Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-03960-428

Combined Assessment Program Summary Report

Evaluation of Advance Directives in Veterans Health Administration Facilities

September 27, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections completed an evaluation of advance directives in Veterans Health Administration facilities. The purpose of the review was to determine whether Veterans Health Administration facilities complied with selected requirements for advance care planning and advance directives for veterans.

We conducted this review at 48 Veterans Health Administration medical facilities during Combined Assessment Program reviews performed across the country from April 1, 2015, through March 31, 2016.

Although we observed many positive practices, we identified two system weaknesses. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that:

- Employees consistently ask inpatients whether they want to discuss advance directives.
- When inpatients request a discussion about advance directives, clinicians consistently document that the discussion occurred using only the two standardized note titles for advance directives discussions.

Comments

The Under Secretary for Health concurred with the findings and recommendations. (See Appendix A, pages 4–8, 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 advance directives (AD) in Veterans Health Administration (VHA) facilities. The purpose of the review was to determine whether VHA facilities complied with selected requirements for advance care planning and ADs for veterans.

Background

Advance care planning is a process for identifying and communicating an individual's values and preferences regarding future health care for use at a time when that person is no longer capable of making health care decisions. Health care team members who speak with their patients about patient preferences are better equipped to interpret those preferences if or when the patient loses decision-making capacity. Advance care planning may, but does not necessarily, result in a written AD document.

VHA defines an AD as a written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that individual becomes unable to make those decisions. Examples of types of ADs include durable power of attorney for health care, living will, and VA AD.

Scope and Methodology

We performed this review in conjunction with 48 Combined Assessment Program reviews conducted from April 1, 2015, through March 31, 2016. The facilities we visited 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.

We reviewed facility policies and conversed with applicable managers and employees. Additionally, we reviewed 1,948 inpatients' electronic health records (EHR). We used 90 percent as our expectation for compliance. The patient samples within each facility were not probability samples and thus do not represent the entire patient population of that facility.

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

We identified several strong practices, including that facilities had policies addressing AD notification, screening, and discussions; employees generally screened inpatients to determine whether they had ADs; and the AD posting in the EHR generally reflected patients' AD statuses. However, we found system weaknesses regarding AD discussions and documentation thereof.

AD Discussions

Upon inpatient admission, VHA requires that employees ask patients whether they would like to discuss ADs and if so, employees must provide additional information about ADs.[1] We found that employees did not ask patients whether they would like to discuss ADs in 16.5 percent of the EHRs. When patients requested a discussion about ADs, clinicians did not document that the discussion occurred in 20.6 percent of the EHRs.

To ensure that ADs and related discussions with patients can be easily identified in the EHR, VHA established two distinct progress note titles—"Advance Directive" and "Advance Directive Discussion."[2] VHA requires that clinicians use only these note titles when assisting patients with their ADs. The requirement to use standardized note titles has been in place since 2009. In our reviews of patient EHRs, we found that clinicians used other than these VHA standardized note titles to document AD discussions in 11.7 percent of the EHRs.

We recommended that employees consistently ask inpatients whether they want to discuss ADs, and when patients request a discussion about ADs, clinicians need to consistently document that the discussion occurred. In addition, clinicians must use only the two VHA standardized note titles for AD discussions. Facility managers need to monitor compliance with these recommendations.

Conclusions

We observed many positive practices during our review, including that facilities had policies addressing AD notification, screening, and discussions; employees generally screened inpatients to determine whether they had ADs; and the AD posting in the EHR generally reflected patients' AD statuses. However, we found system weaknesses regarding AD discussions and documentation thereof. Employees need to consistently ask inpatients whether they want to discuss ADs, and when patients request a discussion about ADs, clinicians need to consistently document that the discussion occurred. Clinicians need to use only the two VHA standardized note titles for AD discussions.

[1] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
[2] VHA Handbook 1004.02.

Recommendations

1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that employees consistently ask inpatients whether they want to discuss advance directives and that facility managers monitor compliance.

2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when inpatients request a discussion about advance directives, clinicians consistently document that the discussion occurred using only the two Veterans Health Administration standardized note titles for advance directive discussions and that facility managers monitor compliance.

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: August 24, 2016

From: Under Secretary for Health (10)

Subject: **Office of Inspector General (OIG) Draft Report, Combined Assessment Program Summary Report – Evaluation of Advance Directives in Veterans Health Administration Facilities (Project No. 2016-03960-HI-0684) (VAIQ 7724764)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the draft report, Evaluation of Advance Directives in Veterans Health Administration Facilities. The Veterans Health Administration (VHA) is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the Department of Veterans Affairs (VA) health care system. VHA is using the input from VA's Office of Inspector General, and other advisory groups to identify root causes and to develop critical actions. As VHA implements corrective measures, we will ensure our actions are meeting the intent of the recommendations. VHA is dedicated to sustained improvement in the high risk areas.

2. The recommendations in this report apply to GAO high risk areas 1 and 4. VHA's actions will serve to address ambiguous policies, inconsistent processes, and inadequate training for VA staff.

3. I have reviewed the draft report, and provide the attached action plan to address the report's recommendations.

4. If you have any questions, please email Karen M. Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

David J. Shulkin, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Combined Assessment Program Summary Report – Evaluation of Advance Directives in VHA Facilities

Date of Draft Report: July 26, 2016

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, ensure that employees consistently ask inpatients whether they want to discuss advance directives and that facility managers monitor compliance.

VHA Comments: Concur

All Veterans who have decision-making capacity have the right to accept or refuse proposed treatments or procedures, to designate a health care agent who will make health care decisions on their behalf if they lose decision-making capacity, and to document their treatment preferences in an advance directive. The OIG's 2016 CAP review on advance directives highlights these rights and provides recommendations that will help ensure that Veterans are asked whether they would like to have a discussion with a clinician about advance directives and that these discussions are documented in an easy-to-find place in the electronic health record.

Requirements surrounding advance directive screening and documentation of advance directive discussions are outlined in VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives which is managed by the VHA National Center for Ethics in Health Care (NCEHC). Advance directive screening requires that, "All patients and CLC residents must be asked whether they want more information about advance directives and whether they want assistance in completing the advance directive forms" (paragraph 6, page 6). In addition, to ensure that information about these discussions is easy to locate in the electronic health record, the Handbook requires that two specific note titles are used: "The 'Advance Directive Discussion' note title is used to document an advance care planning discussion between the practitioner and patient. Discussion about an advance directive that is already in the health record may be documented either with a note titled 'Advance Directive Discussion,' or in an addendum to the 'Advance Directive' note associated with the subject directive" (paragraph 5, page 5).

The positive practices that are noted in the 2016 OIG report may reflect NCEHC's interventions since the 2011 OIG CAP review on advance directives. Since that time, NCEHC has continued to enhance awareness and understanding of advance directive processes in VHA by publishing and extensively communicating a revised version of the Handbook in 2013, and developing and disseminating a variety of educational tools, including an FAQ document and a series of webinar trainings for staff who provide information and assistance with completing advance directives. The NCEHC has delivered the webinar to over 9,000 registered participants over the last four years. We have also provided trainer materials so that the training can be delivered locally, using a PowerPoint and script available on the NCEHC's website for local use.

NCEHC welcomes the opportunity to continue supporting positive practices and to develop a plan to define and assess improvements demonstrating that patient's rights regarding advance directives are respected and information about their advance directive discussions are easily located in the record.

To promote employee engagement, support the field, and complete this recommendation, VHA will:

- Develop and deliver targeted communications to key facility leadership and staff about readily available advance directive resources and education to support adoption of required practices with respect to asking inpatients whether they want to discuss advance directives.
- Develop and deliver enhanced webinar training for staff who are responsible for screening, providing information about advance directives, and assisting Veterans with completing advance directives. Nurses and social workers will be targeted for these trainings as they are the clinical professionals who most commonly perform these functions.
- Develop and deliver a pre-populated Preventive Ethics storyboard, a quality improvement tool that can be used by facilities to address, through the application of quality improvement principles, the screening quality gap recognized in this recommendation. The information within the tool will outline and provide guidance on closing the quality gap.
- Work with the national and facility Quality Management Officers and other subject matter expert offices to provide these educational interventions and develop a plan for defining, assessing and reporting improvements at 12 months.

Status:	Target Completion Date:
In Process	August 15, 2017

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when inpatients request a discussion about advance directives, clinicians consistently document that the discussion occurred using only the two Veterans Health Administration standardized note titles for advance directive discussions and that facility managers monitor compliance.

VHA Comments: Concur

All Veterans who have decision-making capacity have the right to accept or refuse proposed treatments or procedures, to designate a health care agent who will make health care decisions on their behalf if they lose decision-making capacity, and to document their treatment preferences in an advance directive. The OIG's 2016 CAP review on advance directives highlights these rights and provides recommendations that will help ensure that Veterans are asked whether they would like to have a discussion with a clinician about advance directives and that these discussions are documented in an easy-to-find place in the electronic health record.

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NCEHC welcomes the opportunity to continue supporting positive practices and to develop a plan to define and assess improvements demonstrating that patient's rights

regarding advance directives are respected and information about their advance directive discussions are easily located in the record.

To promote employee engagement, support the field, and complete this recommendation, VHA will:

- Develop and deliver targeted communications to key facility leadership and staff about readily available resources and education to support adoption of required practices with respect to documenting advance directive discussions using only the two VHA approved note titles.
- Develop and deliver enhanced webinar training for staff who are responsible for screening, providing information about advance directives, and assisting Veterans with completing advance directives. Nurses and social workers will be targeted for these trainings as they are the clinical professionals who most commonly perform these functions.
- Develop and deliver a pre-populated Preventive Ethics storyboard, a quality improvement tool that can be used by facilities to address, through the application of quality improvement principles, the quality gap regarding documentation of advance directive discussions recognized in this recommendation. The information within the tool will outline and provide guidance on closing the quality gap.
- Work with the national and facility Quality Management Officers and other subject matter expert offices to provide these educational interventions and develop a plan for defining, assessing and reporting improvements at 12 months.

Status:	Target Completion Date:
In Process	August 15, 2017

Office of Inspector General
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