Advance Care Planning, MOLST & eMOLST: Improving Quality & Achieving the Triple Aim

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Discussion Points

- Fundamentals of palliative care & ACP
- Advance Directives vs. MOLST
- MOLST Process
  - Who is appropriate for MOLST?
  - Who should be part of the conversation?
  - Completing the MOLST form
  - Which laws do we need to follow?
  - What documentation is required?
- Alignment with value-based care, ACOs & DSRIP
  - Billing
- eMOLST Application

Palliative Care

Interdisciplinary care

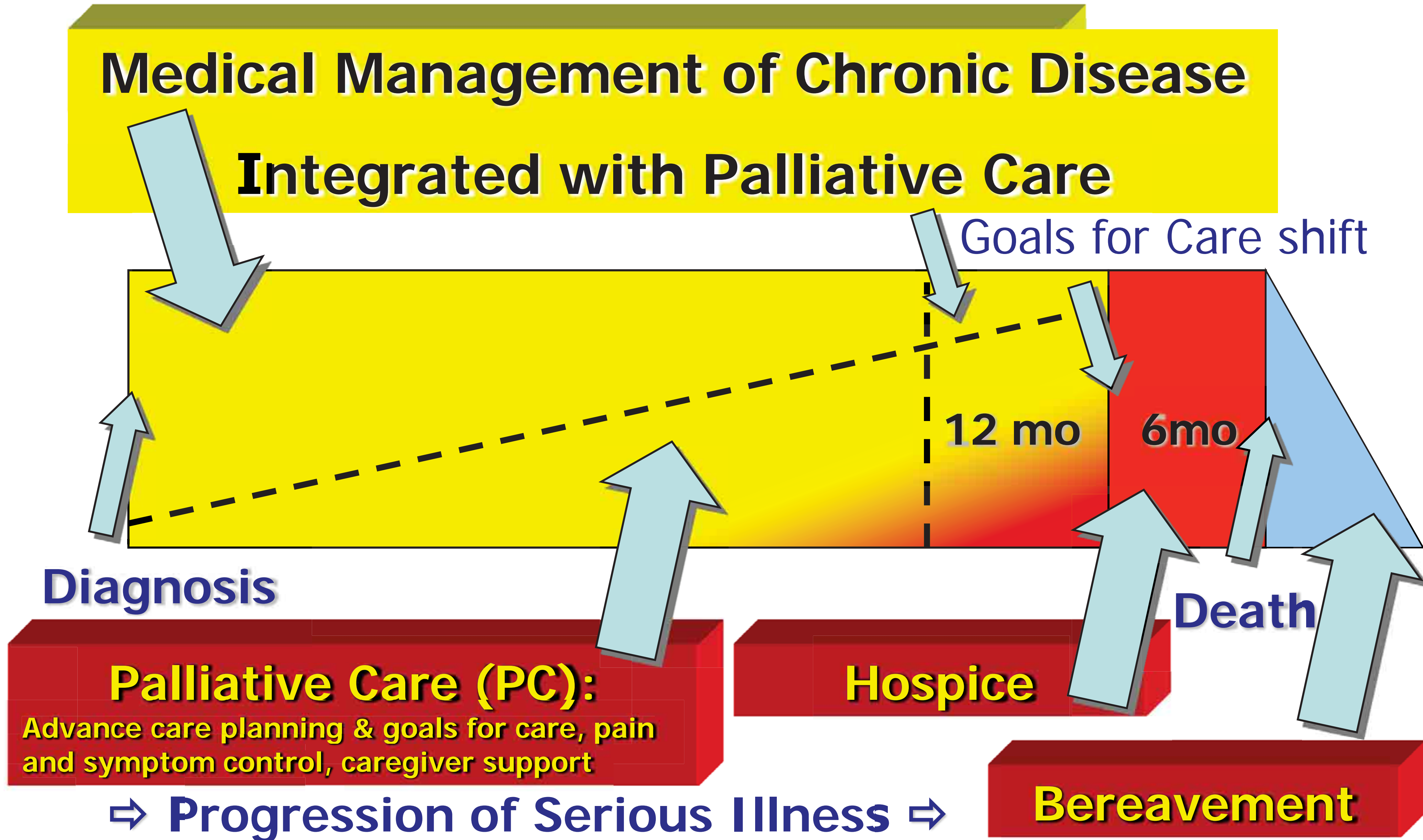
- aims to relieve suffering and improve quality of life for patients with advanced illness and their families
- offered simultaneously with all other appropriate medical treatment from the time of diagnosis
- focuses on quality of life and provides an extra layer of support for patients and families

Three Key Pillars with Psychosocial & Spiritual Support

- Advance Care Planning and Goals for Care
  - Step 1: Community Conversations on Compassionate Care*
  - Step 2: Medical Orders for Life-Sustaining Treatment (MOLST)*
- Pain and Symptom Management
- Caregiver Support

*A Project of the Community-Wide End-of-life/Palliative Care Initiative

Continuum of Care Model for Patients with Serious Illness



Advance Care Planning

Compassion, Support and Education along the Health-Illness Continuum

Advancing chronic illness

Chronic disease or functional decline

Multiple co-morbidities, with increasing frailty

Healthy and independent

Maintain & maximize health and independence

Death with dignity

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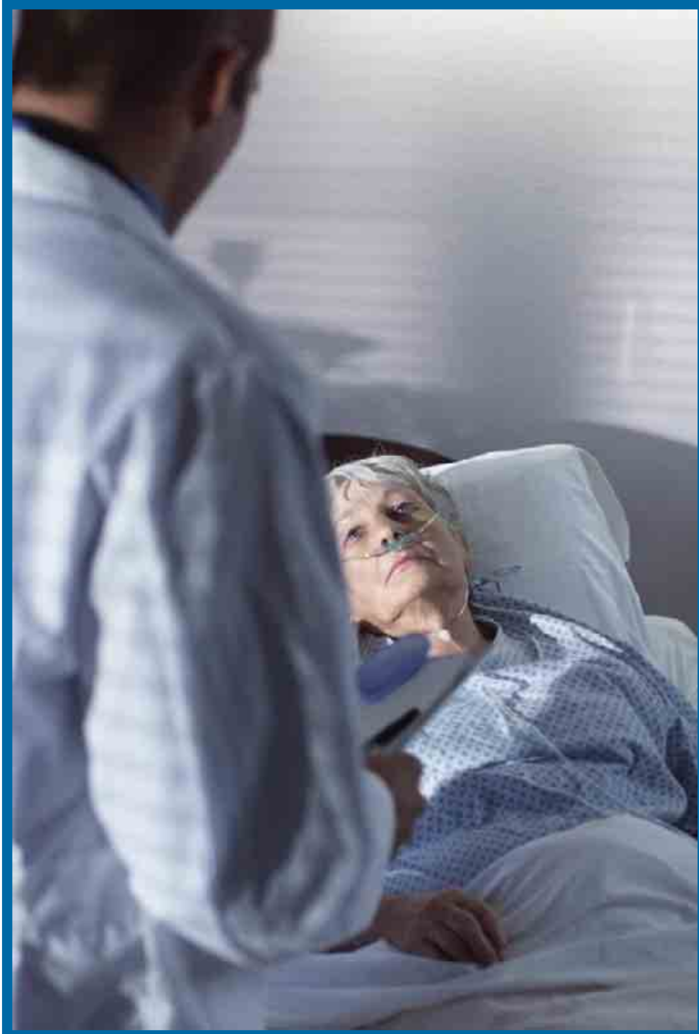
What is Advance Care Planning?

- Process of planning for future medical care in case you are unable to make your own medical decisions.
- Assists you in preparing for a sudden, unexpected illness form which you expect to recover, as well as the dying process and ultimately death.
- Incorporates family conversations & form completion
- Appropriate for everyone 18 and older!
- **Across Upstate NY nearly 90% of people said health care proxy completion was important, but most have not taken the time to do it.**
  - **In the Rochester area 47% have done a HCP**
  - **In the Southern Tier area 44% have done a HCP**

Benefits of Advance Care Planning



- "Gift" to self and family
- Maintain Control
- "Write the Final Chapter"
- Achieve Peace of Mind
- Assure Wishes are Honored
- Begin conversation
- Build trust & establish relationship
- Reduce uncertainty
- Help to avoid confusion and conflict

Health Care Proxies

- Designates someone to make medical decisions for you if you lose the ability to do so
- Choosing the right health care agent is critical
- Agents can only be designated by the patient
- Recommended to name at least one primary agent and one backup agent
- Requires 2 witnesses: age 18 or older and not the health care agent(s)
- Does not require an attorney or notary
- Should include conversations with family!

Disparity between consumer attitudes & actions regarding health care proxies

	UPSTATE	ROCH	CNY	UTICA	S. TIER	WNY
VERY/FAIRLY IMPORTANT	88%	85%	88%	90%	90%	89%
COMPLETED THE HEALTH CARE PROXY FORM	42%	47%	40%	35%	44%	44%

End-of-Life Care Survey of Upstate New Yorkers:
Advance Care Planning Values and Actions,
Summary Report, 2008

Living Wills

- Only can be used for “terminal” and “irreversible” conditions
- Often are too specific, or too vague
- Can’t be implemented in an emergency
- Can’t be directly followed by medical professionals
- Requires 2 witnesses age 18 or older
- Does not require an attorney or notary
- Should include conversations with family!

Community Conversations on Compassionate Care

MOLST

MEDICAL ORDERS FOR

Five Easy Steps

1. Learn about advance directives
   - NYS Health Care Proxy
   - NYS Living Will
   - Advance Directives from Other States
2. Remove barriers
3. Motivate yourself
   - View CCCC videos
4. Complete your Health Care Proxy and Living Will
   - Have a conversation with your family
   - Choose the right Health Care Agent
   - Discuss what is important to you
   - Understand life-sustaining treatment
   - Share copies of your directives
5. Review and Update

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Employee Survey Data

- Excellus BCBS has been surveying employees on ACP practices since 2002
- Online survey with 23 questions
- Health care proxy awareness & knowledge rates reach 99%
- Completion rates have reached 60% and plateaued
- Focused efforts on improving ACP among employees increased HCP completion from 43-57% in 2008-2009
- Happy to share survey tool so you can replicate locally

Health Care Proxy Completion Rates
Comparison to National Metrics

Have Designated a Heath Care Proxy and Completed the Form

	2002	2006	2008	2009	2011	2012	2013	2014	2015
National	20%	29%		26%					
Excellus	30%	33%	43%	57%	57%	58%	58%	57%	60%

Q3. Have you designated a Health Care Proxy and completed a Health Care Proxy form?

Sample Size: 2006 n=2057; 2008 n=2279; 2009q4 n=723; 2011 n=1629; 2012 n=1649; 2013 n=1695; 2014 n=1780; 2015 n=1237

my Name is...

Advance Directives and Actionable Medical Orders

Traditional ADs

For All Adults

Community Conversations on Compassionate Care (CCCC)

- New York
  - Health Care Proxy
  - Living Will
- Organ Donation
- State-specific forms: e.g. Durable POA for Healthcare

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CaringInfo.org

Actionable Medical Orders

For Those Who Are Seriously Ill or Near the End of Their Lives

Medical Orders for Life-Sustaining Treatment (MOLST) Program

- Do Not Resuscitate (DNR) Order
- Medical Orders for Life Sustaining Treatment (MOLST)
- Physician Orders for Life Sustaining Treatment (POLST) Paradigm Programs

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POLST.org

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Differences Between MOLST and Advance Directives

Characteristics	POLST	Advance Directives
Population	For the seriously ill	All adults
Timeframe	Current care	Future care
Who completes the form	Health Care Professionals	Patients
Resulting form	Medical Orders (POLST)	Advance Directives
Health Care Agent or Surrogate role	Can engage in discussion if patient lacks capacity	Cannot complete
Portability	Provider responsibility	Patient/family responsibility
Periodic review	Provider responsibility	Patient/family responsibility

Bomba PA, Black J. The POLST: An improvement over traditional advance directives. Cleveland Clinic Journal of Medicine. 2012; 79(7): 457-64.

Definitions

- National POLST Paradigm: process of communication & shared decision making results in POLST; has established endorsement requirements
- POLST: Physician Orders for Life Sustaining Treatment - different states use different names to describe the state POLST program: such as MOLST, POST, LaPOST, MOST
- MOLST: New York State's Endorsed POLST paradigm program

ENDORSED
www.POLST.org

Why MOLST?

- More than a decade of research has proven that the POLST Program more accurately conveys end-of-life preferences and yields higher adherence by medical professionals.

Lee, Brummel-Smith, et al. JAGS. 2000; 48(10): 1219-1225
Meyers, et al. J Gerontol Nurs. 2004; 30(9): 37-46
Schmidt, Hickman, Tolle, Brooks. JAGS. 2004; 52(9): 1430-1434
Hickman, et al. JAGS 58:1241–1248, 2010

Research: Site of Death vs. Treatment Requested

POLST physician orders for life-sustaining treatment paradigm

MOLST MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT

- Death records: 58,000 people who died of natural causes in 2010 and 2011 in OR
- Nearly 31% of people who died: POLST forms entered in OR's POLST Registry
- Compared location of death with treatment requested
  - 6.4% of people with POLST forms who selected "comfort measures only" died in hospital
  - 34.2% of people without POLST forms in the registry died in the hospital

Compassion and Support at the End of Life CompassionAndSupport.org

Fromme, Erik et al (2014). *JAGS*, on-line June 9, 2014

DOH-5003 MOLST Form

Community-wide Medical Order Form

NEW YORK STATE DEPARTMENT OF HEALTH

Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☐ Female eMOLST NUMBER **(THIS IS NOT AN eMOLST FORM)**

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)

This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient's current medical condition, values, wishes and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders and changes them.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check one:

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**
CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law.

SIGNATURE ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

Who made the decision? ☐ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

SECTION C Physician Signature for Sections A and B

PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

PHYSICIAN LICENSE NUMBER PHYSICIAN PHONE/PAGER NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:
☐ Health Care Proxy ☐ Living Will ☐ Organ Donation ☐ Documentation of Oral Advance Directive

DOH-5003 (6/10) Page 1 of 4 *HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment.*

- Resuscitation instructions when the patient has no pulse and/or is not breathing (CPR or DNR)
- Instructions for intubation and mechanical ventilation when the patient has a pulse and the patient is breathing (DNI/trial/long-term)
- Treatment guidelines
- Future hospitalization/transfer
- Artificially administered fluids and nutrition
- Antibiotics
- Other instructions re: time-limited trial and other treatments (e.g. dialysis, transfusions, etc.)

Patients Have Right to Make Decisions
Nonhospital DNR Form = page 1 MOLST

NEW YORK STATE DEPARTMENT OF HEALTH

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LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☐ Female

eMOLST NUMBER **(THIS IS NOT AN eMOLST FORM)**

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- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

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SIGNATURE ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

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SECTION C **Physician Signature for Sections A and B**

PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

PHYSICIAN LICENSE NUMBER PHYSICIAN PHONE/PAGER NUMBER

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Check all advance directives known to have been completed:
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DOH-5003 (6/10) Page 1 of 4 *HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment.*

State of New York
Department of Health

Nonhospital Order Not to Resuscitate
(DNR Order)

Person's Name:________________________________

Date of Birth: _____/_____/_____

Do not resuscitate the person named above.

Physician's Signature __________________

Print Name ______________________

License Number __________________

Date _____/_____/_____

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart.

The issuance of a new form is **NOT** required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90 day period.

DOH-3474 (2/92)

MOLST and New York State Department of Health (NYSDOH)

- NYSDOH approved MOLST for statewide use in all settings in 2008.
- MOLST became a NYSDOH form in 2010.
- MOLST is the ONLY form approved by NYSDOH for both Do Not Resuscitate (DNR) and Do Not Intubate (DNI) orders.
- All healthcare professionals, including EMS, must follow the MOLST in all clinical settings, including the community.

MOLST: Who Should Have One?

Generally for patients with serious health conditions

- Wants to avoid or receive any or all life-sustaining treatment
- Resides in a long-term care facility or requires long-term care services
- Might die within the next year

MOLST Screening Questions

- Does the person express a desire to avoid or receive any or all life-sustaining treatment?
- Does the person live in a nursing home or receive long term care services at home or live in an ALF?
- Would you be surprised if the person dies in the next year?
- Does this person have one or more advanced chronic condition or a serious new illness with a poor prognosis?
- Does this patient have decreased function, frailty, progressive weight loss, >= 2 unplanned admissions in last 12 months, have inadequate social supports, or need more help at home?

Questions to Help an Individual Prepare for a MOLST Discussion

- What do you understand about your current health condition?
- What do you expect for the future?
- What makes life worth living?
- What is important to you?
- What matters most to you?
- How do you define quality of life?
- Would you trade quality of life for more time?
- Would you trade time for quality of life?

8-Step MOLST Protocol

1. Prepare for discussion
   - Understand patient's health status, prognosis & ability to consent
   - Retrieve completed Advance Directives
   - Determine decision-maker and NYSPHL legal requirements, based on who makes decision and setting
2. Determine what the patient and family know
   - re: condition, prognosis
3. Explore goals, hopes and expectations
4. Suggest realistic goals
5. Respond empathetically
6. Use MOLST to guide choices and finalize patient wishes
   - Shared, informed medical decision-making
   - Conflict resolution
7. Complete and sign MOLST
   - Follow NYSPHL and document conversation
8. Review and revise periodically

Developed for NYS MOLST, Bomba, 2005; revised 2011

Shared, Informed Medical Decision Making

- Will treatment make a difference?
- Do burdens of treatment outweigh benefits?
- Is there hope of recovery?
  - If so, what will life be like afterward?
- What does the patient value?
  - What is the goal of care?

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MOLST Instructions and Checklists

Ethical Framework/Legal Requirements

- Checklist #1 - Adult patients with medical decision-making capacity (any setting)
- Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)
- Checklist #3 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is a Public Health Law Surrogate (surrogate selected from the surrogate list)
- Checklist #4 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy or a Public Health Law Surrogate
- Checklist #5 - Adult patients without medical decision-making capacity who do not have a health care proxy, and the MOLST form is being completed in the community.
- Checklist for Minor Patients - (any setting)
- Checklist for Developmentally Disabled who lack capacity – (any setting) **must** travel with the patient's MOLST

http://www.nyhealth.gov/professionals/patients/patient_rights/molst/

FHCDA Surrogates

- Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
- Patient's spouse, if not legally separated from the patient, or the domestic partner
- Patient's son or daughter, age 18 or older
- Patient's parent
- Patient's brother or sister, age 18 or older
- Patient's actively involved close friend, age 18 or older

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Family Health Care Decisions Act, Laws of New York, Chapter 8. Effective June 1, 2010

Family Health Care Decisions Act

- DOES NOT eliminate the need for open and honest conversations with loved ones about your wishes and desires for medical care.
- DOES NOT eliminate the need for advance care planning or to have advance directives on file with your doctors, your attorney and your family members.

Care Plan to Support MOLST

- MOLST guides treatment in an emergency
- All patients are treated with dignity, respect and comfort measures
- Person-centered care plan based on patient choice
  - Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled
  - Treatments available for pain and symptoms
    - Effective pain management
    - Shortness of breath: oxygen and morphine
    - Nausea, vomiting, etc.
  - No feeding tube or No IV fluids
    - Offer food/fluids as tolerated using careful hand feeding
- Family, caregiver and staff education

Ensuring Effectiveness of MOLST Requires a Multidimensional Approach

- Culture change
- Provider training
- Community education & empowerment
- Thoughtful discussions
- Shared, informed decision-making
- Care planning that supports MOLST
- System implementation
- Dedicated system and physician champion
- Sustainable payment stream based on improved compliance with person-centered goals, preferences for care and treatment
  - improved resident/family satisfaction
  - reduced unwanted hospitalizations

Accountable Care Organizations and Innovative Payment Models

MOLST Takes Time

- Person-centered goals for care discussion
  - May require more than 1 session to complete
- Shared, informed medical decision making process
- Ethical framework/legal requirements
- Completion of form
- Family awareness of person's decision
  - Face-to-face
  - Non face-to-face
- Care Plan to support MOLST
- Goals and preferences may change
  - Discussion and MOLST form change
- Billing: as of 1/1/16 CMS pays for ACP discussions. See webinar here: https://www.youtube.com/watch?v=VCV26ZyGgwY

New York eMOLST: Definitions

- Form: Refers to MOLST form and the Chart Documentation Form (CDF) that documents the key elements of the discussion and process
- Users: persons with different clinical and administrative roles with regards to creating, updating, or accessing MOLST forms or other registry content
- EMR: Electronic Medical Record
- EHR: Electronic Health Record
- Registry: Electronic database centrally housing MOLST forms and CDFs to allow 24/7 access in an emergency
- eMOLST: electronic form completion system for MOLST that serves as the NYeMOLST Registry

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New York eMOLST

- An electronic system that guides clinicians and patients through a thoughtful discussion and MOLST process.
- eMOLST makes sure MOLST is completed correctly and ensures it is accessible.
- Allows the clinician to print a copy of the eMOLST form on bright pink paper for the patient.
- Serves as the registry of NY eMOLST forms to make sure a copy of the medical orders and the discussion are available in an emergency.
- eMOLST is available statewide and accessed at NYSeMOLSTregistry.com.

eMOLST Produces MOLST and MOLST Chart Documentation Form

Align with NYSDOH Checklists

Why eMOLST?

- Adds value
- Improves quality outcomes & patient safety
- Reduces patient harm & improves legal outcomes
- Improves provider satisfaction
- Assures accessibility
- Provides a system-based solution
- Achieves the triple aim

eMOLST Aligns with New Value-Based, Accountable Care Models

- Improves quality: discussion of personal-centered values, beliefs and goals for care drives choice of life-sustaining treatment
- Honors individual preferences: provides MOLST orders and copy of discussion across care transitions
- Reduces unnecessary and unwanted hospitalizations, ED use, service utilization and expense

eMOLST Case, CNY, 2014

- Elderly gentleman with multiple medical problems, including COPD with recurrent acute respiratory exacerbations & recurrent hospitalizations
- Has Health Care Proxy, MOLST form
- Presents to ER with acute respiratory insufficiency; MOLST form left on refrigerator
- Patient evaluated & treated
- Plan: intubation & mechanical ventilation and transfer to SUNY Upstate
- MD in ER signed into eMOLST – goals for care: functionality, remain at home; MOLST: DNR & DNI
- Patient admitted, treated conservatively, discharged home

New York eMOLST

- If you would like to use eMOLST please visit NYSeMOLSTregistry.com.

Contacts

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Questions?

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