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

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CompassionAndSupport.org
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

Medical Management of Chronic Disease

Integrates with Palliative Care

Goals for Care shift

Diagnosis

Palliative Care (PC):
Advance care planning & goals for care, pain and symptom control, caregiver support

Progression of Serious Illness

Hospice

Bereavement
Advance Care Planning

Compassion, Support and Education along the Health-Illness Continuum

Advancing chronic illness

Chronic disease or functional decline

Healthy and independent

Maintain & maximize health and independence

Death with dignity

Multiple co-morbidities, with increasing frailty

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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 from 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

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

**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

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

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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CaringInfo.org

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## Differences Between MOLST and Advance Directives

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

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
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
Schmidt, Hickman, Tolle, Brooks. JAGS. 2004; 52(9): 1430-1434
Research: Site of Death vs. Treatment Requested

- 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

DOH-5003 MOLST Form
Community-wide Medical Order Form

- 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.)
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?
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

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.
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.

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