

ADVANCE CARE PLANNING

1. SUMMARY OF MAJOR CHANGES: This directive:

- a. Establishes a system-wide, patient-centered and evidence-based approach to advance care planning (ACP).
- b. Updates the definition of ACP to align with an international consensus definition (see paragraph 12).
- c. Clarifies timeframes for initiating ACP (see paragraph 3).
- d. Incorporates Veterans Health Administration (VHA) policy on offering, writing and honoring State-authorized portable orders (SAPO) (previously located in VHA Directive 1004.04, State-Authorized Portable Orders, dated February 26, 2019) as SAPO must be written based on a goals of care conversation (GoCC) and offered when establishing a life-sustaining treatment (LST) plan.
- e. Incorporates VHA policy on advance directives (previously located in VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives, dated December 24, 2013), as advance directives, GoCCs, LST plans and SAPO are complementary approaches to ACP.
- f. Aligns processes on resolving conflict with VHA Directive 1004.01, Informed Consent for Clinical Treatments and Procedures, dated December 12, 2023, and outlines processes to clarify patients' treatment preferences when there is inconsistent information documented in a patient's LST plan and advance directive (see paragraph 8).
- g. Updates content to reflect Department of Veterans Affairs (VA) transition to a new electronic health record and to enable implementation of this directive at all VA medical facilities.
- h. Aligns processes with VA's regulation on informed consent and advance directives (38 C.F.R. § 17.32) and with The Joint Commission standards.
- i. Reflects the intent of the Patient Self-Determination Act of 1990 to ensure that all patients are given the opportunity to participate in decisions about their health care.
- j. Aligns processes for conducting GoCCs and establishing LST plans in the VA Intensive Care Unit (ICU) with processes required in settings outside the ICU by removing the separate paragraph on ICU processes.
- k. Removes content related to preparing for GoCCs and elements of GoCCs.

l. Clarifies the role, composition and responsibilities of the VA medical facility multi-disciplinary committee which functions as the patient's advocate in reviewing proposed LST plans for patients who lack decision-making capacity and do not have a surrogate (see paragraph 6).

m. Moves VA practitioner and multi-disciplinary committee procedures regarding establishing LST plans for patients who lack decision-making capacity and do not have a surrogate to the Flowchart: Establishing LST Plans for Patients Who Lack Decision-Making Capacity, Have No Surrogate, and Have No Active LST Orders, located at: https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. **NOTE:** *This is an internal VA website that is not available to the public.*

n. Removes the VA medical facility Director responsibility to develop a VA medical facility policy on LST or ACP, in alignment with this directive; VA medical facilities are still required to create local procedures that implement ACP approaches and tools (see VA medical facility Director responsibilities in paragraph 2.g.).

o. Removes language on conscientious objection regarding LST.

2. RELATED ISSUES: VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021; VHA Directive 1605.06, Safeguarding and Disposing of Patient Wristbands in VA Medical Facilities, dated January 20, 2022; VHA Directive 1004.01, Informed Consent for Clinical Treatments and Procedures, dated December 12, 2023.

3. POLICY OWNER: The National Center for Ethics in Health Care (10ETH) is responsible for the content of this directive. Questions may be referred to VHAethics@va.gov or 202-632-8457.

4. RESCISSIONS: VHA Directive 1004.04, State-Authorized Portable Orders (SAPO), dated February 26, 2019; VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives, dated December 24, 2013; and VHA Handbook 1004.03(3), Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017, are rescinded.

5. RECERTIFICATION: This directive is scheduled for recertification on or before the last working day of December 2028. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

6. IMPLEMENTATION SCHEDULE: This directive is effective upon publication.

December 12, 2023

VHA DIRECTIVE 1004.03

**BY DIRECTION OF THE OFFICE OF THE
UNDER SECRETARY FOR HEALTH:**

/s/ Alan Hirshberg, MD, MPH, FACEP
Acting Associate Deputy Under Secretary
for Health for Oversight, Risk and Ethics

NOTE: All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

DISTRIBUTION: Emailed to the VHA Publications Distribution List on December 15, 2023.

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ADVANCE CARE PLANNING

1. POLICY

It is Veterans Health Administration (VHA) policy that Department of Veterans Affairs (VA) practitioners and health care team members must engage patients in advance care planning (ACP) to ensure that patients receive care in VA and in community care health care settings that aligns with their values, goals and treatment preferences.

AUTHORITY: 38 U.S.C. § 7331; 38 C.F.R. § 17.32. **NOTE:** *In accordance with 38 U.S.C. § 1707, assisted suicide (intentionally providing a prescription or other lethal agent for the purpose of enabling the patient to perform a life-ending act) and euthanasia, also known as mercy-killing (directly administering a lethal agent to a patient with the intent to mercifully end the patient's life), are prohibited in VA regardless of State law.*

2. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Associate Deputy Under Secretary for Health for Oversight, Risk and Ethics.** The Associate Deputy Under Secretary for Health for Oversight, Risk and Ethics is responsible for supporting the National Center for Ethics in Health Care (NCEHC) with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISNs to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **Executive Director, National Center for Ethics in Health Care.** The Executive Director, NCEHC is responsible for:

(1) Providing health care ethics consultation services, education and interpretation to VA medical facilities regarding the policy and procedures outlined in this directive.

(2) Providing oversight for VISN and VA medical facility compliance with this directive by identifying and tracking policy performance measures to monitor implementation. **NOTE:** *Information on policy performance measures is available at https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Policy_Performance_Measures.aspx. This is an internal VA website that is not available to the public.*

(3) Establishing ethical standards for ACP processes and documentation tools outlined in this directive.

(4) Meeting with the Associate Deputy Under Secretary for Health for Oversight, Risk and Ethics as needed to ensure there are sufficient resources to support VA medical facilities in implementing the requirements of this directive.

e. **Director, Health Eligibility Center.** The Director of the Health Eligibility Center is responsible for ensuring that information about patients' rights regarding ACP are included in the Veterans Health Benefits Handbook.

f. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Communicating the contents of this directive to all VA medical facilities within the VISN.

(3) Ensuring that all VA medical facilities within the VISN have the resources to implement this directive.

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

(1) Ensuring overall compliance with this directive and that appropriate corrective action is taken if non-compliance is identified.

(2) Providing information and data to NCEHC as requested regarding policy performance measures available at:

https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Policy_Performance_Measures.aspx. **NOTE:** *This is an internal VA website that is not available to the public.*

(3) Establishing local ACP processes and procedures to implement and monitor ACP approaches and tools outlined in this directive utilizing the standard operating procedure (SOP) template available at:

https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. **NOTE:** *This is an internal VA website that is not available to the public.*

(4) Identifying staff to develop and implement an education plan for current and new staff about the requirements of this directive. Education resources are available at:

https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. **NOTE:** *This is an internal VA website that is not available to the public.*

(5) Appointing the VA medical facility multi-disciplinary committee to review proposed life-sustaining treatment (LST) plans for patients who lack decision-making capacity and do not have a surrogate.

(6) Ensuring that VA medical facility practitioners and health care team members use the national ACP documentation tools outlined in paragraphs 2 and 5 of this directive. **NOTE:** *Information on installation and maintenance of documentation tools is available at:*

https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. This is an internal VA website that is not available to the public.

(7) Ensuring the VA medical facility has an established process for requesting health care ethics consultation services and ensuring VA medical facility Health Care Ethics Consultants (ECs) have the time and resources needed to address ethics consults related to ACP.

h. **VA Medical Facility Chief of Staff.** The VA medical facility Chief of Staff (CoS) is responsible for:

(1) Collaborating with the VA medical facility Associate Director for Patient Care Services (ADPCS) to ensure all relevant personnel under the VA medical facility CoS are supported to implement and follow this directive.

(2) Approving proposed LST plans for patients who lack decision-making capacity and have no surrogate if the proposed LST plan includes limitations on LST, as outlined in paragraph 6 of this directive.

i. **VA Medical Facility Associate Director for Patient Care Services.** The VA medical facility ADPCS is responsible for collaborating with the VA medical facility CoS to ensure that all relevant personnel under the VA medical facility ADPCS are supported to implement and follow this directive.

j. **VA Medical Facility Service Chiefs.** The VA medical facility Service Chiefs are responsible for ensuring that VA health care team members in their services are supported to implement and follow this directive.

k. **VA Medical Facility Chief, Health Information Management.** The VA medical facility Chief, Health Information Management is responsible for:

(1) Ensuring that advance directive and State-authorized portable orders (SAPO) forms are promptly scanned into the electronic health record (EHR) as outlined in paragraph 5 of this directive.

(2) Ensuring that revoked advance directives and revoked SAPO are rescinded in the EHR as outlined in paragraph 5 of this directive.

l. **Chair, VA Medical Facility Multi-Disciplinary Committee.** The Chair, VA medical facility multi-disciplinary committee is responsible for:

(1) Considering the procedural and ethical validity of the proposed LST plan for patients who lack decision-making capacity and have no surrogate, and documenting its findings, as outlined in the Flowchart: Establishing LST Plans for Patients Who Lack

Decision-Making Capacity, Have No Surrogate, and Have No Active LST Orders, available at:

https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. **NOTE:** This is an internal VA website that is not available to the public. This multi-disciplinary committee is unique for the purposes outlined in this directive.

(2) Developing a charter to outline the purpose, scope and responsibilities of the multi-disciplinary committee. **NOTE:** See paragraph 6.g. for information on committee membership. A multi-disciplinary committee charter template is available at https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. This is an internal VA website that is not available to the public.

m. **VA Medical Facility Health Care Ethics Consultants.** The VA medical facility Health Care ECs are responsible for:

(1) Providing healthcare ethics consultation services regarding advance directives, goals of care conversations (GoCCs), LST plans and SAPO.

(2) Identifying at least one VA medical facility Health Care EC to serve on the multi-disciplinary committee that reviews proposed LST plans for patients who lack decision-making capacity and do not have a surrogate as outlined in paragraph 6. **NOTE:** The VA medical facility Health Care Ethics Consultation Service may serve as the multi-disciplinary committee if they meet the requirements outlined in paragraphs 6.g. and 6.h.

n. **VA Practitioners.** **NOTE:** Health professions trainees (HPT) who meet the definition of practitioner outlined in this directive must perform the responsibilities outlined in this paragraph, under the supervision of their supervising practitioner. The supervising practitioner is ultimately responsible for the patient's care. For additional information, see VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019; and VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015. VA practitioners are responsible for following processes and procedures established by the VA medical facility SOP on ACP, including:

(1) Initiating GoCCs, with patients (or surrogates) who meet the high-risk criteria and other patients (or surrogates) as outlined in paragraph 3.

(2) Assisting patients who have decision-making capacity or referring such patients for assistance with completing or updating advance directive forms (including mental health advance directives), if applicable, when establishing or modifying LST plans, including when patients express a desire to name a particular person to serve as a surrogate (i.e., a health care agent (HCA)).

(3) Offering SAPO to patients (or surrogates), if available in the State, each time an LST plan is established or modified. **NOTE:** SAPO must only be written by VA practitioners who are authorized under State law or the State medical board or

association to write SAPO and who are also authorized by this directive to write LST plans or orders.

(4) Documenting GoCCs and LST plans using the standardized Computerized Patient Record System (CPRS) progress note template entitled “Life-Sustaining Treatment” (which must be linked to Crisis, Warnings, Allergies or Adverse Reactions and Directives (CWAD)) and entering do-not-resuscitate (DNR) and other LST orders (if applicable) or using the Cerner PowerForm entitled “Life-Sustaining Treatment” (or subsequent EHR documentation tool designated by NCEHC). **NOTE:** *If a GoCC is indicated but the patient (or surrogate) chooses to defer the conversation or chooses not to make decisions about LSTs, or the VA practitioner determines that delaying the GoCC is clinically indicated, the VA practitioner must document this in the progress note (or equivalent) for the encounter. Documentation in the encounter note does not discharge the obligation to re-initiate the GoCC when the patient (or surrogate) is ready. If a VA practitioner initiates a GoCC, but it does not result in decisions about LSTs, the practitioner may document the GoCC in the CPRS progress note entitled “Goals & Preferences to Inform Life-Sustaining Treatment Plan” or Cerner PowerForm entitled “Goals and Preferences to Inform Life-Sustaining Treatment Plan” as outlined in paragraph 2.o.(5).*

(5) Writing a new CPRS LST progress note or documenting in an addendum to the existing CPRS LST progress note, writing new LST orders (if applicable) and discontinuing LST orders that are no longer active, or updating the Cerner LST PowerForm, when a patient (or surrogate) decides to modify or revoke their LST plan.

(6) Ensuring that advance directive and SAPO forms are submitted for scanning into the EHR as outlined in paragraph 5.

(7) Initiating the multi-disciplinary committee review process to establish an LST plan for patients who lack decision-making capacity and do not have a surrogate or collaborating with other VA health care team members to request the assistance of the Office of Chief Counsel in the District to obtain a special guardian for health care for the patient.

(8) Honoring advance directives, LST plans and SAPO as outlined in paragraph 7 of this directive.

(9) Communicating with VA medical facility Health Care ECs if there are concerns as outlined in paragraph 8 or other matters concerning ACP.

o. VA Health Care Team Members. VA health care team members (i.e., non-practitioner clinicians), are responsible for following processes and procedures established in the VA medical facility SOP on ACP, including:

(1) Educating patients and surrogates about the importance of ACP and providing written information on the types of ACP and documentation that would meet their needs and help ensure that their values, goals and treatment preferences are honored. **NOTE:** *ACP education may occur through individual or group discussion.*

(2) Asking patients (or surrogates) if they have an advance directive (including mental health advance directives) and asking for a copy of existing advance directives; assisting patients who have decision-making capacity with completing or modifying advance directives, including VA Advance Directives (VA Form 10-0137, VA Advance Directive: Durable Power of Attorney for Health Care and Living Will) and State-authorized advance directives; and initiating the process to rescind an advance directive when revoked by a patient who has decision-making capacity when required by paragraph 3 and when clinically appropriate. See paragraph 4 for more information on VA Advance Directives.

(3) Assisting practitioners with identifying patients who meet the high-risk criteria and with conducting elements of GoCCs as outlined on the following website: https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. **NOTE:** *This is an internal VA website that is not available to the public.*

(4) Documenting discussions about advance directives in a CPRS “Advance Directive Discussion” progress note or in a Cerner “Advance Directive/Advance Care Planning” PowerForm (or subsequent EHR documentation tool designated by NCEHC). **NOTE:** *At VA medical facilities that use CPRS, when the discussion concerns an existing advance directive, documentation may be in the form of an addendum to the “Advance Directive” note associated with that directive.*

(5) Documenting information pertinent to a GoCC in the CPRS progress note entitled “Goals & Preferences to Inform Life-Sustaining Treatment Plan” (or other locally developed progress note designed to capture this discussion and associated with the national standard note title: “Goals & Preferences to Inform Life-Sustaining Treatment Plan”) or Cerner PowerForm entitled “Goals and Preferences to Inform Life-Sustaining Treatment Plan” (or subsequent EHR documentation tool designated by NCEHC). The CPRS progress note title used by non-VA practitioners may be linked to CWAD. **NOTE:** *If a VA health care team member discusses advance directives as part of GoCC, the VA health care team member must only document the discussion in the “Goals & Preferences...” note; duplicate documentation in an “Advance Directive Discussion” note is not required.*

(6) Ensuring that advance directive and SAPO forms are submitted for scanning into the EHR as outlined in paragraph 5.

3. INITIATING ADVANCE CARE PLANNING

a. ACP, including conducting GoCC and discussing advance directives, must be initiated with patients who meet the high-risk criteria (i.e., the patient is at high risk for a life-threatening clinical event because they have a serious medical condition associated with a significantly shortened lifespan) and who do not have an active LST plan at the following times:

(1) When the patient in the outpatient setting has a Care Assessment Need (CAN) score of 95 or above or the outpatient VA practitioner makes a clinical determination

that the patient meets the high-risk criteria as defined in paragraph 12. **NOTE:** Additional information on CAN scores is available here: <http://vawww.vhadataportal.med.va.gov/DataSources/CANScores.aspx>. This is an internal VA website that is not available to the public.

(2) Within 24 hours after admission to a VA acute care medical facility, or, if not feasible, at the earliest opportunity and not more than 72 hours after admission. **NOTE:** GoCCs are not required for patients admitted under observation under VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, dated January 13, 2020.

(3) Within 24 hours after admission to a VA Intensive Care Unit, or, if not feasible, at the earliest opportunity and not more than 72 hours after admission.

(4) Within 7 days after admission to a VA Community Living Center.

(5) By the second visit after admission to VA Home-Based Primary Care.

(6) After a new palliative care consultation (within 72 hours for inpatients and by the second visit for outpatients). See VHA Directive 1139, *Palliative Care Consult Teams and Veterans Integrated Services Network Leads*, dated September 9, 2022, for additional information on palliative care consults.

(7) Prior to referral or within 24 hours following admission to a VA hospice.

(8) Prior to referral to a non-VA hospice. **NOTE:** GoCCs are not required for patients who are actively receiving community care and are referred for non-VA hospice paid for by VA.

b. Discussions about advance directives must be initiated with all patients (regardless of whether the patient meets the high-risk criteria defined in paragraph 12) at the following times:

(1) During a patient's first VA primary care or home-based primary care appointment.

(2) During admission to a VA acute care medical facility.

(3) At any patient encounter when the patient expresses a preference to document general preferences for future treatment.

(4) At any patient encounter when the patient expresses a preference to designate a particular person to serve as surrogate.

c. GoCCs must be initiated with all patients (regardless of whether the patient meets the high-risk criteria as defined in paragraph 12) at the following times:

(1) Prior to establishing an LST plan or prior to writing a DNR or do-not-attempt-resuscitation (DNAR) order or other order(s) to limit LST, including SAPO.

(2) At any patient encounter when the patient (or surrogate) expresses a preference to make decisions about limiting or not limiting specific LSTs.

(3) At any patient encounter when the patient (or surrogate) presents with SAPO, unless the patient already has an LST plan and LST orders that are consistent with SAPO.

(4) If the patient (or surrogate) expresses a preference to discontinue an LST that the patient is currently receiving.

d. For patients who have an existing LST plan, advance directive or SAPO, the ACP documentation must be reviewed with the patient (or surrogate) and modified, if necessary, at the following times:

(1) If there is evidence that the ACP documentation no longer represents the patient's preferences.

(2) If there is a significant change in the patient's health status that may impact the patient's decisions or preferences (e.g., new risks and benefits associated with LST, given an updated prognosis).

(3) At least annually or, for patients who do not receive VA health care services during the year following completion (or modification) of the ACP documentation, during the next clinical encounter.

(4) Prior to a procedure involving general anesthesia, initiation of dialysis, cardiac catheterization, electrophysiology studies or any procedure that poses a high-risk of serious arrhythmia or cardiopulmonary arrest. **NOTE:** *A patient's LST orders must not be automatically suspended prior to a procedure. A patient may choose to have their LST orders, including a Do Not Attempt Resuscitation/Do Not Resuscitate Order (DNAR/DNR) order, remain active during a procedure and any decision to suspend an LST order prior to a procedure must be based on a GoCC.*

e. In emergency situations when immediate medical care is necessary to preserve the patient's life or avert serious impairment to the patient's health, and the VA practitioner determines that delaying medical care in order to conduct ACP with the patient (or surrogate) would increase the hazard to the life or health of the patient, the VA practitioner must defer ACP until the earliest opportunity after the patient has been stabilized.

4. VA ADVANCE DIRECTIVE: PATIENT AND WITNESS SIGNATURES

a. A VA Advance Directive is a completed VA Form 10-0137.

b. A VA Advance Directive must be signed by the patient. If the patient is unable to sign a VA Advance Directive due to a physical impairment, the patient may sign the VA Advance Directive form with an "X", thumbprint or stamp. In the alternative, the patient

may designate a third party to sign the directive at the direction of the patient and in the presence of the patient.

c. In all cases, a VA Advance Directive must be signed by the patient in the presence of both witnesses. Witnesses to the patient's signing of an advance directive are attesting by their signatures only to the fact that they saw the patient or designated third party sign the VA Advance Directive form. Neither witness may, to the witness's knowledge, be named as a beneficiary in the patient's estate, appointed as HCA in the advance directive or financially responsible for the patient's care. Nor may a witness be the designated third party who has signed the VA Advance Directive form at the direction of the patient and in the patient's presence. **NOTE:** *VHA staff, including VA practitioners and VA health care team members, may witness the patient's signing of a VA Advance Directive form unless one of these witness exceptions applies.*

d. In circumstances where a witness sees the patient or designated third party sign VA Form 10-0137 through the use of live interactive video, VA will consider the witness to have been “in the presence” of the patient at the time when the witness observed the patient's or third party's act of signing. Such a witness must sign the original advance directive form as soon as possible.

5. MANAGING ADVANCE DIRECTIVE AND STATE-AUTHORIZED PORTABLE ORDER FORMS IN THE ELECTRONIC HEALTH RECORD

a. Advance Directive Forms.

(1) When a patient presents with a paper advance directive, or when a VA health care team member assists a patient in completing a paper advance directive, the team member must:

(a) Follow the locally developed process to ensure that the paper advance directive is promptly scanned into the patient's EHR. Advance directives must be associated with the CPRS progress note title “Advance Directive” which must be linked to CWAD in CPRS or associated with the Cerner Note Type “Advance Directive Documents” (or subsequent EHR documentation tool designated by NCEHC). **NOTE:** *VA Advance Directives completed using VA's Electronic Signature Informed Consent (eSIC) software are automatically saved in the EHR. VA health care team members must provide the patient a printed copy of the VA Advance Directive completed using the eSIC software. See VHA Directive 1004.01, Informed Consent for Clinical Treatments and Procedures, dated December 12, 2023.*

(b) Ensure that the original paper document is returned to the patient.

(2) Initiate the process to rescind any revoked advance directives in the EHR according to the instructions outlined at (see FAQs): <https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Policy.aspx>. **NOTE:** *This is an internal VA website that is not available to the public. A patient who has decision-making capacity may revoke their VA Advance Directive at any time by using any means expressing the intent to revoke. Therefore, VA health care team members must*

initiate the process to rescind a revoked advance even if the patient does not complete a new advance directive.

b. **State-Authorized Portable Order Forms.** When a patient presents with SAPO or a VA practitioner writes a SAPO following a GoCC, the VA practitioner or VA health care team member must:

(1) Ensure that the paper SAPO is promptly scanned into the EHR. SAPO must be associated with the CPRS progress note title “State-Authorized Portable Orders” which must be linked to CWAD in CPRS or associated with the Cerner note type entitled “State-Authorized Portable LST Orders” (or subsequent EHR documentation tool designated by NCEHC). **NOTE:** *VA medical facilities that use CPRS may include a suffix to reflect local needs for example, “State-Authorized Portable Orders – CA Physician Orders for Life-Sustaining Treatment (POLST),” “State-Authorized Portable Orders – Medical Orders for Life-Sustaining Treatment (MOLST).” Regardless of the suffix, the local progress note title must be mapped to the standard title, “State-Authorized Portable Orders.”*

(2) Ensure that the original paper document is returned to the patient (or surrogate).

(3) Initiate the process to rescind any non-current SAPO in the EHR according to the instructions outlined at (see FAQs):

<https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Policy.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

6. ESTABLISHING, REVISING AND DOCUMENTING LIFE-SUSTAINING TREATMENT PLANS FOR PATIENTS WHO LACK DECISION-MAKING CAPACITY

a. If the patient’s decision-making capacity is in question, the VA practitioner must determine whether the patient has capacity to establish an LST plan and document the assessment as outlined in VHA Directive 1004.01.

b. If it is determined that the patient lacks decision-making capacity to establish an LST plan, the VA practitioner must initiate the GoCC with the patient’s surrogate. The surrogate must be identified by the VA medical facility’s established process for identifying surrogates and must make decisions about LSTs using substituted judgment or best interests as outlined in VHA Directive 1004.01.

c. The patient’s surrogate may modify or revoke an existing LST plan except if the change would be clearly inconsistent with the patient’s values, goals and preferences.

d. If a patient who lacks decision-making capacity and does not have a surrogate has no active LST plan and LST orders and presents to VA with SAPO from any State, the VA practitioner must write an LST plan on the standardized CPRS LST progress note template or Cerner LST PowerForm in accordance with the SAPO, unless there is a reason to doubt the SAPO’s validity. The VA practitioner must then request the assistance of the Office of Chief Counsel in the District to obtain a special guardian for health care or initiate a consult to the multi-disciplinary committee within 24 hours. If,

during the multi-disciplinary committee review process the patient experiences an emergency, treatment must be based on the VA LST plan and orders that reflect the SAPO.

e. In an emergency situation, when a patient who lacks decision-making capacity and does not have a surrogate has no active LST plan and LST orders presents without SAPO, the VA practitioner must initiate medically indicated life-saving treatment. In addition, the VA practitioner must either request the assistance of the Office of Chief Counsel in the District to obtain a special guardian for health care or initiate a consult to the multi-disciplinary committee within 24 hours.

f. To develop a proposed new or revised LST plan and initiate the multi-disciplinary committee review process for a patient who lacks decision-making capacity and does not have a surrogate, the VA practitioner must follow the process outlined in the Flowchart: Establishing LST Plans for Patients Who Lack Decision-Making Capacity, Have No Surrogate, and Have No Active LST Orders, available at: https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. **NOTE:** *This is an internal VA website that is not available to the public.*

g. The VA medical facility multi-disciplinary committee must be comprised of three or more different disciplines (e.g., social worker, chaplain) and include at least one VA practitioner(s) who is qualified to assess the specific medical facts (e.g., psychiatrist, oncologist) to help the multi-disciplinary committee determine whether the proposed LST plan will meet the patient's identified goals. The multi-disciplinary committee must also include at least one VA medical facility Health Care EC and must not include members of the patient's primary treatment team. **NOTE:** *The VA medical facility Health Care Ethics Consultation Service may serve as the multi-disciplinary committee if they meet the requirements outlined above.*

h. The multi-disciplinary committee must consider the procedural and ethical validity of the proposed LST plan and 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 interest by following the process outlined in the Flowchart: Establishing LST Plans for Patients Who Lack Decision-Making Capacity, Have No Surrogate, and Have No Active LST Orders, available at: https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. **NOTE:** *This is an internal VA website that is not available to the public.*

i. If the proposed LST plan includes limitations on LST, the VA medical facility CoS must approve or disapprove the proposed LST plan, in writing, as outlined in the Flowchart: Establishing LST Plans for Patients Who Lack Decision-Making Capacity, Have No Surrogate, and Have No Active LST Orders, available at: https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. **NOTE:** *This is an internal website that is not available to the public.*

j. The VA practitioner must complete the CPRS LST progress note and orders or Cerner LST PowerForm to implement the LST plan, in accordance with the results of the multi-disciplinary committee review process.

k. Whether or not SAPO can be written for a patient who lacks decision-making capacity is dependent upon the State law that governs the SAPO.

7. HONORING PATIENTS' TREATMENT PREFERENCES

a. As part of the informed consent process when a patient lacks decision-making capacity, the VA practitioner must review the advance directive with the patient's surrogate as outlined in VHA Directive 1004.01. If the patient does not have a surrogate, the VA practitioner must utilize the advance directive to establish an LST plan for the patient as outlined in paragraph 6 of this directive or to establish a plan for non-LST as outlined in VHA Directive 1004.01.

b. If a patient has active LST orders or presents in an emergency with a SAPO from any State and the SAPO includes limits to LST, the VA practitioner must honor the LST orders or SAPO even in case of a medical emergency, unless there is evidence that the orders no longer represent the patient's preferences. In addition, if LST is initiated and the VA practitioner subsequently discovers that the patient has an order limiting that LST, the VA practitioner must discontinue that LST. **NOTE:** *LST orders in the EHR and SAPO presented in an emergency are the authoritative source for determining if a patient has a DNAR/DNR order. Therefore, VA medical facilities are prohibited from using patient wristbands to communicate code status, including DNAR or DNR status (and other identifiers such as bracelets and necklaces). This prohibition does not apply to SAPO wristbands that are authorized by State law or the State medical board or association.*

c. If an LST other than cardiopulmonary resuscitation (CPR) is not initiated or is discontinued, the VA practitioner must offer supportive and palliative services, whether provided by the primary VA practitioner or palliative specialist, to ensure the patient's comfort and support of the patient's family. Services provided to ensure the patient's comfort must not include assisted suicide or euthanasia.

d. CPR must be attempted on every patient who sustains a cardiopulmonary arrest, except when any of the following applies:

(1) A DNAR/DNR order is documented in the patient's EHR or the patient (or surrogate) consented to a DNAR/DNR order, but the order has not yet been documented in the EHR.

(2) The patient presents in an emergency with SAPO from any State for DNAR/DNR.

(3) During the emergency code response, the VA practitioner responsible for leading the resuscitation team determines that initiation or continuation of resuscitative efforts would be ineffective at restoring spontaneous circulation or that continued efforts would have no chance of producing the patient's goals of care.

(4) A qualified VA practitioner has pronounced the patient dead.

(5) The patient manifests rigor mortis, dependent livedo or other obvious signs of death. **NOTE:** See VHA Directive 1177, *Cardiopulmonary Resuscitation*, dated January 4, 2021, for additional information on CPR and cardiopulmonary arrest.

e. If CPR is initiated before it is known that the patient has a DNAR/DNR order, such efforts must be terminated as soon as a VA practitioner or a health care team member confirms the presence of a DNAR/DNR order in the EHR.

f. LST plans and LST orders do not expire or automatically discontinue based on timeframes or patient movements (e.g., admission, discharge, transfer, during a procedure) within VA, and remain active until the patient (or surrogate) chooses to modify or revoke the plan by communicating the change to their VA practitioner.

8. RESOLVING INCONSISTENCIES OR CONFLICTS

a. The VA practitioner must consult with the VA medical facility Health Care ECs if the VA practitioner believes that the surrogate is making decisions about treatments and procedures that are contrary to the patient's values and wishes, or best interests, as outlined in VHA Directive 1004.01.

b. In an emergency situation, if a patient presents with SAPO that is inconsistent with the patient's LST plan, the most recent document generally supersedes. When questions remain, the VA practitioner must consult the VA medical facility Health Care ECs.

c. If the patient lacks decision-making capacity and therefore cannot modify their advance directive, but there are inconsistencies between the Living Will section of the advance directive and LST plan consented to by the patient when the patient had capacity, the VA practitioner must do the following:

(1) If the Living Will reflects the patient's current preferences, the VA practitioner must either update the LST plan and LST orders through a GoCC with the surrogate or follow the multi-disciplinary committee review process outlined in paragraph 6.g.

(2) If the LST plan and LST orders were completed more recently than the Living Will and reflect the patient's current preferences, the information in the Living Will that no longer reflect the patient's preference(s) for the LST(s) relevant to the treatment plan is revoked by the patient's consent to the LST plan and orders. The patient's consent to the LST plan and orders is considered a means of expressing the intent to revoke as required by 38 C.F.R. § 17.32 (g)(4). The information in the Living Will that still reflects the patient's preferences remain valid. If information in the Living Will is revoked by the patient's consent to the LST plan, the VA practitioner must document in the EHR which information in the Living Will is revoked and which remains valid in an addendum to the CPRS "Advance Directive" note or Cerner "Advance Directive Documents" Note Type associated with the advance directive in question and, if the patient regains decision-making capacity, assist or refer the patient for assistance with completing a new

advance directive. **NOTE:** For VA medical facilities that use CPRS, the note title must not be changed from “Advance Directive” to “Rescinded Advance Directive,” as elements of the advance directive remain valid. An HCA cannot be designated in an LST note. To designate an HCA, the patient must complete the Durable Power of Attorney for Health Care (DPAHC) section of an advance directive. If, during a GoCC, a patient with decision-making capacity expresses a desire for a certain person to serve as their surrogate if they lose capacity, the VA practitioner must assist or refer the patient for assistance with completing a DPAHC.

(3) If the patient lacks decision-making capacity and therefore cannot modify their advance directive, but there are inconsistencies between the Living Will section of the advance directive and LST plan consented to by the surrogate, the VA practitioner must consult the VA medical facility Health Care ECs for assistance.

9. NATURALLY ADMINISTERED NUTRITION AND HYDRATION

a. Naturally administered nutrition and hydration (i.e., food and fluids taken by mouth and provided by hand, spoon, cup or straw) are part of the basic care offered to all patients. Patients may, however, lose the desire to eat and choose to stop eating or drinking, and patients with decision-making capacity have the right to refuse to eat or drink and must not be force-fed.

b. In the case of patients who have lost decision-making capacity, VA health care team members must make reasonable attempts to provide the patient with food and fluids by mouth unless one of the following conditions applies:

(1) The patient has a serious life-limiting condition and made an informed, voluntary decision to stop eating and drinking prior to losing decision-making capacity.

(2) The patient repeatedly resists attempts to provide food and fluid by mouth.

(3) The patient cannot effectively swallow or has a medical contraindication to food or fluid by mouth (e.g., the patient repeatedly chokes or gags or a swallowing assessment indicates that it would be unsafe for the patient to swallow) and the surrogate agrees that, under these circumstances, provision of food and fluids by mouth is disproportionately burdensome to the patient or inconsistent with the patient’s goals of care. **NOTE:** If the patient lacks decision-making capacity, lacks a surrogate and has no active orders to withhold food and fluids by mouth, decision making regarding the withholding of food and fluids by mouth must be made according to the multi-disciplinary committee review process outlined in paragraph 6.g.

10. TRAINING

There are no formal training requirements associated with this directive.

11. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

12. DEFINITIONS

a. **Advance Care Planning.** ACP is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals and preferences regarding future medical care. The goal of ACP is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.

b. **Advance Directive.** An advance directive is a written statement by a person who has decision-making capacity regarding preferences about future health care decisions if that person becomes unable to make those decisions. The various types of advance directives are:

(1) **Durable Power of Attorney for Health Care.** A DPAHC is a type of advance directive in which an individual designates another person as an HCA to make health care decisions on the individual's behalf.

(2) **Living Will.** A Living Will is a type of advance directive in which an individual documents personal preferences regarding future treatment options. A Living Will typically includes preferences about LST, but it may also include preferences about other types of health care.

(3) **Mental Health Advance Directive.** A mental health or psychiatric advance directive is executed by individuals whose future decision-making capacity is at risk due to mental illness. In this type of directive, the individual indicates future mental health treatment preferences.

(4) **State-authorized Advance Directive.** A State-authorized advance directive is a non-VA DPAHC, Living Will, mental health directive or other advance directive document that is legally recognized by a State. The validity of State-authorized advance directives is determined pursuant to applicable State law. For the purposes of this definition, "applicable State law" means the law of the State where the advance directive was signed, the State where the patient resided when the advance directive was signed, the State where the patient now resides or the State where the patient is receiving treatment. VA will resolve any conflict between those State laws regarding the validity of the advance directive by following the law of the State that gives effect to the wishes expressed by the patient in the advance directive.

(5) **VA Advance Directive.** A VA Advance Directive is a completed VA Form 10-0137, VA Advance Directive: Durable Power of Attorney for Health Care and Living Will.

In VA, this form is used by patients to designate an HCA and to document treatment preferences, including medical care, surgical care and mental health care. A VA Advance Directive must be signed and witnessed as outlined in paragraph 4.

c. **Decision-Making Capacity.** Decision-making capacity is the ability to understand and appreciate the nature and consequences of health care treatment decisions, and the ability to formulate a reasoned judgment and communicate a clear decision concerning health care treatments. **NOTE:** See VHA Directive 1004.01 for additional information on decision-making capacity.

d. **Do Not Attempt Resuscitation/Do Not Resuscitate Order.** A DNAR/DNR is an order that establishes that CPR must not be attempted for a patient in cardiopulmonary arrest. Patients with a DNAR/DNR order still receive clinically appropriate emergency interventions short of CPR (e.g., medications, fluids, oxygen, manual removal of an airway obstruction or the Heimlich maneuver) unless otherwise specified in LST orders. **NOTE:** The terms DNR, DNAR, No-CPR and No Code are synonymous. DNAR/DNR orders are distinct from advance directives.

e. **Electronic Health Record.** EHR is the digital collection of patient health information resulting from clinical patient care, medical testing and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including CPRS, Veterans Information Systems and Technology Architecture (VistA) and Cerner platforms. **NOTE:** The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software specific terms while VA transitions platforms.

f. **Goals of Care Conversation.** For the purposes of this directive, GoCC is a conversation between a VA practitioner and a patient (or surrogate) for the purpose of determining the patient's values and goals of care and, based on those factors, establishing an LST plan.

g. **Health Care Agent.** An HCA is an individual named in a DPAHC to make health care decisions on the patient's behalf, including decisions regarding LSTs, when the person can no longer do so. **NOTE:** See paragraph 12.m. as all HCAs are surrogates.

h. **High-Risk Criteria.** For the purposes of this directive, high-risk criteria means the patient is at high risk for a life-threatening clinical event because they have a serious medical condition associated with a significantly shortened lifespan.

i. **Life-Sustaining Treatment.** LST is a medical treatment that is intended to prolong the life of a patient who would be expected to die soon without the treatment (e.g., CPR, artificial nutrition and hydration, mechanical ventilation, dialysis).

j. **Life-Sustaining Treatment Order.** An LST order is a DNAR/DNR order or other medical order to limit LST that is based on a patient's established LST plan. **NOTE:** For VA medical facilities that use Cerner, LST orders also include "Full Code" orders to attempt CPR for a patient in cardiopulmonary arrest.

k. **Life-Sustaining Treatment Plan.** An LST plan is a treatment plan that directs care within VA medical facilities regarding the initiation, discontinuation and limitation of LST.

l. **State-Authorized Portable Order.** A SAPO is a specialized form or identifier (e.g., DNAR/DNR bracelets or necklaces) authorized by State law or the State medical board or association that translates a patient's preferences with respect to LST decisions into standing portable medical orders.

m. **Surrogate.** For the purposes of this directive, a surrogate refers to an individual authorized under 38 C.F.R. § 17.32 and VHA policy to make health care decisions on behalf of a patient who lacks decision-making capacity. A surrogate includes an HCA, legal guardian, next-of-kin or close friend.

n. **VA Practitioners.** For purposes of this directive, a VA practitioner is any physician, dentist or health care provider granted specific clinical privileges to perform the treatment or procedure. A VA practitioner also includes other health care professionals (e.g., physician assistants, nurse practitioners, health professions trainees) whose scope of practice agreement or other formal delineation of job responsibility specifically permits them to obtain informed consent, and who are appropriately trained and authorized to perform the procedure or to provide the treatment for which consent is being obtained.

13. REFERENCES

- a. 38 U.S.C. §§ 1707, 7331.
- b. 38 C.F.R. § 17.32.
- c. VHA Directive 1004.01, Informed Consent for Clinical Treatments and Procedures, dated December 12, 2023.
- d. VHA Directive 1036, Standards for Observation in VA Medical Facilities, dated January 13, 2020.
- e. VHA Directive 1139, Palliative Care Consult Teams and Veterans Integrated Services Network Leads, dated September 9, 2022.
- f. VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021.
- g. VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.
- h. VHA Handbook 1400.04, Supervisions of Associated Health Trainees, dated March 19, 2015.
- i. VA Form 10-0137, VA Advance Directive: Durable Power of Attorney for Health Care and Living Will.

j. Advance Care Planning Policy.
https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Advance_Care_Planning.aspx. **NOTE:** This is an internal VA website that is not available to the public.

k. Care Assessment Need Scores.
<http://vaww.vhadataportal.med.va.gov/DataSources/CANScores.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

l. National Center for Ethics in Health Care. Health Care Ethics Policy FAQs.
<https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Policy.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

m. National Center for Ethics in Health Care. Policy Performance Measures.
https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Policy_Performance_Measures.aspx. **NOTE:** This is an internal VA website that is not available to the public.