Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00727-239

Combined Assessment Program Summary Report

Evaluation of Hospice and Palliative Care in Veterans Health Administration Facilities

August 11, 2014

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections completed an evaluation of hospice and palliative care in Veterans Health Administration facilities. The purposes of the evaluation were to determine whether VHA facilities performed active hospice and palliative care case finding, provided end-of-life care training to staff, and met selected documentation standards and to assess selected Palliative Care Consult Team processes, documentation, and staffing.

Inspectors evaluated hospice and palliative care at 54 facilities during Combined Assessment Program reviews conducted from October 1, 2012, through September 30, 2013.

Although we observed many positive practices, we identified two opportunities for Veterans Health Administration facilities to improve. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility leaders, ensures that:

- Facilities provide at least the minimum required Palliative Care Consult Team staffing.
- Facilities provide end-of-life care training to staff who work in areas where they are likely to encounter patients at the end of their lives.

Comments

The Under Secretary for Health concurred with the findings and recommendations. (See Appendix A, pages 5–8, for the full text of the comments.) The implementation plans are acceptable, and we will follow up until all actions are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections evaluated hospice and palliative care (HPC) in Veterans Health Administration (VHA) facilities. The purposes of the evaluation were to determine whether VHA facilities performed active HPC case finding, provided end-of-life care training to staff, and met selected documentation standards and to assess selected Palliative Care Consult Team (PCCT) processes, documentation, and staffing.

Background

The goal of HPC is to improve end-of-life care by enhancing the quality of life for the terminally ill and their loved ones through a team-oriented approach that includes medical care; pain management; and emotional, social, and spiritual support.

Hospice is a subset of palliative care for patients diagnosed with a known terminal condition with a prognosis of less than 6 months. Hospice care focuses on enhancing the quality of life remaining for patients by providing care 24 hours a day, 7 days a week. In addition, hospice care includes bereavement and counseling services for surviving family and friends. This care can be provided by in-home or inpatient services. Hospice care strives to allow patients to die with dignity and pain-free.[1] Palliative care is a broader term that includes hospice care but does not require the presence of an imminently terminal condition (prognosis of 6 months or less). Palliative care may include a balance of comfort measures and life-prolonging interventions that vary across a wide spectrum.

The Veterans' Health Care Eligibility Reform Act mandates that VHA facilities provide hospice services to all veterans meeting hospice criteria. Facilities should provide in-home or inpatient hospice care. Inpatient hospice care can be provided at a facility, if available, or in the community. We found that 51 of the 54 facilities (94 percent) in our sample provided inpatient hospice and that 88 percent of the facilities with inpatient hospice beds had those beds located in the community living centers.

For optimal end-of-life care, consults to PCCT teams should be initiated as soon as possible so that patients can benefit from the special services for as long as possible. VA's Office of Geriatrics and Extended Care gathers information from facilities to monitor the numbers and effectiveness of PCCT activities. We reviewed the data from fiscal years 2012 and 2013 and noted improvement in the inpatient deaths in which the PCCT was consulted from 68 percent to 71 percent.

End-of-life care relies on a team of clinicians, each of whom brings special expertise in meeting the physical, medical, psychosocial, emotional, and spiritual needs of the patients and their families. Clinicians caring for inpatients receiving HPC are required to complete interdisciplinary care plans, screen for presence of advance directives, and

[1] National Hospice and Palliative Care Organization website, http://www.nhpco.org, accessed October 15, 2010.

assess pain with appropriate frequency. We found that more that 90 percent of the 54 facilities in our sample accomplished these tasks.

Scope and Methodology

Inspectors evaluated HPC at 54 facilities during Combined Assessment Program reviews conducted from October 1, 2012, through September 30, 2013. The facilities were a stratified random sample of all VHA facilities and represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks. OIG generated an individual Combined Assessment Program report for each facility. For this report, we summarized the data collected from the individual facility Combined Assessment Program reviews.

Based on the sampled facilities, we analyzed compliance with selected requirements to estimate results for the entire VHA system. We presented a 95 percent confidence interval (CI) for the true VHA value (parameter). A CI gives an estimated range of values (calculated from a given set of sample data) that is likely to include an unknown parameter. The 95 percent CI indicates that among all possible samples we could have selected of the same size and design, 95 percent of the time the population parameter would have been included in the computed intervals. To take into account the complexity of our multistage sample design, we used the Taylor expansion method to obtain the sampling errors for the estimates. We used Horvitz-Thompson sampling weights, which are the reciprocal of sampling probabilities, to account for our unequal probability sampling. All data analyses were performed using SAS statistical software (SAS Institute, Inc., Cary, NC), version 9.3 (TS1M0).

We reviewed facility policies and staff training records. We also conversed with applicable managers and staff. Additionally, for each of the 54 facilities, we reviewed a sample of patients' electronic health records. The patient and training record samples within each facility were not probability samples, and thus do not represent the entire patient and employee population of that facility. Therefore, the patient and training record results presented in this report are not generalizable to the entire VHA.

Inspectors conducted the reviews in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Facility PCCTs

VHA requires all facilities to assemble a PCCT to ensure veterans with serious, life-limiting illnesses have HPC services available.[2] PCCTs are generally comprised of a core interdisciplinary group of professionals from medicine, nursing, social work, psychology or mental health, and chaplain and an administrative support person. The PCCT may also include other professionals such as pharmacists, dietitians, physical therapists, occupational therapists, recreation therapists, creative art therapists, and community health nurse coordinators.

Physicians or other health care professionals request assistance in treating patients who have a life-limiting or serious illness and their families by submitting HPC consults to the PCCT. Consult requests can be for either inpatient or outpatient settings and may include assessment performance and recommendations related to prognosis; pain and symptom management; goals of care and associated treatment decisions; advanced care planning; psychosocial, spiritual, and other issues; family meetings; and referrals to hospice and other VA and community services. One or more members of the PCCT may respond and involve other team members as indicated by the nature of the consult and the needs of the patient and family.

We reviewed facility policies and 1,076 electronic health records. We found that in general:

- Liaisons with community hospice programs were designated.
- Alternative therapies were available (for example, pet, music, and massage).
- Actions on PCCT consults were within 7 days of the request or sooner based on facilities' policies, and consult responses were properly attached to consult requests.

We reviewed the composition of 54 PCCTs. We found that VHA facilities either met or exceeded minimum staffing requirements for medicine, nursing, social work, and chaplain. However, we estimated that PCCTs lacked required administrative support staff at 45.0 percent (95 percent CI 34.69–55.71) of facilities, and we estimated that PCCTs lacked required mental health providers at 22.2 percent (95 percent CI 14.25–32.88) of facilities.

We recommended that facilities provide at least the minimum required PCCT staffing to ensure that PCCTs can provide the necessary services to patients.

[2] VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.

Issue 2: Staff Training in End-of-Life Care

VHA requires that staff receive training on the unique needs of dying patients and their families.[3] The requirement is general and does not specify whether all VHA staff need such training or only staff working with certain patient populations. We reviewed 450 training records of staff who were assigned to work with HPC patients and found that in general, they had received end-of-life care training.

We attempted to determine whether staff who were not assigned to work with HPC patients but worked in areas where they were likely to encounter patients at the end of their lives had received end-of-life care training. We reviewed training records of staff who worked in intensive care units, emergency departments, and home-based primary care programs. We found that training had not been provided to 29 percent (226/788) of these staff within the 2-year period prior to our visit. Again, the requirement is general and does not specify these three areas. Some facilities told us that they provided end-of-life care training to staff but had not chosen these areas. VHA has an online training site that offers end-of-life care training, and facility PCCTs are required to offer training to staff.

We recommended that facilities provide end-of-life care training for staff who work in areas where they are likely to encounter patients at the end of their lives.

Conclusions

We observed many positive practices during our review, including active case finding, timely response to consults, and documentation of care plans and advance directives. However, facilities could improve HPC by providing required minimum PCCT staffing and end-of-life care training to staff.

Recommendations

1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensures that at least the minimum required Palliative Care Consult Team staffing is provided.

2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensures that end-of-life care training is provided to staff who work in areas where they are likely to encounter patients at the end of their lives.

[3] VHA Directive 2008-066.

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: August 4, 2014

From: Interim Under Secretary for Health (10)

Subject: **OIG Draft Combined Assessment Program Summary Report – Evaluation of Hospice and Palliative Care in Veterans Health Administration Facilities (2014-00727-HI-0372) (VAIQ 7466149)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft Evaluation of Hospice and Palliative Care in Veterans Health Administration (VHA) Facilities. I have reviewed the draft report and concur with the report's recommendations.

2. Attached is VHA's corrective action plan for recommendations one and two.

3. Should you have any questions, please contact Karen M. Rasmussen, M.D., Director, Management Review Service (10AR), at (202) 461-6643 or email at VHA10ARMRS2@va.gov.

Carolyn M. Clancy, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Combined Assessment Program Summary Report – Evaluation of Hospice and Palliative Care in VHA Facilities

Date of Draft Report: March 25, 2014

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensures that at least the minimum required Palliative Care Consult Team staffing is provided.

VHA Comments

Concur

VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, requires the presence of an active interdisciplinary palliative care consult team at every VA medical center (VAMC). These teams play a vital role in meeting the needs of Veterans with serious life-limiting illness across the system.

The Geriatrics and Extended Care Services (GEC), Hospice and Palliative Care (HPC) Program, will continue to require quarterly reporting from all VAMCs regarding the staffing of their PCCTs. The HPC program office shares areas of concern with VHA leadership and collaborates on action planning for VAMCs with persistent vacancies.

HPC Operations will establish a work group with the Deputy Under Secretary for Health for Operations and Management, Office of Mental Health Operations (MHO) to specifically address deficiencies in mental health staffing. The HPC program office has shared information on facilities with persistent vacancies with MHO and they will be using these data in their oversight activities to promote filling of these positions. The workgroup will develop guidance for achieving the mental health palliative care team staffing requirements as outlined in the policy, and will issue a memorandum to field leadership, through GEC Operations, to share this guidance with VAMC leaders. The workgroup will also provide ongoing quarterly briefings to GEC leadership until this issue is resolved.

HPC will also continue to monitor overall staffing, including both inpatient and outpatient workload of PCCTs, while promoting collaboration with primary care and Patient Aligned

Care Teams (PACT) to increase the reach of palliative care expertise beyond the inpatient setting and earlier in the course of disease.

To complete this action plan VHA will provide documentation of:

- An example of meeting minutes taken during the HPC and MHO workgroup.
- The final guidance written for achieving the mental health palliative care team staffing requirements as outlined in the policy.
- The memorandum to field leadership, through GEC Operations, to share guidance with VAMC leaders.
- A briefing to GEC leadership.

In progress November 28, 2014

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensures that end-of-life care training is provided to staff who work in areas where they are likely to encounter patients at the end of their lives.

VHA Comments

Concur

The HPC program will continue to promote educational programs and resources for staff caring for those with advanced illness. Given that education on the needs of dying patients is now a Joint Commission (TJC) standard (PC.02.02.13, part 2: The hospital provides staff with education about the unique needs of dying patients and their families.), HPC will develop and disseminate a brief educational toolkit (less than 1 hour) to address this standard.

HPC Operations will issue a memorandum to inform leadership and staff who interact with Veterans at end of life and their families that basic education on the needs of the dying is now a Joint Commission standard and that facilities have an array of options to provide this education to relevant staff.

This HPC Operations memorandum will establish the target audience for this educational focus to be front line staff working in intensive care units, long-term care settings, emergency departments and home based primary care. Most hospice and palliative care staff will likely have received sufficient education on end-of-life care through their routine job training or qualifications but should be included in this educational initiative if they have no previously documented education or qualifications in end of life care. The HPC Operations memorandum will require facility Directors to develop an action plan that addresses the memorandum's education expectations and communicate their action plan to their VISN's Palliative Care Leader, GEC Leader and Quality Management Officer (QMO). The deadline for submitting their action plan to these VISN leaders is within 90 days of the issuance of the HPC Operations

memorandum. These action plans could include the following approaches or other novel actions to meet the educational expectations;

- Use of the HPC program educational toolkit as facilitated locally
- Revision of new employee orientation to include this educational information
- In-services, which include documentation of education on the unique needs of dying patients and their families
- Virtual education in end of life care as provided by the HPC program office on a regular basis

To complete this action plan VHA will provide documentation of:

- The educational toolkit to educate staff caring for those approaching the end-of-life
- The memorandum with the following requirements:
    - Inform staff and VAMC leadership that this specific education is a Joint Commission standard and is strongly recommended for front line staff who work in intensive care units, long-term care settings, emergency departments and home based primary care.
    - Facility Directors must communicate to their VISN Palliative Care and GEC Leaders and QMO an action plan to address this educational requirement within 90 days of the issuance of the memorandum.
    - Each VISN Palliative Care and GEC Leader will collaborate with their VISN's Quality Management Officer to compile the facility action plans and submit to the HPC program office their VISN action plan to ensure facility compliance with TJC standard PC.02.02.13, part 2.

In progress November 28, 2014

OIG Contact and Staff Acknowledgments

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