



## Frequently Asked Questions

### **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 (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](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 \( \) 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?**

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

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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

**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?**

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)?**

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 (resident, non-LIP APRN or PA) 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?**

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Yes. APRNs with full-practice authority in VA, that is, Certified Nurse Practitioners (CNP), Clinical Nurse Specialists (CNS), and Certified Nurse-Midwives (CNM), 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?**

Facilities are required to develop local policy in alignment with Handbook 1004.03 and so the requirements in Handbook 1004.03 will supersede any local policies that automatically discontinue LST orders. These orders are designed to be durable and exempt from auto-discontinue and timeline discontinuation rules in all circumstances. However, providers may "renew" these orders to show that they have been reviewed. Please review the [LST Handbook](#) (p. 7-8) for information about when to revisit a patient's existing LST plan and orders.

**34. In our facility, we are required to document code status for all patients. When we fully implement the LSTDI, can our facility continue to require that practitioners document code status for all patients?**

No. Under VHA Handbook 1004.03, facilities should eliminate the requirement that practitioners document code status for all patients. Goals of care conversations to discuss life-sustaining treatment plans are required for patients who are at high-risk of a life-threatening clinical event within the next 1-2 years and who do not currently have durable LST orders and LST progress notes in CPRS. These discussions are also required when any patient expresses the desire to

discuss life-sustaining treatments. There is no requirement to discuss life-sustaining treatment decisions, including code status, with every patient.

Prior to the publication of VHA Handbook 1004.03, code status orders were limited to inpatients. Under VHA Handbook 1004.03, LST orders apply to patients in all VA settings. A blanket requirement for documentation of code status would place a huge burden on outpatients and their providers and would require initiating a goals of care conversation with patients for whom this conversation is neither necessary nor clinically appropriate. In addition, requiring practitioners to document code status for all patients, inpatient and/or outpatient, potentially creates an incentive for practitioners to pressure patients to have conversations and make decisions they may not be ready for, simply to meet a documentation requirement.

In the past, Do Not Attempt Resuscitation (DNAR)/Do Not Resuscitate (DNR) orders have been difficult to locate in the patient's electronic health record, sometimes causing uncertainty about whether a patient in cardiopulmonary arrest should be resuscitated. When facilities install and authorize use of the CPRS patch, completed Life-Sustaining Treatment progress notes will be accessible from the CPRS Cover Sheet and Life-Sustaining Treatment orders will default to the top of the list on the Orders tab. This new documentation functionality ensures that information about the patient's goals of care and decisions about life-sustaining treatment are easy to find in the health record.

**35. 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 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.

**36. 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.

**37. 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.

**38. 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.

**39. Prior to the Life-Sustaining treatment Decisions Initiative, our facility asked every patient on admission (or their surrogate) about code status and entered either a “Full Code” order or a DNR/DNAR order, as appropriate. Can you explain why a “full code” is no longer an order option?**

Full Code orders are no longer required or included as an order option, because CPR is always attempted on patients unless a DNR/DNAR order is present in CPRS. This is a big culture change as nursing staff in many facilities are used to having either a Full Code or DNR order on the chart to verify that someone spoke to the patient about their code status. Much to many people’s surprise, asking the patient (or surrogate) about code status is not required for all patients on admission, either by the Joint Commission or by VA policy. Initiation of a goals of care conversation and documentation of life-sustaining treatment decisions are required for patients who are at high risk of a life-threatening clinical event in the next 1-2 years and who don’t already have LST plans documented in CPRS. They are also required for low-risk patients who express the desire to discuss/limit life-sustaining treatments. These discussions are documented in the LST progress, and *limits* to life-sustaining treatment are documented in LST orders. Because the orders document limits to LST, orders are not written to tell staff to resuscitate the patient – that’s the default; the discussion and decisions are documented within the LST note.

It is still a good idea to screen low-risk patients for any preferences for treatment limitations, whether by the admitting nurse or medical provider. We are strongly encouraging that this screening be broader than a direct question about CPR, such as, *“We’re going to take good care of you while you’re here in the hospital. To make sure we plan ahead in case something unexpected happens, are there any treatments you know you would want to avoid in an emergency?”* Some patients wouldn’t want blood products, or a ventilator – typical quick code status discussions wouldn’t catch this. If the patient wants to limit anything or wants to talk more about life-sustaining treatment limitations, it’s a trigger for a goals of care conversation, which would be documented in LST notes/orders. If the patient doesn’t want to limit anything, this can be documented in the H&P or standard progress note for that encounter. No LST note or orders are required.

This is a big culture change in facilities where code status orders have been required on every patient. Some of our demonstration sites had Full Code orders prior to LSTDI implementation, and initially it took some getting used to; the good news – there are no problems now that it’s standard practice. During the initial period of LSTDI implementation it will take education (and probably re-education) of nursing staff, residents, and attendings. Please let everyone know that Full Code orders will no longer appear on the Orders tab, and should not be entered as text orders. If nursing staff are in the habit of verifying that someone has screened the patient for

LST limitations preferences, then it might be a good idea to add an item to the H&P where that information can reliably be found (or they can use the screening question above themselves, and notify the med team if limitations are desired). And of course LST notes/orders will be durably in place for high-risk patients.

Your Chief Resident will probably be key to making sure residents understand new processes, including how to screen low-risk patients for *any* treatment limitation preferences (not just quick “code status” discussions). It’s also important to let residents know to review existing LST notes/orders with patients to see if anything had changed, rather than starting from scratch and re-writing them at every admission. It can really save them time, and keeps the Postings box from getting too cluttered with unnecessary extra LST notes. Any changes can be added as an addendum to the note, and obsolete orders can be d/c’d from the Orders tab.

**40. In our facility, we’re required to document full code orders. I don’t see full code orders on the LST order set. Can we modify the LST order set to add full code orders?**

No. An order to initiate cardiopulmonary resuscitation (CPR) in the event of cardiopulmonary arrest is not necessary. Full code is the default code status for all patients in cardiopulmonary arrest who do not have a Do Not Attempt Resuscitation (DNAR)/Do Not Resuscitate (DNR) order. Based on a goals of care conversation (GoCC) with the patient (or surrogate), the patient’s preference for full code can be documented in the LST progress note. This will not, however, launch a full code order. Facilities may not modify the national standard LST order set or develop supplemental, stand-alone orders or order sets for life-sustaining treatments.

Documenting a full code order is not required by law, regulation or national VHA policy. Also, documenting a full code order would require a GoCC and informed consent discussion, explaining the risks, benefits and alternatives associated with an order for full code status, which would place an undue burden on patients and practitioners.

In the past, discussions about life-sustaining treatments and Do Not Attempt Resuscitation (DNAR)/Do Not Resuscitate (DNR) orders have been difficult to locate in the patient’s electronic health record, sometimes causing uncertainty about whether a patient in cardiopulmonary arrest should be resuscitated. When facilities install and authorize use of the CPRS patch, completed Life-Sustaining Treatment progress notes will be accessible from the CPRS Cover Sheet and Life-Sustaining Treatment orders will default to the top of the list on the Orders tab. This new documentation functionality ensures that information about the patient’s goals of care and decisions about life-sustaining treatment are easy to find in the health record.

**41. 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](#)

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[Decisions Initiative and For Clinical Application Coordinators/Health Informatics Specialists Installing LST Tools in CPRS.](#)

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.

**42. 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.

**43. 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.

**44. 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.

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

Yes, unless the patient has a DNAR/DNR order, CPR may be provided to a patient who has a Life-Sustaining Treatment order limiting mechanical ventilation. LST orders to limit mechanical ventilation apply only in circumstances *other* than during a cardiopulmonary arrest. CPR on the other hand, applies during cardiopulmonary arrest and includes airway management, with intubation when needed. Patients should not be given the option of *not* having their airway supported during CPR, because partial CPR has not proven to be effective. A good goals of care conversation is the best way to help the patient understand the options regarding CPR and mechanical ventilation.

**46. 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.

**47. 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](mailto: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.

**48. 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: \_\_\_\_\_”

**49. 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:

- “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 goal of care conversation is the best way to help the patient understand the options regarding mechanical ventilation.

**50. 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.

**51. 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.

July 18, 2018- Check this link for the newest version: <http://www.ethics.va.gov/lst/faq.asp>.

- 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 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.

**52. 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.

**53. 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



**54. 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.

**55. 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.

**56. Do we need to conduct a goals of care conversation and write VA Life-Sustaining Treatment (LST) orders if the patient has a state-authorized portable order (SAPO)?**

Yes. The VA LST orders are the mechanism for ensuring that a patient's SAPO are translated into VA orders. Unless a patient already has LST orders in CPRS consistent with the SAPO, when a patient presents with SAPO, the practitioner must initiate a goals of care conversation and, based on that conversation, write VA LST orders. Please review [VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences for more information about LST orders and SAPO](#).

**57. 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.

**58. 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.

**59. 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>

**60. 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.

**61. How should Life-Sustaining Treatment progress notes and orders be written when the patient is an organ donor who wants to remain on mechanical ventilation only to facilitate the retrieval of organs?**

[VHA Handbook 1102.07, Organ Donation after Circulatory Death \(DCD\)](#) establishes policy and procedures regarding organ procurement following the death of the patient after the voluntary removal of life-sustaining treatments. The SCOPE section of Handbook 1102.07 specifies that organ procurement in the context of DCD may “only occur at VHA medical facilities that have an active inpatient surgical program and that meet all of the criteria and procedures established in this Handbook.” So, patients (or their surrogate) requesting DCD in such facilities will need to be advised that DCD would require transfer to another facility. As noted in paragraph 2d of Handbook 1102.07, DCD requires first, “the informed consent for an end-of-life treatment plan that involves withdrawal of life-sustaining treatment.” That informed consent is conducted based on a goals of care conversation and the establishment of a life-sustaining treatment plan and orders.

When completing the LST progress note and associated LST orders, **the patient’s goals and decisions related to organ donation after circulatory death can be documented as follows:**

- **LST progress note template:**
  - In the free text areas for section 5: “Patient’s goals of care in their own words , or as stated by the surrogate(s): \_\_\_\_\_”  
or “To achieve life goals, including: \_\_\_\_\_.”
  - In the free text areas for section 6, documenting LST for “circumstances other than cardiopulmonary arrest”:
    - “Limit mechanical ventilation as follows: \_\_\_\_\_”
    - “Limit other life-sustaining treatment as follows: \_\_\_\_\_”
    - Other sections, as needed, to ensure documentation of related life-sustaining treatment decisions that meet the patient’s goal to be a DCD donor
- **LST orders:**
  - In the free text of associated LST orders, copy and paste information from the LST progress note (or addendum) so the order(s) reflect the documentation in the LST progress note/addendum, such as:
    - “Limit mechanical ventilation as follows: \_\_\_\_\_”
    - “Limit other life-sustaining treatment as follows: \_\_\_\_\_”

As noted above, the LST reminder dialog progress note template is designed with free text boxes. We highly recommend that sites link the LST orders to be launched by the LST reminder dialog, so that the orders requiring “free text” are launched while the progress note is in the background, making it easier for the practitioner to copy and paste the “free text” from the LST progress note into the LST order “free text” boxes as they are launched.

**62. Are special protections for patients who lack decision making capacity and have no surrogate established by regulation?**

Yes. VA regulation 38 CFR Section 17.32, *Informed consent and advance care planning*, establishes special protections for patients who lack decision-making capacity and have no surrogate. Section 8 of VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, explains the process required when life-sustaining treatment plans are needed for such patients.

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

Under ideal circumstances, VA patients participate in shared decisions about life-sustaining treatments, based on their wishes, values and preferences. Patients without capacity who have a surrogate are represented by someone who advocates for the patient's values, goals, and preference and/or best interests, and patients without a surrogate are entitled to similar representation. For patients who lack decision-making capacity, have no surrogate and thus cannot express their wishes, values and preferences, the multidisciplinary committee review process was established to ensure that decisions related to life-sustaining treatments for these vulnerable, otherwise unrepresented patients, are made through a consistent process that is based on the patient's wishes, values and preferences, if known, or if not known, on the basis of the patient's best interests.

**64. 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?**

Section 8 of [VHA Handbook 1004.03, \*Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences\*](#), outlines the requirements for establishing, revising and documenting life-sustaining treatment plans for patients who lack decision-making capacity and have no surrogate. This section replaces and supersedes paragraph 14.c.(3) of Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, which was the original location for policy on decisions concerning the withdrawal and withholding of life-sustaining treatment for patients who lack decision making capacity and have no surrogate.

**65. 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. 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.

**66. 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.

**67. 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://vhaaacweb3.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.

**68. 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](mailto:tamara.box@va.gov).

**69. What is the genesis of the list of patients' goals included in the LST progress note template?**

The VHA National Center for Ethics in Health Care (NCEHC) heard from providers during multiple phases of testing that they wanted a mix of check-boxes, that are quick and easy to complete, and free text boxes, that allow customization of content. In designing the check boxes, NCEHC relied on the literature about goals that are most commonly reported by seriously ill patients, particularly the work that has been done by Lauris Kaldjian and others (Kaldjian LC, Curtis AE, Shinkunas KT. Cannon, Goals of care toward the end of life: a structured literature review. Am J Hosp Palliat Care. 2008 Dec-2009 Jan; 25(6): 501-511.) NCEHC included the commonly-reported goals in the template as check-boxes to make it easier for practitioners to record the goals that are spontaneously reported by the patient/surrogate. Practitioners should not use the checkboxes as a checklist or a menu from which patients are asked to choose but, rather, should use them and the free-text boxes to document goals that are spontaneously reported by the patient/surrogate.

**70. Our facility currently includes a patient's do not attempt resuscitation (DNAR/DNR) status on the wristband. Should we continue this practice?**

No. Facilities are strongly advised to discontinue the practice of including DNAR/DNR status on patient wristbands. Multiple processes for staff are required to ensure that DNAR/DNR display on the wristband accurately reflect the orders that are present in CPRS. However, there is

July 18, 2018- Check this link for the newest version: <http://www.ethics.va.gov/lst/faq.asp>.

evidence that such processes are not reliably in place or practiced across facilities that display DNAR/DNR status on the wristband. For example, a 2015 OIG report concluded that: “the patient’s wristband had the incorrect code status of [DNR] printed on it and staff did not verify the wristband code status during the patient’s 9-day hospital stay.” (Report No. 15-00533-440).

A 2016 VAMC Issue Brief indicated that: “In August 3, 2016, a root cause analysis (RCA) was initiated after a Veteran on the inpatient medical/surgical unit at a VAMC was found to have DNR code status noted on his wristband for over a week before it was realized that Veteran actually held a full code status. In 2016, a random system audit found that 1 out of 9 wristbands listed an incorrect code status.

In addition, with implementation of the Life-Sustaining Treatment (LST) Decisions Initiative, both inpatients and outpatients may have durable DNAR/DNR orders in CPRS. Outpatients don’t wear wristbands, and you don’t want your code team to assume that the patient doesn’t have a DNR order when they aren’t wearing a wristband that says “DNR.”

Staff often treat DNAR/DNR on the wristband as if is a medical order – and it’s not. CPRS is the definitive source for DNAR/DNR orders and staff responding to a code should *always* check CPRS for orders, whether or not the patient has a wristband.

LST progress note and orders are designed to make code status information very easy to find in CPRS. When installed and authorized for use at your facility, LST orders (including DNAR/DNR orders) will default to the top of the Orders tab and LST progress notes will be accessible from Postings. Many facilities have iPads with wireless connections to the network and CPRS, and those could be included with crash carts or carried to the code by the code team to quickly access CPRS.

We recommend that facilities that currently use the wristband for DNAR/DNR display to reengineer their processes to eliminate this practice to coincide with the 18 month implementation deadline of [VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients’ Values, Goals and Preferences.](#)

**71. VHA Handbook 1004.03 requires a goals of care conversation with a patient without active LST orders and/or LST progress notes, “Prior to initiating or discontinuing a treatment intended to prolong the patient’s life when the patient would be expected to die soon without the treatment”. Is there a list of these treatments?**

No. Whether or not a patient would be expected to die soon if a particular treatment was discontinued or was not initiated is a clinical, often patient-specific, determination. So, goals of care conversations with high-risk patients must be initiated under certain circumstances, as outlined in the Handbook, and when clinically appropriate.

**72. VHA Handbook 1004.03 requires a goals of care conversation with a high risk patient without active LST orders and/or LST progress notes, “After admission to a VA community living center (e.g., within 7 days)”. Is that 7 calendar days or 7 business days?**

7 calendar days. Please note that the timeframes in VHA Handbook 1004.03 are recommended (“e.g.,...”) rather than strictly required. Your facility can modify the timeframes in your local policy, if needed, to accommodate staffing issues, local practices, etc.

**73. Is there data on the percentage of patients who have a completed LST progress note and LST orders (if necessary) in their record?**

No. The [VSSC monitoring reports](#) show the *number* of completed LST progress notes, but there is no denominator information that would allow for a percentage calculation.

**74. How did the demonstration sites identify high-risk inpatients? Was it only CAN scores?**

The demonstration sites primarily used clinical judgment to identify high-risk inpatients. CAN scores are easy to pull up on your panel of patients if you’re a primary care provider, but generally it’s a more complicated process to access CAN scores for inpatients.

VISN 10 has developed a report that they can access that shows CAN scores of their inpatients, but in other places you have to go to the VSSC website, find the CAN report, and type in the patient’s name and full SSN. It isn’t possible to import CAN scores directly into CPRS, because the CAN scores are calculated in the Corporate Data Warehouse, which is a completely different system than CPRS.

The Madison VA is now implementing new processes for heart failure admissions involving a cardiology consult and calculation of prognosis, followed by a goals of care conversation in the hospital or referral to their outpatient care planning clinic.

**75. At the demonstration sites, are life-sustaining treatment decisions (and LST progress notes/orders) addressed after admission or prior to admission for Veterans admitted for planned surgical procedures?**

The demonstration sites are working on addressing life-sustaining treatment decisions (and LST progress notes/orders) during pre-op visits when procedures are planned. This is primarily the case when patients have *existing* DNR or no mechanical ventilation orders that need to be discussed and potentially modified prior to the procedure. *New* goals of care conversations/LST orders are generally not completed by surgery/anesthesiology, as they are not the clinicians who are managing the patient’s overall care.

**76. What timeframe is recommended for initiating goals of care conversations and writing LST progress notes/orders for patients admitted to the ICU?**

Although VHA Handbook 1004.03 does not indicate a timeframe for initiating goals of care conversations in the ICU, the [National Quality Forum](#) endorses quality standards that include



documentation of care preferences within 48 hours of ICU admission. For more information about life-sustaining treatment decisions for patients admitted to ICU, see paragraph 7 of VHA Handbook 1004.03.

**77. If an outpatient practitioner who does not have inpatient privileges writes LST orders, are the LST orders valid in the inpatient setting?**

Yes. As long as the practitioner has the authority to write LST notes/orders, the orders are durable and valid across clinical settings, including outpatient and inpatient within VHA.

**78. In our facility, DNR orders written by residents are only valid for 24 hours and must be re-written by the attending physician. When we fully implement the LSTDI, will DNR orders written by residents still need to be re-written by the attending physician?**

No. LST orders are durable and do not need to be re-written by the attending physician. 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. (Note: Because attending supervision/concurrence is documented in an addendum or a co-signature to the LST progress note, not the LST orders, 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.)

**79. How should a health care team member (e.g., social worker, RN, chaplain, psychologist), who has a conversation with a patient about the patient's values, goals, and treatment preferences, notify the practitioner that the patient needs an LST progress note/orders?**

Each facility or clinical team should determine how these hand-offs occur. For example, facilities/teams can decide to add the practitioner as an "additional signer" to the team member's note or decide to discuss hand-offs in morning huddles, weekly meetings, or via email. In addition, Primary Care teams can use task alerts through the Patient Care Assessment System (PCAS), either to alert the practitioner directly or to alert the person who will make an appointment for the practitioner to have a discussion with the patient (or surrogate).

**80. Can a practitioner write an LST note/orders on the basis of a health care team member's (e.g., social worker, RN, chaplain, psychologist) note about the a patient's values, goals, and treatment preferences?**

No. According to VHA Handbook 1004.03, "Shared decision-making about LSTs is the responsibility of the entire team however, confirming the LST plan, obtaining informed consent, and documenting LST orders are the responsibility of practitioners who are authorized to write LST orders whether the goals of care conversation was initiated by the practitioner or others on the team." If a team member has a conversation with a patient about the patient's values, goals, and treatment preferences, the practitioner still has to have a conversation with the patient before completing the LST progress note/orders.

**81. When a supervised practitioner (e.g. resident physician, physician assistant, advanced practice registered nurse) enters the LST note and LST orders after duty hours and the attending LIP is unable to co-sign the note until the following day, will the orders still be valid, even if the attending's co-signature is pending?**

Yes, if the attending physician or other LIP has delegated to the supervised practitioner responsibility for conducting GoCCs and writing LST plans and LST orders, including DNAR/DNR orders. This is similar to other situations where a supervised practitioner's orders are valid. For example, facilities may have a requirement for co-signature of resident notes for the initial plan of care for an inpatient, but the diet orders, labs, pain medications and other orders entered to support the treatment plan are active and valid upon signature and release within CPRS, prior to co-signature of the note. The same applies here. The policy allows for this in the definition of a "Practitioner" in [VHA Handbook 1004.03 Life-Sustaining Treatment Decisions: Eliciting, Document & Honoring Patient's Value, Goals & Preferences](#) paragraph 3r, "only when an attending physician or other LIP has delegated to them the responsibility for conducting GoCCs and writing LST plans and LST orders, including DNAR/DNR orders."

**82. In addition to obtaining informed consent for the LST plan and writing LST orders, what steps must the practitioner take to initiate or discontinue a specific LST? For example, is it necessary for the practitioner to conduct an informed consent conversation and write orders to initiate a specific LST? Is it necessary for the practitioner to write separate orders to discontinue an LST?**

Specific orders to initiate or discontinue a specific LST (other than CPR) are not written through the LST order set. Paragraph 11, on page 17, of VHA Handbook 1004.03 states:

"b. **Orders to Initiate a New LST.** Orders to initiate an LST are written separately from the Life-Sustaining Treatment Order Set, according to local protocols.

c. **Orders to Discontinue an LST.** Orders to discontinue an LST that the patient is currently receiving are written separately from the Life-Sustaining Treatment Order Set, according to local protocols."

VHA Handbook 1004.03 requires that practitioners conduct goals of care conversations with high-risk patients, establish LST plans, obtain oral informed consent for those LST plans, and, if necessary, write LST orders to limit LSTs (e.g. "No artificial nutrition").

If a decision is made that an LST will be initiated in circumstances other than cardiopulmonary arrest, the practitioner must obtain informed consent for that specific treatment or procedure. This ensures that the patient has the information they need to make an informed decision about that specific treatment or procedure before it is initiated. Please see [VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures](#), for additional information on informed consent.

Based on the patient's (or surrogate's) informed consent, the practitioner must write orders, separate from the Life-Sustaining Treatment Order set, to initiate the treatment or procedure. These orders communicate the specific steps or technical specifications needed to initiate the

LST (e.g., ventilator setting or units of blood to administer), and authorize the staff to provide the treatment. This is not a change in practice; practitioners already do this.

If a decision is made that an LST will be discontinued, the practitioner must write orders, separate from the Life-Sustaining Treatment Order set, to discontinue the treatment or procedure. These orders specify the plan for, and authorize the staff to, discontinue the treatment. This is not a change in practice; practitioners are already doing this.

The language noted in paragraph 11 was included in VHA Handbook 1004.03 to be sure staff understand that specific orders to begin or stop a specific LST (other than CPR) are not written through the LST order set.

**83. Are LST orders written at *another* facility active in *my* facility?**

It depends. If your facility and the other facility have an integrated VistA/CPRS database, then the LST orders written at the other facility are active in your facility. If your facility and the other facility have an integrated VistA/CPRS database, and LST orders are written at the other facility, you will be able to see LST progress notes on the cover sheet and in the progress notes tab and you will be able to see LST orders at the top of the orders tab.

If your facility and the other facility do NOT have an integrated VistA/CPRS database, then the LST orders written at the other facility are NOT active in your facility. If your facility and the other facility do NOT have an integrated VistA/CPRS database and LST progress notes and orders are written at another facility, you can view them in VistA Web or JVL (Joint Legacy Viewer) for informational purposes only. You must not write LST progress notes and orders at your facility based on progress notes and orders from another facility, without confirming the information with the patient (or surrogate). (Note: If you confirm the information with the patient (or surrogate), do not simply copy and paste from remote data as it will not reflect the associated health factors and/or launch LST orders, you must complete the LST progress note template.)

**84. Do practitioners need to discontinue a “DNAR/DNR” order when entering a “DNAR/DNR with exception: ONLY attempt CPR during the following procedure” order into a patient’s record?**

Yes, practitioners must discontinue a “DNAR/DNR” order before entering a “DNAR/DNR with exception” order into a patient’s record. If they do not, the patient’s record will have inconsistent orders that could cause confusion about the patient’s code status. The order should reflect the patient’s current treatment decision.

The “DNR with exception” order specifies that the patient who otherwise would not want to be resuscitated, has chosen to make an exception so that CPR would be attempted during a procedure that might have a high risk of cardiopulmonary arrest. By contrast, the standard “DNAR/DNR” order tells staff that the patient does not ever want to be resuscitated during a cardiopulmonary arrest. Having inconsistent active orders in the record related to DNAR/DNR could create a patient safety problem where clinical staff and code teams are uncertain as to the patient’s intended DNAR/DNR status.

**85. How can I write a “DNAR/DNR with exception” order to specify that the patient’s DNR order will not be in effect for a certain period of time following a procedure (e.g., “72 hours postop”)?**

Practitioners should not write a “DNAR/DNR with exception” order specifying a timeframe after a procedure during which CPR should not be attempted (e.g., “72 hours postop”). Staff may not know when the procedure occurred and ended, so would not know whether the exception is still in place without further chart review. If, based on the patient’s goals of care, the patient (or surrogate) and practitioner decide that CPR should be attempted for a specified time period following the procedure, then the standard “DNAR/DNR” order should be discontinued and re-written when CPR should no longer be attempted. These instructions are noted in the LST progress note template.

So, when a practitioner fills in the open text field to specify the “DNAR/DNR with exception” order, they should not specify a period of hours, they should clearly specify the procedure during which CPR should be attempted. Examples of appropriate “DNAR/DNR with exception” orders are:

“DNR with exception: ONLY attempt CPR during the following procedure: **ORIF of left hip**”  
“DNR with exception: ONLY attempt CPR during the following procedure: **ORIF of left hip until the patient leaves the recovery room.**”

**86. Can the patient have multiple “DNAR/DNR with exception” orders if they want CPR during multiple procedures?**

No, patients should not have multiple DNAR/DNR orders. Existing “DNAR/DNR with exception” orders can be edited when patients want CPR attempted during additional procedures. “DNAR/DNR with exception” orders can be edited as follows:

- Right-click on the original order (e.g., *DNAR/DNR with exception: ONLY attempt CPR during the following procedure: **hemodialysis***).
- Select “Change.” This will bring up the original order, which can be edited.
- Add the new procedure (e.g., cardiac catheterization) to the text box (e.g., *DNAR/DNR with exception: ONLY attempt CPR during the following procedure: **hemodialysis and cardiac catheterization***).

*NOTE: This change must be documented in a new LST progress note or an addendum to the most recent LST progress note.*

**87. What happens if the “DNAR/DNR with exception” order isn’t discontinued after a procedure and replaced with a standard “DNAR/DNR” order?**

When “DNAR/DNR with exception” orders remain in place *after the procedure is over*, CPR will not be attempted in the event of a cardiopulmonary arrest. This is consistent with the patient’s wishes, as the exception to the DNAR/DNR applies only during the procedure. Ideally,

“DNAR/DNR with exception” orders will be discontinued and replaced by standard “DNAR/DNR” orders, if those orders continue to reflect the patient’s decisions.

**88. “We’re trying to decide whether our local LST policy will allow practitioners to write addenda to LST progress notes or require them to write a new LST note whenever there is a change. Do you have any guidance about this decision?”**

Per VHA Handbook 1004.03, practitioners may document changes to the LST plan either in an addendum to the LST progress note or in a new LST progress note. However, your local facility may decide (and communicate in local policy) that practitioners may not write addenda to LST progress notes. There are pros and cons to each approach:

*Writing an addendum to the LST progress note (if permitted by your facility):*

**Pros:** If you are only documenting a simple change that the patient wants to make (e.g., patient has stated that he no longer wants artificial nutrition), documenting this in an addendum ensures that it will appear alongside the other information documented in the most recently dated LST progress note. Some practitioners may consider it easier to write an addendum rather than writing a new note.

**Cons:** A standard text addendum will not have templated options like the LST template offers, requiring more typing and possible inconsistency in the language between life-sustaining treatments in the addendum and the verbiage in standardized LST orders. Also, a standard text addendum will not automatically launch LST orders, requiring the practitioner to go to the Orders tab and manually write new LST orders, if needed. In a text addendum, there is no assurance that the practitioner will document the patient’s decision-making capacity, goals of care, and informed consent for the change – which are part of the required-field design of the template. Also, changes to surrogate information will not be formatted the same way as when using the LST template.

**Note:** *Facilities may make the LST template available as a standalone template to use when writing addenda. Using the LST template in the addendum makes it quick and easy to document the patient’s current decision-making capacity, goals of care, changes to LST decisions, and informed consent. The template will launch associated LST orders from the addendum, which may lead to a duplication of LST orders that already exist. However, duplicate orders may be easily cancelled before signing.*

*Writing a new LST progress note:*

**Pros:** If the patient/surrogate makes significant changes to the LST plan, then writing a new LST progress note to document the patient’s goals of care will provide more automated support than a standard text addendum. It will automatically launch new orders from within the LST template. The LST template’s required-field design ensures that the practitioner will also document the patient’s decision-making capacity, goals of care, code status and informed consent for the change. The template also provides helpful hints and information that may be relevant to the discussion about changes to

the LST plan. These hints are not available without using the template that is attached to a new note. The template also allows, but does not require, the documentation of other information that may change, such as surrogates, advance directives, and goals of care.

**Cons:** If the practitioner writes a new LST progress note and the new note is not as comprehensive as earlier notes in reflecting the patient’s other values, goals, and LST decisions, then staff must open earlier LST progress notes to find that information. Also, the practitioner will have to go to the Orders tab and discontinue any duplicate LST orders that are entered launched by the template.

**Note:** *If facilities do not allow practitioners to write addenda to LST progress notes, they must ensure that staff are educated to review all LST progress notes in the patient’s chart to find comprehensive documentation of the patient’s values, goals, and LST decisions.*

**89. If a patient wants a “DNAR/DNR with exception” order, should practitioners document that in an addendum to the LST progress note or in a new LST progress note?**

Per VHA Handbook 1004.03, practitioners may document that a patient wants a “DNAR/DNR with exception” order either in an addendum to the LST progress note or in a new LST progress note. However, your local facility may have decided and communicated in local policy that practitioners may not write addenda to LST progress notes. There are pros and cons to each approach:

*Writing an addendum to the LST progress note (if permitted by your facility):*

**Pros:** If documenting a decision to attempt CPR during a procedure is the only change that the patient wants to make, documenting it in an addendum ensures that it will appear alongside the other information documented in the most recently dated LST progress note. Some practitioners may consider it easier to write an addendum rather than writing a new note.

**Cons:** A standard text addendum will not automatically launch LST orders, requiring the practitioner to go to the Orders tab, discontinue the standard DNAR/DNR order, and write the “DNAR/DNR with exception” order. In a text addendum, there is no assurance that the practitioner will document the patient’s decision-making capacity, goals of care, and informed consent for the change – which are part of the required-field design of the template.

*Writing a new LST progress note:*

**Pros:** Writing a new LST progress note to document a “DNAR/DNR with exception” order will automatically launch that order from within the LST template. (The practitioner must still go to the Orders tab and discontinue the patient’s standard “DNAR/DNR” order.) The LST template’s required-field design ensures that the practitioner will also

document the patient's decision-making capacity, goals of care, and informed consent for the change.

**Cons:** If the practitioner writes a new LST progress note and the new note is not as comprehensive as earlier notes in reflecting the patient's other values, goals, and LST decisions, then staff must open earlier LST progress notes to find that information.

**Note:** *If facilities do not allow practitioners to write addenda to LST progress notes, they must ensure that staff are educated to review all LST progress notes in the patient's chart to find comprehensive documentation of the patient's values, goals, and LST decisions.*

**90. Our facility has chosen to automatically launch LST orders from the LST progress note template, and we are not allowing practitioners to access the LST order menu from the Orders tab in CPRS. However, without another option for launching LST orders, practitioners will have to write a new LST progress note to enter any new LST orders, including "DNAR/DNR with exception" orders. Can our facility develop a local reminder dialog template for addenda that launches some LST orders, including the "DNAR/DNR with exception" order, so practitioners don't have to complete the entire template?**

No, facilities may not create a local reminder dialog template for addenda that launches LST orders. Standardization is important in maintaining a shared understanding of how and where patients' goals and LST decisions are documented. As we move toward a new national electronic health record, maintaining continuity between facilities is vital, so different template versions at different facilities are not allowed.

Facilities may make the full Life-Sustaining Treatment reminder dialog template available as a standalone template to use when writing addenda to a current Life-Sustaining Treatment progress note. Using this template in an addendum would launch new/updated LST orders, and require the practitioner to document the patient's decision-making capacity at the time of the change, the patient's goals of care, and informed consent for the change. The facility's Clinical Applications Coordinators can make the LST progress note available for use in LST addenda.

**91. Should our facility allow practitioners to access the LST progress note template from the Template Drawer, so they can use it to document changes to LST decisions in addenda to an existing LST note?**

There are pros and cons to making the LST template available in the Template Drawer. Your facility can choose whether or not to do so.

**Pros:** Using the LST template in an addendum to the LST note standardizes documentation, ensuring that practitioners will document the patient's current decision-making capacity, goals of care, code status, and informed consent. It will automatically launch LST orders. If the LST template is available for use in addenda and is set up to automatically launch LST orders, then there is no need to make the LST Order Set available on the Orders menu. The only avenue for writing LST orders would

be through the LST template in a new LST note or addendum. Also, when the template is used in an addendum, the conversation will be reflected in the VSSC LST Report of goals of care conversations completed in the facility.

**Cons:** When the LST template is available in the Template Drawer, providers might import it into other progress notes, which makes information about the patient's goals and LST decisions difficult for other staff to locate. This is not allowed by policy. The template requires documentation of code status; for patients who already have a DNAR/DNR order in place, completion of the template in an addendum will launch a duplicative DNAR/DNR order, which the practitioner would need to cancel.

**Note:** *If facilities make the LST template available for importing into an addendum to an LST progress note, providers and staff should be informed that they must **not** import the template/data into other progress notes with titles other than "Life-Sustaining Treatment."*

## **92. What are the CPT codes for a goals of care conversation (GoCC)?**

Please contact your local Patient Billing office to discuss coding with them – they should be able to consult the coding rules and give you the best advice. They may have you use the CPT codes for advance care planning (99497 and 99498), as a GoCC is voluntary and includes discussion about the care the patient would want to receive if they are unable to speak for themselves. There are no limits on the number of times these codes can be used, as it is recognized that the patient's goals, values, preferences, and decisions may need to be readdressed as the patient's illness progresses. Some patients will choose to fill out an advance directive as a result of the conversation, some will not; filling out an advance directive is not required for the clinician to use these codes. This following link is to a Centers for Medicare & Medicaid Services resource describing these codes: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf>.

## **93. What LSDTI training/education is required?**

For patient safety reasons, it is important that staff who care for patients with serious illness receive education about the LSDTI before facilities implement new LST processes, including education on why proactive goals of care conversations are important and how to use and find new progress notes and orders that document goals of care and LST decisions.

VHA Handbook 1004.03 requires that facilities develop a plan to educate staff to ensure that staff are able to carry out activities required by the policy:

### **"17. RESPONSIBILITIES:**

c. **Medical Facility Director.** The medical facility Director is responsible for:...



(b) The medical facility develops and implements a coordinated and well-timed plan with appropriate time dedicated to educate appropriate staff and bring about the significant practice change this policy requires.

**d. Facility Chief of Staff and Associate Director for Patient Care Services (ADPCS)/Nurse Executive (NE).** The facility Chief of Staff and ADCPS/NE are responsible for:

(1) Ensuring that all relevant personnel are appropriately trained and supported to implement and follow the policy, and held accountable for doing so.”

VHA Handbook 1004.03 does not require **specific** training. It is up to each facility to decide *who* needs training, *how* they are trained, *when* they are trained, and *by whom* they are trained.

The National Center for Ethics in Health Care has developed a number of trainings, resources, and tools (including a TMS training and *Goals of Care Conversations* training) that facilities can use, but *are not required to use* to educate staff. Individual facilities may decide to mandate certain training for their facility. LSTDI education, resources, and tools are available on the Ethics Center’s website: [www.ethics.va.gov/LST/ClinicalStaffResources.asp](http://www.ethics.va.gov/LST/ClinicalStaffResources.asp).

The TMS training (*Life-Sustaining Treatment Decisions Initiative: New Processes to Support Patient-Centered Care*) is a knowledge-based training. It is designed to educate staff about the initiative itself, including the use of the progress notes and orders. Here is a link to the LSTDI TMS training, TMS ID 31722: [LSTDI TMS Training](#).

The *Goals of Care Conversations* (GoCC) training is face-to-face skills training to educate practitioners and team members how to conduct goals of care conversations with patients and families. It is not required that facilities provide this skills training to all clinicians prior to implementing the LSTDI and launching the LST progress note and order set. The GoCC trainings are skills trainings (vs. knowledge-only trainings about the LSTDI itself), that require interactive practice, and take between 4 and 7 hours to complete. Facility GoCC trainers are only expected to deliver three (or more) courses per year for the next three or more years, so it will take some time to deliver this training to all clinicians who care for patients with serious illness.

**94. If staff attend Goals of Care Conversations (GoCC) training, do they have to complete separate training on the LSTD Initiative itself/new LST documentation practices?**

It depends. The GOCC training for **MDs, PAs, and APRNs** does not include information about the LSTDI or new LST documentation practices – it focuses exclusively on the communication skills required to conduct goals of care conversations with patients and families. So, staff who attend this training will need separate training on LSTDI and new LST documentation processes before local roll-out. Some facilities are adding a brief segment about LSTDI/documentation to MD/APRN/PA GOCC training so participants won’t have to complete separate TMS or other training to learn about those elements.

The GoCC training for **nurses, social workers, chaplains, and psychologists** incorporates information about the LSTDI and new documentation practices, so if staff attend ALL of this training BEFORE rolling out the new note and orders, they may not need additional TMS or other training about the initiative and new documentation practices. However, if staff attend this training AFTER local roll-out, then this knowledge-based part of the curriculum will serve as a review and an opportunity to ask questions about how to apply new practices when conducting GOCCs.

**95. Once LST notes are written, should the patient’s existing, historical DNR CWAD notes written under the old policy be demoted from the posting box or can they remain in posting box?**

- If the historic DNR/Code note is demoted, it will still be viewable from CPRS Notes tab.
- If the historic DNR/Code note is NOT demoted, there will be both a DNR/Code note and LST note in CPRS posting box.

There are no national policy requirements about what sites must do in this situation, or what must be done if a new LST note is added that replaces the previous LST note. Both situations will require a local decision on processes and policy. We suggest that your LST Advisory Board consider and establish a process for these situations. Different sites have different processes for rescinding/not rescinding CWAD note titles. Some sites may determine that the historic notes significantly help inform clinicians on the patient’s decisions/goals and may decide to keep the historic and most recent titles visible in CWAD. Some sites may opt to rescind historic note titles to help minimize CWAD “clutter” and reduce potential confusion about the patient’s current code status.

**96. If a patient who has an LST progress note written at another facility is then admitted to our facility, will the actual note transfer to our CPRS notes section so we can make addenda if the plan changes?**

No. Remotely written LST notes and orders will not automatically transfer from another facility’s CPRS to your local CPRS. There is NO functionality in CPRS to import remote LST progress notes and orders into your local CPRS. The LST notes and orders written at another facility will not be visible in your facility’s CPRS notes and orders tabs unless you “share” CPRS with that facility. A few facilities have an “integrated CPRS” and can view each other’s notes and orders as if they were one facility. Your Specialty Chief and/or Clinical Application Coordinators can confirm whether you have an integrated CPRS. If you cannot see the notes from the other facility just like you can for your own patients, you will need to use remote data views that are available (e.g. Joint Legacy Viewer, Remote Data View, VistA Web) to view the remote LST notes and orders. Remote data views do NOT show up in your local CPRS “Postings” section of CPRS). Only orders visible on the local CPRS orders tab are active and valid in the facility where you are treating the patient.

As a basis for making and documenting life-sustaining treatment decisions for the patient in the local record, clinical staff will need to review the remote LST notes and orders, conduct a goals of care conversation, and document a new, local LST note and associated LST orders based upon the conversation with the patient/surrogate. Clinical staff should NOT simply copy the

information from the remote LST note into the local CPRS without conducting a goals of care conversation with the patient/surrogate.

**97. Will we be able to view LST orders written at different VA's?**

Yes. You may view LST notes and orders, but you will need to use remote data viewing options (e.g., Joint Legacy Viewer, Remote Data View, VistA Web). (Note: A few facilities have an "integrated CPRS" and can view each other's notes and orders as if they were one facility. Your Specialty Chief and/or Clinical Application Coordinators can confirm whether you have an integrated CPRS.) Remember that only orders visible on the local CPRS orders tab are active and valid in the facility where you are treating the patient.

**98. Will we be able to change/discontinue LST orders written at different VA's?**

No. You can only change/discontinue the LST orders visible on your local CPRS orders tab. (Note: A few facilities share an "integrated CPRS" and can view and take actions on each other's notes and orders. Your Specialty Chief and/or Clinical Application Coordinators can confirm whether you have an integrated CPRS.)

**99. What is the timeframe for educating VHA facility staff about the Life-Sustaining Treatment Decisions Initiative (LSTDI) and goals of care conversations (GoCC)?"**

There are two main categories of staff education, and each are on different timelines:

1. Education about the LSTD initiative, including new requirements for proactive goals of care conversations and new documentation processes. Anyone who may talk with patients about goals of care and LST decisions, and write or read LST notes, LST orders, and/or "Goals & Preferences..." notes in CPRS should receive this education before documentation processes change at your facility. It's up to your facility to identify which groups of staff should be trained, how, and when. For patient safety purposes, this should be done by the time these new processes are required by policy in your facility, otherwise you may have staff who don't what the LST orders mean, where to look for them, or even that their patient may already have durable LST orders in the record. LSTDI training resources can be found at:

<http://vaww.ethics.va.gov/LST/ClinicalStaffResources.asp>

2. Goals of Care Conversations training. This training is designed to improve the communication skills of staff who are having (or should be having) goals of care conversations with patients. It's up to your facility to decide who needs this training and how quickly it should be rolled out. Because it is designed to develop skills and requires active practice, it's more intensive than the knowledge-based education about LSTDI, and most facilities only have a few people who can deliver the training. That means it's going to take longer to disseminate. People who attend the GOCC train-the-trainer sessions are expected to deliver at least 3 trainings per year for 3 (or more) years. Whether they have the support to conduct training sessions at a faster pace is up to their facility. GoCC training resources can be found at:

<http://vaww.ethics.va.gov/LST/ClinicalStaffResources.asp>

**100. What should practitioners do when the LST order set and the state-authorized portable order (SAPO) form are not identical?**

You are right that the fields available in SAPO and in the VA LST note and orders may not be identical, even though these forms are all used to document orders related to life-sustaining treatment. The LST note and orders allow customization that the SAPO may not (e.g., “Limit invasive mechanical ventilation as follows: \_\_\_\_\_).” The best way to ensure that there is consistency across these documents is to complete **both** the LST note and orders and SAPO during a goals of care conversation. Taking the time to complete both will help ensure that these documents are accurate and consistent in reflecting the patients decisions so that there is no confusion when decisions need to be implemented. If the SAPO form is not as comprehensive as VA LST orders, advise the patient to keep a copy of the LST note with the SAPO.

If the patient’s clinical circumstances are such that LST decisions need to be implemented now but the information documented in the patient’s LST orders and SAPO are inconsistent, the information in the document with the most recent date generally supersedes the information in the prior document(s). If there are questions about how to implement decisions when there are inconsistencies between these documents, consult your local Ethics Consultation Service or your District Chief Counsel, as needed.