Session Objectives

- Define the key issues in, obstacles to, and requirements for improving end-of-life care

- Illustrate how one community initiative, New York’s eMOLST (Medical Orders for Life-Sustaining Treatment), improves quality and patient safety, ensures accessibility and achieves the triple aim

- Outline a multidimensional approach health plans can follow to support the 2014 IOM Dying in America recommendations
What Do Common Ways of Dying Look Like?

How Americans Wish to Die
Medicare payments in last year of life account for 25% of all Medicare spending


“30% of health care is unnecessary or harmful”

How do we shift the cultural mindset from “more treatment is better” to “the right treatment and care, and no more?”

Triple Aim, Institute of Healthcare Improvement
Choosing Wisely Campaign. An Initiative of the ABIM Foundation
Community Needs Assessment
Honing Patient Preferences for EOLC

- IOM Report Approaching Death: Improving Care at the EOL, 1997
  - Gaps in care and quality issues
    - Location of death, pain management, treatment preferences and hospice admissions
  - RIPA/EBCBSRR EOL/Palliative Care Professional Advisory Committee, Regional Variations in Site of Death
- Community-Wide End-of-life/Palliative Care Initiative, 2001
  - Regional Variations in Cost of Care at EOL
  - Functional Health Illiteracy
  - Healthcare Professional Communication Skills

www.iom.edu/CMS/3909/12887.aspx
www.CompassionAndSupport.org/index.php/about_us
Community-wide End-of-life/Palliative Care Initiative

- Advance Care Planning
  - Community Conversations on Compassionate Care
- Honoring Preferences
  - Medical Orders for Life-Sustaining Treatment (MOLST)
  - Guidelines for Long Term Feeding Tube Placement
- Pain Management and Palliative Care
  - Community Principles of Pain Management
  - CompassionNet
- Education and Communication
  - Education for Physicians on End-of-life Care (EPEC)
  - Community web site: CompassionAndSupport.org

Community-Wide EOL/Palliative Care Initiative, Launch May 2001

Six Steps to Develop and Implement:
Community-wide End-of-life/Palliative Care Initiative

1. Define Vision, Mission, Values
2. Employ results-oriented approach
3. Design effective, inclusive coalition membership
4. Create effective leadership
5. Demonstrate strong commitment to purpose
6. Monitor performance
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
Integrated with Palliative Care

Goals for Care shift

Diagnosis

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

Hospice

Progression of Serious Illness

Bereavement
IOM Report Dying in America

- Delivery of person-centered, family-oriented care
- Clinician-patient communication and advance care planning
- Professional education and development
- Policies and payment systems
- Public education and engagement

Key Recommendations
Policies and Payment Systems Actions

- Encourage states to develop and implement a Physician Orders for Life-Sustaining Treatment (POLST) paradigm program in accordance with nationally standardized core requirements
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

*As of 2006*
Chronic disease or functional decline

Advancing chronic illness

Multiple co-morbidities, with increasing frailty

Healthy and independent

Maintain & maximize health and independence

Death

Advance Care Planning

Compassion, Support and Education along the Health-Illness Continuum

© Patricia A. Bomba, MD, MACP
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

Differences Between POLST/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>

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, 2001-2003

Disparity between consumer attitudes & actions regarding health care proxies

Public-Private Partnership

Medical Orders for Life-Sustaining Treatment (MOLST) Program – More Than a NYSDOH Form

- Standardized clinical process
- Discussion of patient’s values & goals for care
- Shared medical decision-making between health care professionals and seriously ill patients
- Documentation of discussion
- **Result**: portable medical orders
- reflect the patient’s preference for life-sustaining treatment they wish to receive or avoid
- common community-wide form

https://www.nysemolstregistry.com

https://www.health.ny.gov/professionals/patients/patient_rights/molst/
Patients Have Right to Make EOL Decisions

MOLST vs. Nonhospital DNR Form

https://www.health.ny.gov/professionals/patients/patient_rights/molst/

MOLST Legislation/Regulation

NYSDOH and OPWDD

- 2005: NYSDOH approved MOLST for use in all health care facilities
- 2008: MOLST signed into NYPHL. NYSDOH approved MOLST for statewide use in all settings, including the community*
- 2009: HEAL 5 grant to RRHIO includes eMOLST
- 2010: MOLST became a NYSDOH form; FHCDA passed
- 2011: OPWDD approved use of MOLST in the community 1/21/11; OPWDD Checklist must be completed & accompany the MOLST
- 2011: NYeMOLSTregistry.com complies with FHCDA/§1750-b
- 2015: IPRO CMS Special Innovations Project Award for eMOLST

* 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 settings.
NYSPHL Medical Decision Making
Persons with DD/ID

- 1969 – 17A Guardian
- 2003 – Surrogate’s Court Procedure Act (SCPA) § 1750-b (allows a guardian of a person with DD to make end-of-life (eol) health care decisions)
- 2005 – SCPA § 1750-b – Person with DD with capacity can make EOL decisions
- 2007 – Expanded authority of guardians to include involved family members
- 2010 – FHCUDA – surrogate decision-making follows § 1750-b
- January 21, 2011 – OPWDD approved use of DOH MOLST for those served in the OPWDD system
  - MUST use the OPWDD MOLST Legal Requirements Checklist & attach
  - Special procedures (SCPA § 1750-b) must be followed before MOLST is signed

https://www.health.ny.gov/professionals/patients/patient_rights/molst/

Key NYS Public Health Law

- Health Care Proxy Law
- MOLST
- Family Health Care Decisions Act (FHCUDA)
- Surrogate Decision Making Act for Persons with ID/DD § 1750-b
- Palliative Care Information Act (PCIA)
- Palliative Care Access Act (PCAA)
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

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
AFTER FHCDA: 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

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
Potential Barrier to Thoughtful MOLST Discussions

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

Key Recommendations

Policies and Payment Systems Actions

Provide financial incentives for:
- medical and social support services that decrease the need for emergency room and acute care services
- coordination of care across settings and providers (from hospital to ambulatory settings as well as home and community)
- improved shared decision making and advance care planning that reduces the utilization of unnecessary medical services and those not consistent with a patient’s goals for care
CMS Approves Advance Care Planning CPT Codes

- Two new codes: 99497 and 99498
- Reimbursement to health care professionals for providing advance care planning services to Medicare and Medicaid members
- Advance care planning is an integral component of the practice of medicine
- Overcomes a key barrier

Why There Are Failure in Following MOLST Orders

- 82 yo woman with multiple medical problems and frailty receives all care in one health system
- Hospitalized in early December; transferred to NH for rehab. **MOLST done at SNF**: CPR, DNI, No feeding tube; MD signature illegible, no license # or printed name; no documentation of discussion or capacity available at transfer.
- Hospitalized in January in different system; no medical records
- Admission orders: **DNR, DNI**; no documentation of discussion, capacity determination
- Family unaware of MOLST or DNR/DNI order
**Why There Are Failure in Following MOLST Orders**

- Patient develops acute respiratory insufficiency, hypoxia & lacks ability to make decisions
- **Family discussion:** family asserts patient did not have capacity to make decisions in early December or at time of admission; family unaware of MOLST or DNR/DNI
- Family asks to rescind DNR, DNI. Patient intubated.
- **Clinical assessment:** successful vent wean unlikely
- Family alleges person centered values & beliefs: DNI acceptable, terminal wean off ventilator is not acceptable
- **Staff moral distress:** disregard of patient preferences & requests Ethics Consultation

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**Why There Are Failure in Following MOLST Orders**

- Clinicians, patients, families are unaware of their obligations to follow MOLST and implications of failure to follow MOLST
- Advance care planning is not recognized as a dynamic process, including MOLST
  - Emphasis should be on **communication**
  - Forms are the end of the process

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Why There Are Failure in Following MOLST Orders

- Attention is given to the discussion, but ADs or MOLST are not completed or done incorrectly (incompatible orders)

- Avoiding early discussions or focusing on interventions, rather than personal values, beliefs and goals for care and #WhatMattersMost

- Wrong Health Care Agent is chosen


Why There Are Failure in Following MOLST Orders

- Lack of understanding of the differences between advance directives (HCP, LW) and medical orders (MOLST)

- Failure to assess and document capacity & other legal requirements

- Lack of accessibility to MOLST and documentation of the discussion

Recommendations

- Strengthen clinician training
- Encourage public education and engagement in advance care planning
- Expand use of eMOLST

Key Recommendations
Policies and Payment Systems Actions

- Require the use of interoperable electronic health records that incorporate advance care planning to improve communication of individuals’ wishes across time, settings, and providers, documenting:
  - the designation of a surrogate/decision maker
  - patient values and beliefs and goals for care
  - the presence of an advance directive
  - the presence of medical orders for life-sustaining treatment for appropriate populations

NY’s eMOLST highlighted in IOM Report
Research: Oregon POLST Registry
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


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.
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
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eMOLST Produces MOLST and MOLST Chart Documentation Form

MOLST and OPWDD MOLST Legal Requirements Checklist for Individuals with DD
MOLST/eMOLST: End-of-life Care Transitions Program

Hospital

LTC

Office

Why eMOLST: NYSDOH Attorney, Physician Feedback Quality, Patient Safety and Accessibility

CompassionAndSupportYouTubeChannel
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

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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
Mean Number of Days Spent at Home in the Last 6 Months of Life, by Hospital Referral Region, for Medicare Beneficiaries Who Died in 2012 or 2013

Effective MOLST/eMOLST Implementation Requires a Multidimensional Approach

1. Culture change*
2. Professional training of physicians, clinicians & other professionals* 
3. Public advance care planning education, engagement & empowerment* 
4. Thoughtful discussions* 
5. Shared, informed medical decision-making* 
6. Care planning that supports MOLST 
7. System implementation, policies and procedures, workflow 
8. Dedicated system and physician champion 
9. Leverage existing payment stream (CPT codes 99497 and 99498) to encourage upstream shared, informed, decision making* 
10. Standardized interoperable online completion and retrieval system available in all care settings to ensure accuracy and accessibility (i.e. NYSeMOLSTregistry.com)*

**FUTURE:** Sustainable payment stream based on improved compliance with person-centered goals, preferences for care and treatment
- improved resident/family satisfaction & reduced unwanted hospitalizations

*Recommended by the 2014 IOM *Dying in America* report


NY MOLST, Bomba, 2004-present
Where eMOLST Aligns With NY Health System Priorities

- Palliative Care
- Advance Care Planning
- Quality, Patient Safety & Risk Management
- Compliance with NYSPhL
- Care Transitions
- Reducing Readmissions
- Accountable Care Organizations
- Innovative Payment Models
- Medicaid Redesign: DSRIP, FIDA, Health Homes
- NY State Health Innovation Plan
- IOM Dying in America Recommendations
Key MOLST Resources

- **MOLST Training Center** and MOLST pages on [CompassionAndSupport.org](https://www.compassionandsupport.org/index.php/for_professionals/molst_training_center)
- **MOLST Video Revised 2015!** (28:14) [https://youtu.be/CITAG1RX8w](https://www.youtube.com/watch?v=CITAG1RX8w)
  
  "Writing Your Final Chapter: Know Your Choices. Share Your Wishes"
  
  Original release 2007; revised to comply with FHrDA
- **CompassionAndSupport YouTube Channel** ACP and MOLST playlists
  
  [http://www.youtube.com/user/CompassionAndSupport?feature=mhee](http://www.youtube.com/user/CompassionAndSupport?feature=mhee)
- **Thoughtful MOLST Discussions in Hospital & Hospice**
  
  [https://youtu.be/gKseJkuuFuk?list=PLCSvowXDkV5IfzLoGqQ-n3ocGn8lWZ2](https://www.youtube.com/watch?list=PLCSvowXDkV5IfzLoGqQ-n3ocGn8lWZ2)
- **Thoughtful MOLST Discussions in Nursing Home**
  
  [https://youtu.be/LyAT43hXxwq?list=PLCSvowXDkV5IfzLoGqQ-n3ocGn8lWZ2](https://www.youtube.com/watch?list=PLCSvowXDkV5IfzLoGqQ-n3ocGn8lWZ2)
- "**New CPT Codes for Advance Care Planning and MOLST Discussions**" [https://dl.dropboxusercontent.com/u/69456301/ACP.MOLSTdiscussionsNewCodes.071816.ppt?dl=1](https://www.dropbox.com/s/69456301/ACP.MOLSTdiscussionsNewCodes.071816.ppt?dl=1)
Additional eMOLST Resources

- **eMOLST tools**
  - NYSeMOLSTregistry.com

- **CompassionAndSupport YouTube Channel**
  - eMOLST playlist
    - http://www.youtube.com/playlist?list=PLCSvowXDKV5iEJX39GHvbs8ekkfNXec55

- **eMOLST Overview (5:37)**
  - https://youtu.be/MjL8Qz944lU?list=PLCSvowXDKV5iEJX39GHvbs8ekkfNXec55

- **NYSDOH Attorney’s Perspective on eMOLST (1:38)**

- **Advantages of eMOLST: A Nursing Home Physician’s Perspective (7:24)**
  - https://youtu.be/jn47FlYsxss?list=PLCSvowXDKV5iEJX39GHvbs8ekkfNXec55

- **eMOLST webinar sponsored by IPRO and includes Q & A (2:00)**
  - https://qualitynet.webex.com/qualitynet/ldr.php?RCID=f2c519e24280c8a7763dab9ad1bf68ea