DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Summary Report: Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2020

CHIP REPORT | REPORT #21-01505-68 | FEBRUARY 10, 2022

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Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
GoCC	goals of care conversation
LST	life-sustaining treatment
LSTD	life-sustaining treatment decisions
OIG	Office of Inspector General
VHA	Veterans Health Administration

Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years. The OIG selects and evaluates specific areas of focus each year.

The purpose of this report's evaluation was to determine whether VHA facility leaders and clinicians complied with selected program requirements related to life-sustaining treatment decisions for hospice patients. The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. These inspections involved interviews with key staff and reviews of clinical and administrative processes. The OIG also randomly selected and reviewed electronic health records from five additional facilities but did not conduct site visits or issue individual reports to these facilities because of COVID-19 restrictions.[1] The results in this report are a snapshot of VHA performance at the time of the fiscal year 2020 OIG reviews and may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.[2]

Inspection Results

During the time frame of this retrospective review, VHA policy required certain elements of goals of care conversations to be documented in patients' electronic health records. However, in March 2020, VHA revised this policy to require fewer elements. The OIG observed general compliance with the selected requirements after these rules were updated during the review period. Under VHA's original requirements that were in place when patients received their care, the OIG estimated that providers did not consistently

- identify a surrogate should the patient lose decision-making capacity;
- address previous advance directives, state-authorized portable orders, and/or life-sustaining treatment plans; or
- address the patient or surrogate's understanding of the patient's condition.[3]

[1] The five facilities were: VA Central Iowa Health Care System in Des Moines; VA Black Hills Health Care System in Fort Meade, South Dakota; Iowa City VA Health Care System in Iowa; Minneapolis VA Health Care System in Minnesota; and VA Nebraska-Western Iowa Health Care System in Omaha.

[2] Fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020.

[3] Detailed statistical analyses can be found within the Results and Recommendations section of this report.

VHA requires that medical records be timely, relevant, necessary, and complete. "Completeness implies that all required data is present and authenticated."[4] VHA changed documentation requirements on March 19, 2020, for the above steps in caring for patients with life-sustaining treatment decisions. The OIG is concerned that care may be provided but not clearly and completely reflected in patients' electronic health records, and the updated requirements could mislead practitioners to address only those goals of care conversation elements that are required to be documented in the life-sustaining treatment progress note.

Conclusion

The OIG conducted detailed inspections at 36 VHA medical facilities and electronic health record reviews at these and five additional facilities to ensure staff implemented life-sustaining treatment decision processes for hospice patients. The OIG found discrepancies in practice that do not reflect or support the importance of ensuring complete goals of care conversations or maintaining a complete medical record. The OIG did not issue recommendations but developed this summary report for the Under Secretary for Health, Veterans Integrated Service Network directors, and facility senior leaders to consider when improving operations and clinical care at VHA facilities.

VA Comments and OIG Response

The Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health, concurred with the comprehensive healthcare inspection report (see appendix B, pages 9–10). The OIG responded to VHA's concern that all elements of goals of care conversations must be documented in a single progress note in an addendum to appendix B (see page 10).

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Assistant Inspector General
for Healthcare Inspections

[4] VHA Handbook 1907.1, *Health Information Management and Health Records*, April 15, 2004.

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Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

The OIG selects and evaluates specific areas of focus on a rotating basis each year. The evaluation of VHA facilities' care coordination processes is a recurring review topic because the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.[1] These leaders are directly accountable for program integration and communication within their level of responsibility.

The purpose of this report's evaluation was to determine whether VHA facility leaders and clinicians complied with selected requirements for life-sustaining treatment decisions (LSTD) for hospice patients.

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. LSTs may include artificial nutrition, hydration, and mechanical ventilation. VHA issued an LSTD handbook in January 2017 to standardize practices related to discussing and documenting goals of care and LSTD.[2] Per VHA, the intent is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "eliciting, documenting, and honoring patients' values, goals, and preferences."[3]

VHA healthcare facilities were expected to fully implement new procedures outlined in the LSTD handbook by July 11, 2018. Implementation requirements included initiating conversations about the goals of care. A goals of care conversation (GoCC) is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and based on the discussion, make choices about starting, limiting, or ceasing LSTs.[4] VHA requires practitioners to initiate GoCCs with high-risk

[1] Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. No. 111-163, § 505 (2010).
[2] VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.
[3] VHA Handbook 1004.03. (This handbook was in place for the time frame reviewed for this report. The handbook was amended on March 19, 2020 (1004.03(1)), and again on May 10, 2021 (1004.03 (2)). All handbook versions contain the same or similar language related to LSTD.)
[4] VHA Handbook 1004.03. A surrogate is authorized under VA policy to serve as the decision maker on behalf of the patient should the patient lose decision-making capacity.

patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[5]

VHA policy defined the elements of a GoCC to be documented in an LST progress note in the electronic health record, which included

- decision-making capacity;
- identification of a surrogate should the patient lose decision-making capacity;
- patient or surrogate understanding of the patient's condition;
- goals of care;
- plan of care for the use of LST, including whether cardiopulmonary resuscitation will be attempted in the event of cardiac arrest; and
- informed consent for the LST plan.[6]

However, on March 19, 2020, VHA amended the requirements related to documenting patients' goals of care. Although the elements of the GoCC are still required, practitioners are only required to document four elements in the LST progress note:

- Decision-making capacity
- Goals of care
- Plan of care for the use of LST
- Informed consent for the LST plan[7]

The OIG is concerned that the requirement changes could mislead practitioners to address only those GoCC elements that are now required to be documented in the LST progress note.

VHA facilities were assessed for adherence to the requirements for GoCCs, including

- completion of LSTD notes,

[5] VHA Directive 1139, *Palliative Care Consult Teams (PCCT) and VISN Leads*, June 14, 2017. Hospice patients are defined as individuals diagnosed with a terminal condition with a life expectancy of six months or less if the disease runs its projected course. VHA Handbook 1004.03(2). Triggering events requiring GoCCs include "prior to referral or following admission (e.g., within 24 hours) to VA or non-VA hospice."

[6] VHA Handbook 1004.03. (This handbook was in place for the time frame reviewed for this report. The handbook was amended on March 19, 2020 (1004.03(1)), and again on May 10, 2021 (1004.03(2)). The handbook versions all contain the same or similar language related to informed consent for the LSTD plan.)

[7] "Frequently Asked Questions: New Amendment to VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting, and Honoring Patient's Values, Goals, and Preferences (originally published January 11, 2017)," VHA, accessed March 24, 2020, https://vaww.ethics.va.gov/LST/AmendmentFAQs.pdf. (This is an internal VA website not publicly accessible.)

- timely documentation of LSTD,
- inclusion of required elements in LSTD documentation, and
- completion of LSTD notes/orders by an authorized provider or delegation to a designee who met all requirements.

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be comprised of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[8] Inspectors determined if facilities established an LSTD committee, verified multidisciplinary membership and representation from the Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether facilities implemented LSTD for hospice patients, the OIG reviewed relevant documents, interviewed key employees, and reviewed the electronic health records of 1,721 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

The results in this summary report are a snapshot of national-level VHA performance at the time of the fiscal year 2020 OIG reviews and may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.[9]

[8] VHA Handbook 1004.03. (This handbook was in place for the time frame reviewed for this report. The handbook was amended on March 19, 2020 (1004.03(1)), and again on May 10, 2021 (1004.03(2)).) The handbook versions all contain the same or similar language related to the multidisciplinary committee.

[9] Fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020.

Methodology

To determine whether VHA facilities complied with selected program requirements related to LSTD, the OIG initiated comprehensive healthcare inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. The OIG interviewed key staff and reviewed clinical and administrative processes. The OIG also randomly selected and reviewed the electronic health records of 1,721 patients from July 12, 2018, through June 30, 2019. This electronic health record review also included patients from five additional facilities that did not have CHIP site visits.[10] The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks.

Except for the five facilities without site visits, the OIG published individual CHIP reports for each facility. For this report, the OIG analyzed data from the individual facility reviews to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance for the areas discussed.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[11] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[10] The five facilities were: VA Central Iowa Health Care System in Des Moines; VA Black Hills Health Care System in Fort Meade, South Dakota; Iowa City VA Health Care System in Iowa; Minneapolis VA Health Care System in Minnesota; and VA Nebraska-Western Iowa Health Care System in Omaha.

[11] Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

VHA defines a high-risk patient as one who is likely to encounter a life-threatening clinical event because of serious medical conditions that are "associated with a significantly shortened lifespan."[12] This includes hospice patients who are "diagnosed with a known terminal condition with a prognosis of 6 months or less if the disease runs its normal course."[13] The OIG assessed compliance with selected requirements for LSTD for hospice patients.

Findings and Recommendations

The OIG observed general compliance with adherence to GoCCs, which included completion of LSTD notes, timely documentation of LSTD, inclusion of required elements in LSTD documentation, completion of LSTD notes/orders by an authorized provider or delegate, and establishment of an LSTD committee with multidisciplinary membership. For VHA's original requirements that were in place when the patients received care, the OIG estimated that

- 21 percent of patients' LST progress notes did not address identification of a surrogate should the patient lose decision-making capacity;[14]
- 33 percent of patients' LST progress notes did not address previous advance directives, state-authorized portable orders, and/or LST plans; and[15]
- 21 percent of patients' LST progress notes did not address the patient or surrogate's understanding of the patient's condition.[16]

[12] VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017. (This handbook was in place for the time frame reviewed for this report. The handbook was amended on March 19, 2020 (1004.03(1)), and again on May 10, 2021 (1004.03(2)). The handbook versions all contain the same or similar language related to high-risk patients.)

[13] VHA Directive 1139, *Palliative Care Consult Teams (PCCT) and VISN Leads,* June 14, 2017.

[14] The OIG estimated that 95 percent of the time, the true compliance rate is between 71.6 and 85.3 percent, which is statistically significantly below the 90 percent benchmark.

[15] The OIG estimated that 95 percent of the time, the true compliance rate is bet ween 58.9 and 74.0 percent, which is statistically significantly below the 90 percent benchmark.

[16] The OIG estimated that 95 percent of the time, the true compliance rate is between 71.4 and 85.0 percent , which is statistically significantly below the 90 percent benchmark.

In March 2020, VHA removed requirements for the documentation of these elements in the LST progress note.[17] The OIG made no recommendations because general compliance was observed after these rules were updated. However, the OIG remains concerned that this change could result in an incomplete medical record, less effective communication between healthcare team members, and practitioners failing to address important GoCC elements.

[17] VHA "Frequently Asked Questions: New Amendment to VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting, and Honoring Patient's Values, Goals, and Preferences (originally published January 11, 2017)," accessed March 24, 2020, https://vaww.ethics.va.gov/LST/AmendmentFAQs.pdf. (This is an internal VA website not publicly accessible.)

Appendix A: Parent Facilities Inspected

Table A.1. Parent Facilities Inspected
(October 1, 2019, through September 30, 2020)

Names	City
VA Ann Arbor Healthcare System	Ann Arbor, MI
Charlie Norwood VA Medical Center	Augusta, GA
Battle Creek VA Medical Center	Battle Creek, MI
Birmingham VA Medical Center	Birmingham, AL
Boise VA Medical Center	Boise, ID
Ralph H. Johnson VA Medical Center	Charleston, SC
Jesse Brown VA Medical Center	Chicago, IL
Chillicothe VA Medical Center	Chillicothe, OH
Cincinnati VA Medical Center	Cincinnati, OH
Harry S. Truman Memorial Veterans' Hospital	Columbia, MO
Columbia VA Health Care System	Columbia, SC
VA Illiana Health Care System	Danville, IL
Dayton VA Medical Center	Dayton, OH
Atlanta VA Health Care System	Decatur, GA
John D. Dingell VA Medical Center	Detroit, MI
Carl Vinson VA Medical Center	Dublin, GA
Edward Hines, Jr. VA Hospital	Hines, IL
Oscar G. Johnson VA Medical Center	Iron Mountain, MI
Kansas City VA Medical Center	Kansas City, MO
William S. Middleton Memorial Veterans Hospital	Madison, WI
Marion VA Medical Center	Marion, IL
VA Northern Indiana Health Care System	Marion, IN
Clement J. Zablocki VA Medical Center	Milwaukee, WI
Central Alabama Veterans Health Care System	Montgomery, AL
Captain James A. Lovell Federal Health Care Center	North Chicago, IL
John J. Pershing VA Medical Center	Poplar Bluff, MO
VA Portland Health Care System	Portland, OR
Roseburg VA Health Care System	Roseburg, OR
Aleda E. Lutz VA Medical Center	Saginaw, MI
VA Puget Sound Health Care System	Seattle, WA

Names	City
Mann-Grandstaff VA Medical Center	Spokane, WA
VA St. Louis Health Care System	St. Louis, MO
Tomah VA Medical Center	Tomah, WI
VA Eastern Kansas Health Care System	Topeka, KS
Tuscaloosa VA Medical Center	Tuscaloosa, AL
Robert J. Dole VA Medical Center	Wichita, KS

Source: VA OIG.

Appendix B: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: December 23, 2021

From: Deputy Under Secretary for Health, Performing the Delegable Duties of Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2020 (2021-01505-HI-1149) (VIEWS 6437829)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2020. The Veterans Health Administration (VHA) concurs with the report.

2. VHA agrees that patients' medical records must be timely, relevant, and complete. Comprehensive documentation is necessary to ensure that clinicians are aware of and can honor patients' Life-sustaining treatments (LSTs) plans. VHA is concerned that OIG's draft report attempts to set a dangerous and incorrect expectation that all elements of Goals of Care Conversations (GoCCs) must be documented in a single progress note. VHA's expectations and policy are for clinicians to conduct GoCCs iteratively; meaning that GoCCs should occur over time. For example, at a first visit the patient may be ready to discuss their values and goals, but not yet ready to discuss surrogacy or make decisions about life-sustaining treatments (LSTs). These sensitive conversations often involve team members from multiple disciplines. For example, only the practitioner is authorized to establish the LST plan with the patient, but the nurse or social worker may be uniquely qualified to introduce the conversation, discuss surrogates, or conduct a family meeting. This iterative, multidisciplinary process is and should be documented across multiple progress notes. Requiring all elements of a high-quality GoCC process to be documented in just one progress note could press clinicians into dangerously rushing through these important conversations without allowing patients and their

loved ones time to work through their emotions or concerns privately. It could pressure clinicians to forego consideration of important input and engagement from appropriate team members, ultimately resulting in poorly developed goals of care, hasty LST plans, and patients receiving care that does not align with their core values.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D.

Addendum to the Memorandum: OIG Response

The OIG appreciates the feedback from VHA and provides the following response to the Deputy Under Secretary for Health's concern that OIG's draft report attempts to set a dangerous and incorrect expectation that all elements of GoCCs must be documented in a single progress note. The OIG recognized that GoCCs may take place over several meetings with patients and caregivers and acknowledged any documentation of such conversations found in the patients' progress notes. The OIG remains concerned that VHA's updated requirement could mislead practitioners to address only those GoCC elements that are required to be documented in the LST progress note.

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