Frequently Asked Questions:
For Health Care Facilities Implementing the Life-Sustaining Treatment Decisions Initiative

VHA Handbook 1004.03: Life-Sustaining Treatment (LST) Decisions: Eliciting, Documenting and Honoring Patients’ Values, Goals and Preferences

1. What is the Life-Sustaining Treatment Decisions Initiative (LSTDI)?

The LSTDI is a national VHA quality improvement project led by the National Center for Ethics in Health Care (NCEHC). The aim of the initiative is to promote personalized, proactive, patient-driven care for Veterans with serious illness by eliciting, documenting, and honoring their values, goals, and preferences. The initiative involves a new national policy (VHA Handbook 1004.03) to standardize practices related to discussing and documenting goals of care and life-sustaining treatment decisions, and the tools, resources, education, and monitoring to support clinicians and facilities in making practice changes.

2. What is the ethical basis for the Life-Sustaining Treatment Decisions Initiative (LSTDI)?

Patients with decision-making capacity have the right to accept or decline recommended medical treatments and procedures, including life-sustaining treatments (LST). Health care providers have a professional obligation to respect and honor those decisions. Patients who lack decision-making capacity have the right to have a surrogate make decisions on their behalf based on the patient’s known values, goals, and preferences.

Many patients do not have an opportunity to discuss and make decisions regarding LSTs before they become critically ill or unable to speak for themselves. Practitioners are often reluctant to discuss decisions about cardiopulmonary resuscitation (CPR) and other LSTs with patients, and often postpone such discussions until a crisis occurs or until the patient is within days or even hours of death – at which time patients are often unable to participate in discussions and surrogate decision makers are highly stressed.
Living wills, also called instructional advance directives, can be useful in allowing patients to communicate general preferences in advance for care they would like to receive after losing decision-making capacity. However, most patients complete living wills without having a discussion with a health care team about their goals of care and the treatment plans that would be likely – or not likely – to support those goals. In addition, living wills are often completed far in advance of a diagnosis of serious illness, and goals of care and the potential benefits of treatment may change over the course of illness. As such, instructions provided in living wills are often too simplistic or vague to be readily translated into specific medical decisions, and living wills do not serve as orders. Instead, they need to be carefully read and discussed by health care providers and surrogates before they can be implemented, and they are often interpreted in different ways by different people. For these reasons, advance directives alone are no longer considered sufficient for patients for whom decisions about LST need to be made, such as patients with serious life-limiting medical conditions. For such high-risk patients, there is a need for an explicit discussion tailored to each individual patient (i.e., a goals of care conversation) that involves shared decision-making between the patient (or surrogate) and the health care practitioner. For these discussions to have clinical impact, they need to be translated into a plan and orders that are readily accessible in the health record.

The Life-Sustaining Treatment Decisions Initiative is designed to assist VA providers to develop and deliver treatment plans that are aligned with the values, goals, and preferences of high-risk patients.

3. How was VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients’ Values, Goals and Preferences, developed?

VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients’ Values, Goals and Preferences (LST Handbook) was developed by the VHA National Center for Ethics in Health Care (NCEHC) over a 10+ year period with input from a large number of stakeholders at all levels of the organization. It went through the VHA concurrence process and achieved the concurrence of all program offices before it was signed by the Under Secretary for Health on January 11, 2017. The foundational components of the policy are grounded in the literature around patient-centered care for patients with serious illness, including work that has been done on state-authorized portable orders and improving communications with patients and families near the end of life. Some of the foundational literature is cited in the LST Handbook. The NCEHC implemented new practices in four demonstration sites based on a waiver from the VHA Deputy Under Secretary for Health for Operations & Management authorizing those facilities to follow a draft version of the LST Handbook. In response to the experiences and input of clinicians and Advisory Boards at the four sites, the NCEHC made multiple changes to requirements/processes specified in the LST Handbook, and made related iterative changes to the LST progress note template and LST orders, and developed/changed staff education processes/materials/tools and patient education resources.

4. What outcomes were measured in the four-site LSTDI demonstration project?

The four-site demonstration project was not a research project to measure outcomes, but a quality improvement project to refine all components of the Life-Sustaining Treatment Decisions Initiative.

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Initiative (LSTDI) before it was released in VA nationwide. In response to the experiences and input of clinicians and Advisory Boards at the four sites, the National Center for Ethics in Health Care made multiple changes to requirements/processes specified in VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients’ Values, Goals and Preferences (LST Handbook), made iterative changes to the LST progress note template and LST orders, and developed/changed staff education processes/materials/tools and patient education resources. We used demonstration site recommendations and “lessons learned” to create the Implementation Guide to inform all VA medical facilities in their implementation plans.

5. Where can I get a copy of VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients’ Values, Goals and Preferences?

The Handbook is available on the VHA Forms and Publications page at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=4308. You can also access it on the National Center for Ethics in Health Care’s (NCEHC) website.

6. How soon does our facility have to implement new processes outlined in VHA Handbook 1004.03?

Your facility will have until July 11, 2018 (that is, 18 months from the publication date (January 11, 2017) of VHA Handbook 1004.03) to fully implement new processes. Given the scope and significance of this practice change, we recommend that facilities begin steps toward implementation as soon as possible. Please see the step-by-step Implementation Guide and information about the monthly Implementation Support calls.

7. How soon does our facility have to develop local policy that aligns with national policy, VHA Handbook 1004.03?

Your facility will have until July 11, 2018 (that is, 18 months from the publication date (January 11, 2017) of VHA Handbook 1004.03) to fully implement new processes. As part of implementation, facilities must develop local policy that aligns with VHA Handbook 1004.03. Given the scope and significance of new practice changes outlined in VHA Handbook 1004.03, we recommend that facilities begin steps toward implementation as soon as possible, including developing local policy. The National Center for Ethics in Health Care has developed a Medical Center Memorandum (MCM) template that facilities can use to develop local policy that is consistent with VHA Handbook 1004.03.

Facilities should continue to follow their current local policy and documentation processes until they have developed and implemented local policy to align with VHA Handbook 1004.03 (within 18 months).

8. We only have outpatients. Do we have to implement the LST process if our facility only has outpatients?

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Yes. VHA Handbook 1004.03 requires conducting and documenting goals of care conversations with high-risk patients in all clinical settings, including outpatient and home-based primary care clinics, and thus the LST progress note and orders must be installed in CPRS in every VA facility. High-risk patients are defined as those who are at risk for a life-threatening clinical event within the next 1-2 years, and goals of care conversations are to be conducted proactively in outpatient settings whenever possible, prior to a medical crisis or loss of decision-making capacity. Life-Sustaining Treatment Orders, including DNR orders, that are written on the basis of a goals of care conversation will now be durable across all care settings, so outpatients may have active DNR orders that are to be honored if the patient experiences a cardiopulmonary arrest during an outpatient visit. Proactively identifying high-risk patients, documenting goals of care, writing LST orders, and honoring LST orders may be new practices for outpatient clinicians at your facility, so staff education prior to policy implementation is very important.

9. Are there resources available to support facilities and staff to implement new processes outlined in VHA Handbook 1004.03?

Yes. Implementation resources, including a step-by-step Implementation Guide, monthly implementation support teleconferences, and an implementation monitoring tool are available on the National Center for Ethics in Health Care’s LSTDI implementation website.

10. What is a goals of care conversation (GoCC)?

A GoCC is a conversation between a health care practitioner and a patient (or surrogate if the patient lacks decision-making capacity) for the purpose of determining the patient’s values, goals, and preferences for care, and, based on those factors, making decisions about whether to initiate, limit, or discontinue life-sustaining treatments.

11. When should a goals of care conversation (GoCC) be initiated?

A GoCC should be initiated with a high-risk patient (or surrogate) whenever clinically appropriate, unless it has already been completed during another encounter. This includes:

- After admission to a VA Community Living Center
- At a Primary Care or Home-Based Primary Care visit
- After a new Palliative Care consultation
- Prior to referral to VA or non-VA hospice (or after admission to hospice for patients referred from outside VA)
- Prior to initiating or discontinuing treatment that is intended to prolong the patient’s life when the patient would be expected to die soon without the treatment
- After admission to a VA acute care hospital
- At any encounter when the patient presents with a state-authorized portable order (e.g., POLST, MOLST)
- Prior to writing orders to limit life-sustaining treatment, including Do Not Resuscitate (DNR) or Do Not Attempt Resuscitation (DNAR) orders
- At any patient encounter when the patient expresses a desire to make decisions about limiting or not limiting life-sustaining treatments as part of the current treatment plan

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12. When should a goals of care conversation (GoCC) be deferred?

When a GoCC is indicated, it may be deferred in the following circumstances:

- In emergency situations when delaying medical care in order to conduct a GoCC would increase the hazard to the life or health of the patient.
- When the patient (or surrogate) declines or defers.
- When the practitioner determines that delay is clinically indicated.

The practitioner should document the reason for deferring the conversation, and re-initiate the discussion as soon as the patient has stabilized or when the patient (or surrogate) is ready.

13. When should a patient’s life-sustaining treatment plan and orders be revisited in a new goals of care conversation (GoCC)?

When a high-risk patient already has a life-sustaining treatment plan and orders in place, they should be revisited in a new a GoCC:

- When there is evidence that previous decisions are no longer consistent with the patient’s wishes.
- For patients who have a DNAR/DNR order, prior to a procedure involving general anesthesia, initiation of hemodialysis, cardiac catheterization, electrophysiology studies, or any procedure that poses a high risk of serious arrhythmia or cardiopulmonary arrest.

14. What is a Life-Sustaining Treatment (LST) Plan?

A LST plan is a treatment plan resulting from a goals of care conversation about LSTs.

15. What is a life-sustaining treatment (LST)?

An LST is a medical treatment that is administered in an attempt to prolong the life of a patient who would be expected to die soon without the treatment. Examples of LSTs include cardiopulmonary resuscitation (CPR), mechanical ventilation, dialysis, artificial nutrition, and artificial hydration.

16. Who is a high-risk patient?

A high-risk patient is a patient who is considered to be at high risk for a life-threatening clinical event because they have a serious life-limiting medical condition associated with a significantly shortened lifespan. If a patient’s provider would not be surprised if the patient experienced a life-threatening clinical event within the next one to two years, the patient would be considered “high-risk”.

17. How do we identify high-risk patients?

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The Care Assessment Need (CAN) score can be used to complement clinical judgement in identifying patients who are at high risk for a life-threatening clinical event because they have a serious life-limiting medical condition associated with a significantly shortened lifespan. The CAN score is a predictive analytic tool that represents the estimated probability of hospitalization or death within a specified time period of 90 days or one year. CAN scores are available to Primary Care teams through the Primary Care Almanac and the Patient Care Assessment System (PCAS). PCAS can be accessed at: https://secure.vssc.med.va.gov/PCAS/. Please search this FAQ list for more information about using CAN scores.

18. What is the Life-Sustaining Treatment (LST) progress note?

The LST progress note is a nationally standardized CPRS progress note template used by practitioners to document a goals of care conversation and resulting LST plan.

The LST progress note contains information about the patient’s capacity to make decisions about LSTs, the patient’s surrogate, whether documents reflecting the patient’s wishes were available and reviewed, the patient’s (or surrogate’s) understanding of the patient’s medical condition and prognosis, the patient’s goals of care, the plan for use of LSTs, and who gave consent for the LST plan.

19. What is a Life-Sustaining Treatment (LST) Order?

LST orders are Do Not Resuscitate (DNR)/Do Not Attempt Resuscitation (DNAR) orders or orders to limit or not place limits on one or more LST, including artificial nutrition, artificial hydration, mechanical ventilation, other LSTs, and transfers to the hospital or ICU.

LST orders will not expire or automatically discontinue based upon dates, timeframes, or patient movements (e.g., admission, discharge, transfer), but will remain in effect unless they are modified based on a revised LST plan.

20. What is a Do Not Attempt Resuscitation (DNAR)/Do Not Resuscitate (DNR)/order?

A DNAR/DNR order is an order that establishes that cardiopulmonary resuscitation (CPR) shall not be attempted for a patient in cardiopulmonary arrest (i.e., the loss of airway, breathing, or circulation necessary to maintain life). Patients with a DNAR/DNR order should still receive clinically appropriate emergency interventions short of CPR (for example medications, fluids, oxygen, manual removal of an airway obstruction or the Heimlich maneuver) unless otherwise specified in Life-Sustaining Treatment orders.

21. What’s the difference between a Do Not Attempt Resuscitation (DNAR) and a Do Not Resuscitate (DNR) order?

The terms DNR and DNAR are used synonymously. “Do not attempt resuscitation” was introduced as a way of indicating that CPR attempts may not be successful.

22. What is cardiopulmonary resuscitation (CPR)?

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Cardiopulmonary resuscitation (CPR) is the use of Basic Life Support and Advanced Cardiac Life Support in an attempt to restore spontaneous circulation following cardiopulmonary arrest (i.e., the loss of airway, breathing, or circulation necessary to maintain life).

23. Can we alter the Life-Sustaining Treatment (LST) progress note title or template?

Facilities cannot alter the LST progress note title. This will allow the note title to be easily discoverable when looking for remote data at other facilities. Standardized titling also supports national data collection to help demonstrate implementation at your facility.

Facilities also cannot alter the LST progress note template. However, facilities may customize the template by adding optional functionality to launch related consults from the progress note.

24. Does the Life-Sustaining Treatment (LST) progress note title display in the Crisis, Warnings, Allergies, and Advance Directive” (CWAD)/Postings sections of CPRS?

Yes. The LST progress is displayed in the CWAD/Postings sections of CPRS, as required by VHA Handbook 1004.03.

25. Who can conduct goals of care conversations (GoCC) and write a Life-Sustaining Treatment (LST) progress notes and/or LST orders?

Ultimately, GoCCs are the responsibility of attending physicians or other licensed independent practitioners (LIP) who are in charge of the patient’s care, or who are serving as consultants for LST planning.

Attending physicians and other LIPs may delegate this responsibility to those they supervise, including residents, non-LIP APRNs, and physician assistants (PAs), who are deemed competent to conduct these discussions with patients and surrogates.

LST progress notes and LST orders, including DNAR/DNR orders, may be written by LIPs and residents as well as physician assistants (PAs), and advance practice registered nurses (APRNs) without full practice authority who have been delegated responsibility for conducting GoCCs and writing LST plans and LST orders. In the past, DNAR/DNR orders could only be written by attending physicians or residents.

In order for APRNs without full-practice authority and PAs to conduct GoCCs and write LST plans and LST orders, the authority to write LST progress notes and orders must be explicitly reflected in their scope of practice agreement or other formal delineation of job responsibilities.

When a delegated practitioner writes LST orders, including DNAR/DNR orders, they do not need to be re-written by the LIP, however, the LIP practitioner must document review of the LST plan within 24 hours (or 72 hours in a Community Living Center, outpatient setting, or Home-Based Primary Care setting) Each facility’s LST Medical Center Memorandum must specify whether the LIP documents supervision through an addendum or a co-signature to the LST progress note.

26. **Who can add addenda to a Life-Sustaining Treatment (LST) progress note?**

Practitioners who are authorized to write LST progress notes and orders can add addenda to the LST progress note. In addition, other health care team members, who cannot write LST progress notes and orders, may be authorized by local policy to add addenda to the LST progress note. Please see your local policy for additional information.

27. **Can advanced practice registered nurses (APRN) with full-practice authority in VA conduct goals of care conversations (GoCC) and write Life-Sustaining Treatment (LST) plans/orders?**

Yes. APRNs with full-practice authority in VA, that is, Certified Nurse Practitioners (CNP), Clinical Nurse Specialists (CNS), and Certified Nurse-Midwives (CMN), are licensed independent practitioners (LIP) and are authorized to conduct GoCCs, write LST plans and LST orders without the clinical supervision or mandatory collaboration of physicians. APRNs without full-practice authority in VA, that is, Certified Registered Nurse Anesthetists (CRNA), are only authorized to conduct GoCCs and write LST plans and LST orders when an attending physician or other LIP has delegated that responsibility to them. (See Handbook 1004.03, para. 3r)

28. **Will Life-Sustaining Treatment (LST) orders written by residents expire within 24 hours?**

No. Attending physicians and other licensed independent practitioners may delegate the responsibility for conducting goals of care conversations and writing LST plans and orders to residents, APRNs without full practice authority, and PAs. LST plans and orders do not need to be re-written by the LIP, however, the LIP must document review of the LST plan within 24 hours (or 72 hours in a Community Living Center, outpatient setting, or Home-Based Primary Care setting). Please see paragraph 9.c. of VHA Handbook 1004.03 for documentation requirements related to LST plans and orders written by residents and other delegated practitioners.

29. **What is the role of other health care team members (those who are not authorized to write Life-Sustaining Treatment orders) in conducting goals of care conversations (GoCC)?**

Ultimately, GoCCs are the responsibility of attending physicians or other licensed independent practitioners who are in charge of the patient’s care, or who are serving as consultants for LST planning. However, multiple health care team members may be involved in discussing the patient’s values, goals, and preferences. Based on team members’ scopes of practice, they may be involved in, for example, identifying patients who are appropriate for a GoCC, identifying a patient’s authorized surrogate, preparing patients (or surrogates) for GoCC, etc.

Whether or not conversations about these issues have been conducted by other team members, confirming and obtaining consent for the LST plan is the responsibility of practitioners who are authorized to write LST orders.

30. **Where should other health care team members document conversations about patients’ values, goals and preferences related to serious illness?**

When a team member without the authority to write Life-Sustaining Treatment (LST) progress notes and orders has a discussion with a high-risk patient or their surrogate about the patient’s values, goals of care, and preferences (including information about the patient’s surrogate), appropriate documentation of the information depends on whether or not the patient has an existing LST progress note.

When no LST progress note is in the patient’s chart and information pertinent to the goals of care conversation is discussed with the patient or surrogate, the team member must document this information in a "Goals and Preferences to Inform LST Plan" progress note or other progress note developed by the facility to capture this information. The "Goals and Preferences to Inform LST Plan" note title or other locally developed note title may be linked to the Postings section of the CPRS Cover Sheet so it is easy for other health care team members to find.

When an LST progress note is in the patient’s chart and the team member has a discussion with the patient or the surrogate about the patient’s values, goals, and preferences, the team member must document the information in an addendum to the LST progress note, if authorized, or if not authorized, under the "Goals and Preferences to Inform LST Plan" or other locally developed note title. The team member must add the LIP in charge of the patient’s care as an additional signer. When the patient’s goals or preferences have changed in a way that impacts active LST orders, the team member must also contact the LIP in charge of the patient’s care directly about the information provided.

31. Do Life-Sustaining Treatment (LST) orders expire or discontinue?

No. LST orders will not expire or automatically discontinue based upon dates, timeframes, or patient movements (e.g. admission, discharge, transfer), but will remain in effect unless they are modified based on a revised LST plan.

32. Will there be a requirement to update Life-Sustaining Treatment (LST) orders annually?

No. LST orders will not expire or automatically discontinue based upon dates, timeframes, or patient movements (e.g., admission, discharge, transfer), but will remain in effect unless they are modified based on a revised LST plan. LST orders should be updated if and when a patient’s values, goals, and treatment decisions change.

33. Our local policy requires that all orders are either renewed or discontinued and reordered based upon a timeline. Can this be applied to the Life-Sustaining Treatment (LST) orders?

Coming soon.

34. Can Life-Sustaining Treatment (LST) plans and orders be changed?

Yes. A patient may change the LST plan. To document this change, the practitioner must conduct a goals of care conversation and enter an addendum to the LST progress note (or write a new LST progress note), discontinue LST orders that no longer reflect the current LST plan, and write

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new LST orders. If an addendum is added to the LST progress note, LST orders will not launch automatically, so new orders must be written under the CPRS Orders tab.

35. If a patient establishes a Life-Sustaining Treatment (LST) plan, can the patient’s surrogate change the plan after the patient has lost decision-making capacity?

Yes. It is the responsibility of the patient’s surrogate to act on behalf of the patient based on the patient’s wishes, if known and, in that capacity, the surrogate can initiate a request to modify or revoke the LST plan after the patient has lost decision making capacity. The original LST plan completed on the basis of a goals of care conversation with the patient should be regarded as a clear statement of the patient’s wishes and no change should be requested by a surrogate that is clearly inconsistent with the patient’s values, goals, and preferences. Please see paragraph 15 of VHA Handbook 1004.03 for information on resolving inconsistencies or conflict regarding LSTs.

36. Where are Life-Sustaining Treatment (LST) orders displayed in the orders tab?

LST orders appear at the top of the list of orders on the CPRS Orders tab when the page is in “Default” view.

37. Our nurses like to use the custom order view to see only “Nursing Orders.” How can they see the Life-Sustaining Treatment (LST) orders if the LST orders are not “Nursing Orders”?

The LST order group may be added to the “Nursing Orders” group. Work with your local Clinical Application Coordinators who will ensure that the LST order group defaults to the top of the “Nursing Orders” group.

38. In our facility, we have used “Full Code” orders for patients who would want CPR if they had a cardiopulmonary arrest. Will we still use “Full Code” orders for those patients once we begin using Life-Sustaining Treatment (LST) orders?

No. A patient does not need an order for full code status – this is the default code status for all patients who do not have a Do Not Attempt Resuscitation (DNAR)/Do Not Resuscitate (DNR) order.

39. Can we still use orders and progress notes that are currently in use at our facility to document goals of care conversations and life-sustaining treatment orders?

After full implementation of Handbook 1004.03, facilities will be required to use the national standardized Life-Sustaining Treatment (LST) progress note and Life-Sustaining Treatment (LST) orders. The National Center for Ethics in Health Care (NCEHC) will be conducting monthly support calls to assist facilities make the transition to the new processes. For more information see the resources For Health Care Facilities Implementing the Life-Sustaining Treatment Decisions Initiative and For Clinical Application Coordinators/Health Informatics Specialists Installing LST Tools in CPRS.

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Until facilities install and authorize use of the new national standardized LST progress note and LST orders, facilities should continue to use their current progress notes and orders to document goals of care conversations and LST orders. Facilities have until July 11, 2018 (that is, 18 months from the publication date (January 11, 2017) of VHA Handbook 1004.03) to fully implement new processes.

40. Are Life-Sustaining Treatment (LST) orders linked to the LST Progress note?

LST orders can be launched automatically from the LST progress note. Talk with your Clinical Applications Coordinator or Health Informatics Specialist if you have questions about this process.

41. Should other life-sustaining treatments (LST) be withheld because a patient has a DNAR/DNR order?

No. A DNAR/DNR order means only that cardiopulmonary resuscitation will not be attempted if the patient is in cardiopulmonary arrest (i.e., the loss of airway, breathing, or circulation necessary to maintain life). Other LSTs that are medically indicated, for example, dialysis, artificial nutrition and hydration, should be provided unless the patient has LST orders limiting them.

42. Can Life-Sustaining Treatment (LST) orders ever be written without first conducting a goals of care conversation with the patient?

LST orders, including DNAR/DNR orders, may be written on the basis of a valid state-authorized portable order (e.g., POLST, MOST) for patients who lack decision making capacity and have no surrogate. Review by the multidisciplinary committee must be initiated within 24 hours.

43. May CPR be provided to a patient who has a Life-Sustaining Treatment order limiting mechanical ventilation?

Coming soon.

44. May providers ever withhold CPR when a patient does not have a DNAR/DNR order?

If a patient does not have a DNAR/DNR order (either a DNAR/DNR VA order, or a state-authorized order for DNAR/DNR) and sustains a cardiopulmonary arrest, CPR must be attempted, except when:

- The patient has given unequivocal verbal instructions not to use CPR; or
- During the emergency code response, the clinical judgment of the physician or resuscitation team lead determines that initiation or continuation of resuscitative efforts would be ineffective at restoring cardiopulmonary function to a level of viability or that continued efforts would have no chance of producing the patient’s goals of care; or
- A qualified practitioner has pronounced the patient dead; or
- The patient manifests rigor mortis, dependent livedo, or other obvious signs of death.

45. What should practitioners do when family members disagree with a Life-Sustaining Treatment (LST) order, including DNAR/DNR orders?

Conflicts regarding LSTs can occur when there is disagreement or lack of clarity about the patient’s medical condition or prognosis, the patient’s values, goals, and preferences, or the appropriate LST(s) to meet the goals of care. As a first step to addressing conflict, practitioners must engage patients, surrogates, and members of the patient’s health care team and family, if appropriate, in a goals of care conversation to clarify the patient’s values, goals, and preferences for care.

As outlined in VHA Handbook 1004.03, if conflicts about LSTs cannot be resolved, the practitioner must consult the facility’s Ethics Consultation Service. The facility’s Ethics Consultation Service is encouraged to contact the National Center for Ethics in Health Care’s Ethics Consultation Service at vhaethics@va.gov for assistance, particularly in cases that might potentially involve limiting or discontinuing an LST over the objection of the patient or surrogate.

If the conflict is not resolved through the ethics consultation process, the facility Director must make a decision as described in VHA Handbook 1004.03, paragraph 15.

46. Some patients with a DNAR/DNR order would want CPR attempted during a procedure, like an upcoming surgery or cardiac catheterization. Is there a Life-Sustaining Treatment (LST) order to cover that situation?

Yes. The following LST order is available when a patient (or surrogate) decides that CPR should be administered during a specific procedure but not at other times. The practitioner must complete the open text field with specific information about the procedure during which CPR will be administered.

“DNR with exception: ONLY attempt CPR during the following procedure: _________________”

47. In our facility, we have used a Do Not Intubate (DNI) order if the patient does not want to be intubated. Will we still use DNI orders for those patients?

No. DNI orders will no longer be used. Testing with a large number of clinicians during the Life-Sustaining Treatment Demonstration Project indicated that the term “DNI” meant different things to different people and led to confusion and misunderstandings.

CPR includes airway management, with intubation when needed. Patients should not be offered a menu of options related to CPR and should not be given the option of not having their airway supported during CPR, because partial CPR has not proven to be effective.

The following LST orders are available if the patient (or surrogate) chooses to limit mechanical ventilation in circumstances other than during a cardiopulmonary arrest:

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• “No invasive mechanical ventilation (e.g., endotracheal or tracheostomy tube)”
• “No non-invasive mechanical ventilation (e.g. CPAP, BiPAP)”
• “Limit mechanical ventilation as follows: __________________________” (The “Limit mechanical ventilation as follows” order is used when the patient would want mechanical ventilation in some circumstances but not others; for example, for a time-limited trial but not long term.)

A good goals of care conversation is the best way to help the patient understand the options regarding mechanical ventilation.

48. What is the difference between life-sustaining treatment (LST) orders and the instructional or “living will” portion of an advance directive (AD)?

ADs can be completed by any adult with decision making capacity, at any time whether they are young or old, healthy or ill. The instructional or “living will” portion of an AD documents preferences for future health care and serve as a general guide for health care decisions after a patient loses decision-making capacity. ADs are not active medical orders; they are a guide that must be interpreted by others to determine whether they are applicable to the clinical circumstances when the patient has lost decision-making capacity.

LSTs orders are for high-risk patients (a patient who is considered to be at high risk for a life-threatening clinical event because they have a serious life-limiting medical condition associated with a significantly shortened lifespan) and are written by a patient’s practitioner after a goals of care conversation. LST orders are durable, active medical orders for the patient’s current treatment plan and apply whether or not the patient currently has decision-making capacity. LST orders are comparable to state mechanisms such as POLST, MOLST, or POST, which are durable, active medical orders regarding life-sustaining treatments.

49. Some patients with a serious illness have an advance directive (AD). Isn’t that enough?

No. There are several reasons why an AD is not enough for patients who have a serious illness.

• Most patients don’t complete ADs.
• When patients do complete ADs, they often don’t complete them based on a conversation with their health care providers and/or surrogate/family members about their values and goals of care.
• ADs describe future hypothetical situations, not the patient’s current health status. So, when patients do complete ADs, they don’t have information on the risks and odds of success of life-sustaining treatments related to their specific clinical circumstances.
• ADs must be interpreted by the patient’s surrogate and health care team when the patient loses decision-making capacity. This may cause confusion or conflict about the meaning of the AD’s content or how to apply it in the present circumstances.

When a patient has a serious illness, it is important for health care teams to have a conversation with the patient about the patient’s values and goals of care, in the context of their current health status, and document decisions about life-sustaining treatments (LST) in active medical

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orders (LST orders). A goals of care conversation and documented orders are the best way to ensure that the treatment plan for the patient’s serious illness is based on the patient’s goals, values and preferences.

50. If a patient has VA Life-Sustaining Treatment (LST) orders, are there any reasons why they would still need an advance directive (AD)?

Yes. If a patient has VA LST orders, there are several reasons why they would still need an AD. First, the “proxy directive” or Durable Power of Attorney for Health Care portion of the VA AD is used to name a health care agent to serve as a patient’s surrogate decision-maker. Second, if a patient receives care in non-VA facilities where LST orders are not used, the AD can serve its purpose to help guide health care decisions after the patient loses decision-making capacity. Finally, an AD can be used to indicate mental health preferences unrelated to LSTs.

51. In VA, who is the patient’s authorized surrogate?

The authorized surrogate is the individual authorized to make health care decisions on behalf of a patient who lacks-decision making capacity. The order of surrogate priority in VA is:

1. Health Care Agent (named in a Durable Power of Attorney for Health Care)
2. Legal Guardian or Special Guardian (appointed by a court of law)
3. Next of kin, 18 years of age or older, in the following order of priority:
   - Spouse
   - Child(ren)
   - Parent(s)
   - Sibling(s)
   - Grandparent(s)
   - Grandchild(ren)
4. Close friend

52. Do all people at the same level in the surrogate hierarchy (e.g. several adult children), have equal standing as the authorized surrogate?

Yes. Individuals at the same level of the hierarchy have equal standing as the patient’s surrogate. For example, if a Veteran does not have a Health Care Agent or Legal Guardian, and is not married, the Veteran’s two adult children would have equal standing as the patient’s surrogate. Patients can ensure that the person they want to make decisions on their behalf if they lose decision-making capacity is at the top of the surrogate hierarchy by naming that person as their health care agent in a Durable Power of Attorney for Health Care.

53. What is a state-authorized portable order (e.g. POLST, MOST)?

State-authorized portable orders (SAPO), such as Oregon’s Physician Orders for Life-Sustaining Treatment [POLST], West Virginia’s Physician Orders for Scope of Treatment [POST], New York’s Medical Orders for Life Sustaining Treatment [MOLST], have been developed in some states as a way to communicate a patient's life-sustaining treatment (LST) decisions to providers and

emergency personnel in the community through medical orders. Depending on the state, they may address cardiopulmonary resuscitation (CPR) and other LSTs (e.g., mechanical ventilation, feeding tubes). SAPO are important for Veterans who live in the community or receive care in non-VA health care settings. It is important that Veteran’s SAPOs and VA LST orders are consistent with each other. Please see VHA Handbook 1004.04, State-Authorized Portable Orders (SAPO), for additional information.

54. Do we need to write VA Life-Sustaining Treatment (LST) orders if the patient has a state-authorized portable order (SAPO)?

Coming soon.

55. If a Veteran has VA Life-Sustaining Treatment (LST) orders, is there any reason why the Veteran should also have a state-authorized portable order (SAPO), like a POLST or a MOST form?

Yes. VA LST orders are only valid within VA. Because a Veteran with LST orders may also live in or receive care in the community, VA practitioners should offer to complete a SAPO for the Veteran at discharge and at other opportunities as indicated in VHA Handbook 1004.04, State-authorized Portable Orders (SAPO). Assisting the Veteran in this way ensures that the Veteran’s the SAPO and VA LST orders are consistent with each other.

56. If a Veteran has a Life-Sustaining Treatment (LST) order in their record limiting a specific treatment, should we offer that treatment to the Veteran?

If a Veteran has LST orders indicating that a specific treatment should not be initiated, then that treatment should not be offered. If a Veteran has LST orders indicating that there may be circumstances under which a specific life-sustaining treatment would be acceptable, then the treatment should be offered to the patient under those circumstances.

57. What is the Care Assessment Need (CAN) score and how can it be used to complement clinical judgement in identifying Veterans who may benefit from a goals of care conversation (GoCC)?

The CAN score is a predictive analytic tool that represents the estimated probability of hospitalization or death within a specified time period of 90 days or one year. CAN scores are available to Primary Care teams through the Primary Care Almanac and the Patient Care Assessment System (PCAS). PCAS can be accessed at: https:\\secure.vssc.med.va.gov/PCAS/.

The CAN score is expressed as a percentile from 0 (lowest risk) to 100 (highest risk) and is an indicator of how a given Veteran compares with other individuals in terms of likelihood of hospitalization and death. Patients with a very high score (e.g., 99) have a risk of admission or death that approaches 72% at one year, while for those with a low score (e.g., 5) that risk is only about 3%. The CAN score is generated using sophisticated statistical prediction models that utilize demographic data (e.g., age, gender) and clinical information (e.g., medical conditions, use of VA health care, vital signs, medications and laboratory tests) from VHA administrative data. Risk data is updated on a weekly basis. Its primary use has been to support outpatient care management for the most vulnerable Veterans. Clinicians can use this objective measure, along
with their knowledge of the patient’s condition to screen and prioritize patients for GoCC. Most patients with a CAN score of 95 or greater are likely to benefit from a GoCC. Patients with a CAN score of less than 95 may also be appropriate for a GoCC, based on the clinical judgment of the health care team. More information on CAN scores can be found at this link: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=4554.

58. Do Life-Sustaining Treatment orders apply to patient’s receiving Home-Based Primary Care? Yes. LST orders will not expire or automatically discontinue based upon dates, timeframes, or patient movements (e.g., admission, discharge, transfer), but will remain in effect unless they are modified based on a revised LST plan. Therefore, LST orders apply to patients receiving care in Home-Based Primary Care and all VA settings. Because non-VA providers are not obligated to follow VA orders, it is important to also offer state-authorized portable orders (SAPO) (if available) to the Veteran so they can make these orders available for care, including emergency care, that they receive in the community.

59. How should Life-Sustaining Treatment orders be written when the patient is an organ donor who wants to remain on mechanical ventilation only to facilitate the retrieval of organs? Coming soon.

60. Are special protections for patients who lack-decision making capacity and have no surrogate established by regulation? Coming soon.

61. What is the ethical basis for requiring special protections for patients who lack decision-making capacity and have no surrogate? Coming soon.

62. What is the VA policy on establishing, revising and documenting Life-Sustaining Treatment (LST) plans for patients who lack decision-making capacity and have no surrogate? Coming soon.

63. What is the role and composition of the multidisciplinary committee? The multidisciplinary committee must consider the procedural and ethical validity of the recommended Life-Sustaining Treatment (LST) plan for a patient who lacks decision-making capacity and has no surrogate. The multidisciplinary committee must function as the patient’s advocate by determining whether the proposed LST plan is consistent with the patient’s wishes or in the patient’s best interests, review information provided by the practitioner and collect additional information if needed, and base its recommendations on substituted judgment or, if the patient’s values and preferences are unknown, on the patient’s best interests.

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The multidisciplinary committee is appointed by the facility Director and must be comprised of three or more different disciplines, must include at least one member of the Ethics Consultation Service, and must not include members of the patient’s primary treatment team. The facility Director may appoint the Ethics Consultation Service, Integrated Ethics Council or subcommittee, or an independent or ad hoc group to serve as the multidisciplinary committee. Local policy should specify the composition of the multidisciplinary committee.

64. Will it be necessary for the multidisciplinary committee referenced in paragraph 8 of Handbook 1004.03 to meet over a weekend or holiday?

For patients who lack decision-making capacity and do not have a surrogate, the multidisciplinary committee must review the proposed Life-Sustaining Treatment plan and document the committee’s findings and recommendations within 48 hours or as soon as reasonably possible over a weekend or holiday, and in a timeframe that meets the clinical needs of the patient. Facilities should specify the multidisciplinary committee process over weekends and holidays in local policy.

65. What monitoring reports will be available and how can they be used to support facilities in implementing the Life-Sustaining Treatment Decisions Initiative?

Reports for each facility are available on the VSSC website accessed through the following link https://vhaacweb3.vha.med.va.gov/lst/. The reports are based on the Health Factors associated with the LST progress note and template and updated daily from VA’s corporate data warehouse. The LST facility report provides a count of initial (i.e., first occurrence of a GoCC for a distinct Veteran using the LST progress note template) and total GoCC (i.e., a patient may have more than one GoCC, especially when health status changes) by fiscal quarter and location (i.e., inpatient, outpatient, and nursing home/community living center). Within each location, facilities may drill down further to treating specialty or clinic, clinical provider and the patient whose GoCC was documented. Access to provider and patient-level information is limited to those with PII/PHI authority.

The facility report provides a bar chart and table that tracks GoCC by location to help facilities ensure that GoCC are being conducted earlier in the patients’ course of illness, such as when they are receiving outpatient or home-based primary care, and not only following a health crisis that results in hospital admission. The report also provides a pie chart that shows the distribution of Care Assessment Need (CAN) scores at the time of the patient’s initial GoCC. The CAN score is an analytic tool based on Veteran health information that predicts the risk of hospitalization and/or death within a specified time frame. Along with clinical judgement, it can help clinicians screen for Veterans who may be appropriate for a GoCC - the higher the CAN score, the greater the likelihood of death or hospitalization. CAN scores are available for all Veterans receiving care within VA inpatient and outpatient settings and are updated weekly. VA facilities will also have access to a national summary report. This report allows facilities to compare their performance with other facilities within their geographic network, as well as by facility level of complexity.

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66. What is Patient Care Assessment System (PCAS) and how does it help primary care clinicians identify high-risk patients for Goals of Care Conversations (GoCC)?

PCAS is a national web-based application designed to optimize the health care that VA’s Patient-Aligned Care Teams (PACT) provide patients, especially high-risk patients. Specifically, PCAS helps PACT care managers and teamlets identify patients who require focused attention based on risk characteristics, and improved coordination of the services and care their patients receive. The National Center for Ethics in Health Care has developed a Goals of Care Conversations tool within PCAS to help PACT teams identify, manage, and track completion of GoCC with their high-risk patients. The GoCC tool within PCAS includes the following features:

- An automatically-generated list of Veterans on the teamlets panel who are at highest risk of hospitalization or death based on a Care Assessment Need (CAN) score of 95 or greater and who may be appropriate for GoCC.
- The ability to manually add other Veterans to the list whom the teamlet, based on clinical judgment, considers at high risk for a life-threatening clinical event in the next 1-2 years.
- A Table that provides a snapshot of high-risk Veterans’ status with respect to GoCC, along with information about upcoming appointments.
- The ability to assign, schedule and manage tasks associated with a GoCC across the teamlet.
- Tool Tips to guide appropriate use.

PCAS can be accessed at: https://secure.vssc.med.va.gov/PCAS/. For more information or to request a demo of PCAS, including the Life Sustaining Treatment Initiative’s Goals of Care Conversations tool, please contact Tamara Box, PhD at tamara.box@va.gov.

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