use of observation admissions), or result in health care disparities and/or adverse Veteran clinical outcomes.

Implementing the following specific actions would reduce these challenges:

1. As a general practice, VHA policies should use consistent terminology and definitions when referring to ambulatory or outpatient procedures, sedation and/or anesthesia regimens, attendant or companion requirements, and transportation modalities (such as public transportation).
2. Revise the language of VHA Directive 1107, Fisher Houses and Other Temporary Lodging, to allow unaccompanied Veterans to be discharged to temporary lodging when assessed as medically stable by VA clinical staff following outpatient procedures using sedation and/or anesthesia.
 - a. The current VHA Directive states that "Veterans or Servicemembers must be determined medically stable, capable of self-care or accompanied by an



- individual able to provide such care, and able to stay in an unsupervised setting. VA does not provide nursing or other medical care in temporary lodging facilities. Veterans or active duty Servicemembers receiving conscious sedation during a procedure may not receive overnight accommodations in Temporary Lodging post procedure unless they are supervised by an accompanying individual.”
- b. The National Anesthesia Service, the Anesthesia Director, and the Anesthesia Field Advisory Committee all recommend deletion of the following sentence from VHA Directive 1107 “Veterans or active duty Servicemembers receiving conscious sedation during a procedure may not receive overnight accommodations in Temporary Lodging post procedure unless they are supervised by an accompanying individual.”
 - c. This statement is based on the 38 USC 1708 – Temporary Lodging which directs the Secretary to include provisions to establish criteria for “use of the premises of temporary lodging facilities” and “other limitations, conditions, and priorities the Secretary considers appropriate with respect to lodging”.
 - d. 38 CFR 60.10 establishes the Veteran staying in temporary lodging is “medically stable and capable of self-care or accompanied by an individual who is able to provide all necessary care.”
 - e. In current practice, overnight stays for a Veteran undergoing moderate sedation is prohibited. There are no specific directions for Veterans undergoing deep sedation or general anesthesia. This stipulation is presumably due to field concerns about VHA proceduralists and/or anesthesia providers who discharge Veterans to a temporary lodging when a Veteran has significant medical problems and is otherwise without medical staff or a companion available to attend to them.
 - f. The Anesthesia Field Advisory Committee (FAC) has forwarded the following recommendation for temporary lodging eligibility consideration following an outpatient procedure involving sedation and/or anesthesia: the Veteran must be assessed with an Aldrete score of 9 or greater (see figure below), not have sleep apnea, and be capable of self-care before and after the outpatient procedure involving sedation and/or anesthesia.



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Motoric activity	
▪ Spontaneous movement when addressed	2
▪ Weak spontaneous movements when addressed	1
▪ No movement	0
Breathing	
▪ Coughs on comment or cries	2
▪ Keeps the airway open	1
▪ Obstructed airways	0
Blood pressure compared to reference measurement*	
▪ $\Delta < 20$ mm Hg	2
▪ $\Delta = 20 - 50$ mm Hg	1
▪ $\Delta > 50$ mm Hg	0
Consciousness	
▪ Awake	2
▪ Response to stimulus, reflexes intact	1
▪ No answer, reflexes absent	0
Oxygen saturation	
▪ 100 - 98 %	2
▪ 97 - 95 %	1
▪ < 95 %	0
*Reference measurement was performed 1½ minutes after administration of the spasmolytic agent.	

- g. The Veteran may not have sleep apnea and be receiving post-operative opiate analgesics.
- h. The Veteran must have been able to provide self-care prior to the procedure and is expected to be able to provide self-care following the procedure.
- i. A VHA health care provider will be responsible for determining the current medical stability of the Veteran or active duty Servicemember, and whether the Veteran or active duty Service-member is capable of self-care at the time of temporary lodging or has an accompanying individual who can provide care. This determination includes whether the Veteran can be lodged in an unsupervised setting. Determination of medical stability, self-care, and staying in an unsupervised setting are to be documented in the Veteran's medical record in CPRS.
- j. The decision on when a Veteran is eligible for a Hoptel stay without an accompanying adult will be dependent on the sedatives or anesthetics provided. Anesthetics are by nature reversible and the effects of limited duration. The redistribution half-life of fentanyl is 40 minutes. The redistribution half-life of midazolam is 1.5-2.5 hours. The redistribution half-life of Propofol is 5-10 minutes. Inhaled agents are excreted by the lung with half-lives of less than 10 minutes. Therefore, a reasonable time to wait after the administration of the most common anesthetic agents is 4-5 hours. Most



Veterans will be Hoptel eligible approximately four hours after the last administration of intravenous or inhalant sedating agent.

- k. The FAC argues the temporary lodging criteria to lodge without an accompanying adult should be based on the anesthesia or sedative used and the clinical status of the Veteran upon discharge from the procedural area. Most anesthetics are reversible with limited effective duration, and in most cases a reasonable time period to wait following administration of the most common anesthetic agent is no longer than 4-5 hours.
3. Revise the language of VHA Directive 1073, Moderate Sedation by Non-Anesthesia Providers for clarify and scope. Section 4.d.(5)(b)1 contains confusing language with about the use of VTS services, facility van drivers, and DAV services for transportation of Veterans following sedation or anesthesia. Beyond this, the Directive does not clearly define public transportation and uses nebulous language about attendant or companion requirements. Lastly, the Directive does not govern the management of Veterans who undergo outpatient procedures involving deep sedation or general anesthesia, or anesthesia regimens provided by anesthesia providers (e.g. MAC), limiting the applicability of the Directive. It is unclear if other VHA Directives specifically direct VA management of Veterans following outpatient procedures involving sedation and/or anesthesia not covered by VHA Directive 1073. If not, consideration should be given to adding those Veterans to the scope of this directive.
 4. Reconsider the language of VHA Directive 1695 Veterans Transportation Services.
 - a. Page 14 defines eligibility for Veterans discharged following outpatient surgical procedures involving moderate sedation. The language is too narrow and should include nonsurgical invasive procedures and other levels of sedation and/or anesthesia. Recommend language similar to that recommended for temporary lodging above.
 - b. Appendix page B-3, item 8 and Appendix page B-4, item 9 pertain to moderate sedation and surgical Veterans, respectively. Appendix page B-4, item 9 (surgical Veterans) defers all authority to local facility SOP's/regulations overseen by the local Veterans Transportation Program (VTP) Board. Appendix page B-3, item 8 (moderate sedation Veterans) lists very prescriptive requirements. Authority is granted to the attending physician on about the necessity of an attendant during transportation, but the Directive mandates the presence of a responsible adult at the Veteran's discharge destination to assist and monitor the Veteran upon arrival. Recommend consistent, pragmatic, and robust language in the revision commensurate with the recommendations contained in this toolkit.



- c. Consider a thorough review of all governing Federal statutes, and regulations, to determine funding and/or statutory authority for VA contracted taxi or ride hailing services to non-BT eligible VHA Veterans following outpatient procedures involving sedation and/or anesthesia. If none exist, recommend the VA Office of Congressional and Legislative Affairs review this topic for possible inclusion in future legislative pursuits.
5. Include additional language to VHA Handbook 1140.6 Purchased Home Health Care Services. Section 7.a-b. details policy about eligibility and determinations of need for VA home health care services which influences funding authority for medical companion services at VA medical facilities to support otherwise unaccompanied Veterans for medically necessary outpatient procedures involving sedation and/or anesthesia. Funding authority exists for VA medical facilities to use Purchased H/HHA Services when clinically appropriate and when funds are available. It is beneficial to the field if this is explicitly outlined in the VHA handbook.
6. Revise the language of VHA Handbook 1620.02, Volunteer Transportation Network (VTN) to explicitly state that if a medically necessary attendant or companion may travel with the Veteran following outpatient procedures involving sedation and/or anesthesia. It is beneficial to the field if this is explicitly outlined in the VHA handbook.



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38 U.S. Code § 111A. Transportation of individuals to and from Department facilities.

38 U.S. Code § 501 (Pub. L. 111-163). Rules and regulations.

38 U.S. Code § 1708. Temporary lodging.

38 U.S. Code § 1720. Transfers for nursing home care; adult day health care.

38 U.S. Code § 7301. Functions of Veterans Health Administration: in general.

38 CFR § 17.38. Medical benefits package.

38 CFR § 60.10. Eligibility criteria for Fisher House or other temporary lodging.

38 CFR § 70.10. Eligible persons.

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38 CFR § 70.70. Purpose and definitions.

38 CFR § 70.71. Eligibility.

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38 CFR § 70.73. Arranging transportation services

42 CFR § 416.42. Condition for coverage – Surgical services.

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Acknowledgement of the Post Sedation & Anesthesia Care Workgroup

Jennifer Halter, LICSW, DCSW
Chair
Social Work Executive
Clement J. Zablocki VA Medical Center

Jason A. Dominitz, MD, MHS
Chair, Clinical Appropriateness
National Gastroenterology Program Director

Scott Pawlikowski, MD
Chair, Policy
Primary Care Lead Physician/Deputy CMO
VA Great Lakes Health Care System

Cecelia Satterly, LSW
Chair, Consult Implementation
Philadelphia VA Medical Center

Kenneth A. Berkowitz, MD FCCP
Chief, Ethics Consultation
VA National Center for Ethics in Health Care (10E1E)

Amy S. Chomsky, MD
Chief of Ophthalmology
VA Tennessee Valley Healthcare System

Karen Dudding, RN, MSN
VA Central Office
Quality, Safety & Value Utilization and Efficiency Management

Stephania Griffin
VA Central Office
Director, Information Access & Privacy Office



U.S. Department of Veterans Affairs
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Brian Hertz, MD
VA Central Office (Field Based)
Senior Medical Advisor
Office of Veterans Access to Care

Peter Kaboli, MD
Chief of Medicine
Iowa City VA Medical Center

Bill Klotzbucher
Attorney
VA Office of General Counsel
Health Care Law Group

Jennifer Koget, LCSW, BCD
National Program Manager
VA Fisher House and Family Hospitality Program

Victoria Marrs
ACNS Perioperative Services
Central Texas Veterans Health Care System

Thomas Mattras, MD
Chief of Primary Care
Bay Pines VA Healthcare System

Paul Perry
Acting Director
Veteran Transportation Program

Robin Pete, LCSW
Social Work Section Chief
Bay Pines VA Healthcare System

Andrew Pomerantz
VA Central Office
Office of Mental Health and Suicide Prevention



U.S. Department of Veterans Affairs
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Catovia B. Rayner, MSW, MPH, LCSW
Chief, Social Work Service
Tennessee Valley Healthcare System

Jennifer Silva, LCSW-S
Assistant Chief, Social Work
Tennessee Valley Healthcare System

Laura Taylor, LSCSW
VA Central Office
National Director of Social Work

Arthur Wallace, MD, PhD
Chief of Anesthesia Service
San Francisco VA Medical Center

Lisa J. Warner, MHA, RN, CNOR
Office of Nursing Services
Clinical Nurse Advisor for Periop & Surgical Quality Nurse
Phoenix VA Health Care System

Robert Zing, RN
Nurse Manager
VA Puget Sound Health Care System

VA

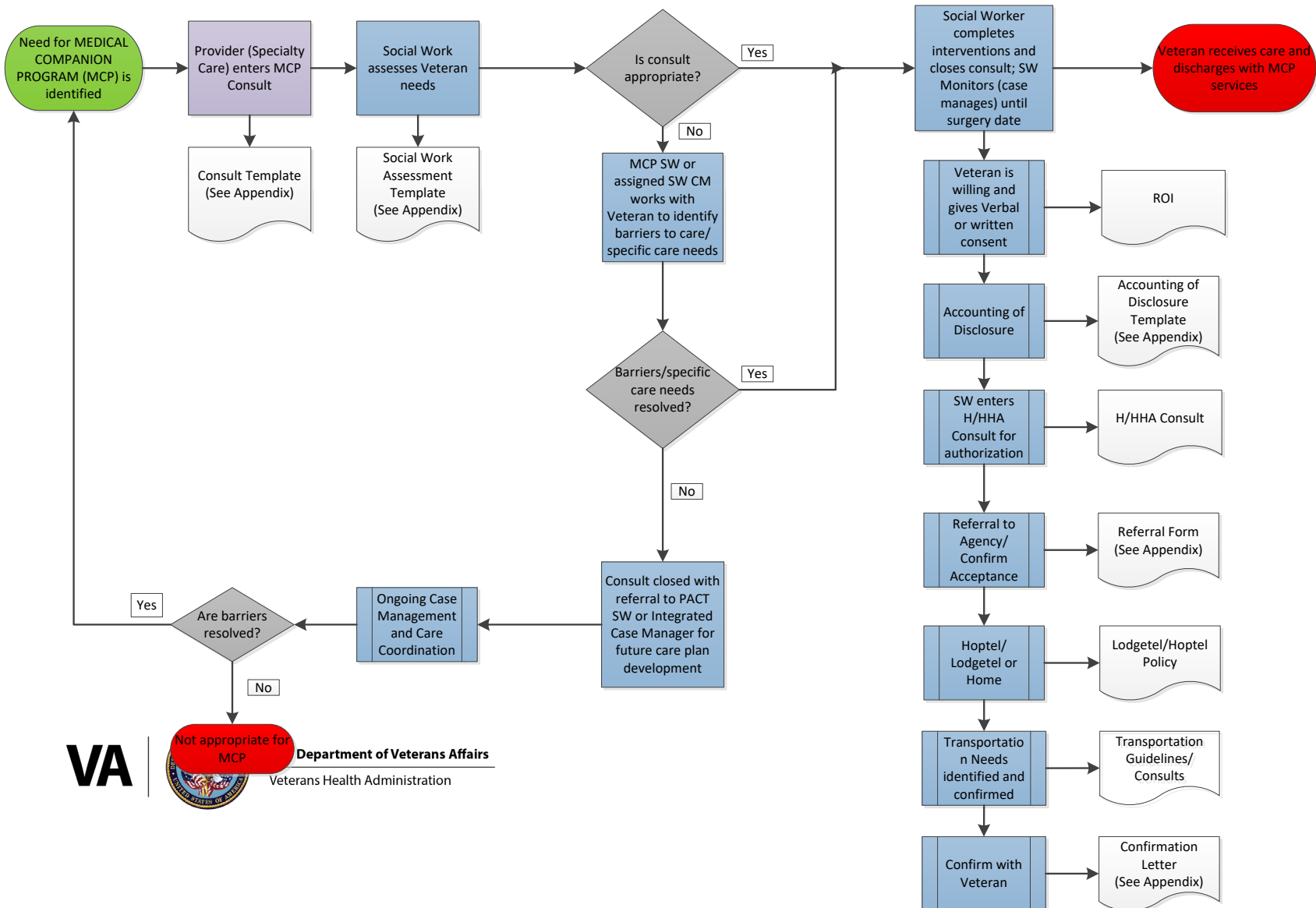


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Appendix

MEDICAL COMPANION CONSULT PROCESS



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[Medical Companion \(Social Work\) Consult for Providers](#)



Medical
Companion Consult

[Social Work Clinical Assessment Template](#)



Social Work Clinical
Assesment

[Accounting of Disclosure Template](#)



Accounting of
Disclosure

[Referral Form for H/HHA Agency](#)



Referral Form

[Confirmation Letter for Veteran](#)



Confirmation Letter



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