Advance Care Planning & MOLST

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Objectives

- Define Advance Care Planning as a key part of palliative care and differentiate MOLST vs. Advance Directives
  - 5 criteria for evaluating MOLST appropriateness
    - specific considerations for AKI, CKD & ESRD patients

- Components of MOLST discussions
  - 8-Step MOLST Protocol
  - Conversation tips and navigating family conflict
  - Legal & ethical requirements; associated documentation

- Review available resources
  - eMOLST
  - CompassionAndSupport.org, MOLST.org
  - ECHO MOLST
  - Print materials

- Confirm CPT Codes
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

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

Goals for Care shift

Diagnosis

Hospice
Advance care planning & goals for care, pain
and symptom control, caregiver support

Bereavement

Progression of Serious Illness

12 mo
6 mo
Advance Care Planning

Compassion, Support and Education along the Health-Illness Continuum

Chronic disease or functional decline

Advancing chronic illness

Multiple co-morbidities, with increasing frailty

Healthy and independent

Maintain & maximize health and independence

Death

Bomba PA & Vermilyea Integrating POLST into Palliative Care Guidelines: A Paradigm Shift in Advance Care Planning in Oncology JNCCN 2006; 4(8) 819-829 (pg 822)
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

CompassionAndSupport.org
CaringInfo.org

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CompassionAndSupport.org
POLST.org
## Differences Between POLST/MOLST and Advance Directives

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>POLST</th>
<th>Advance Directives</th>
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<tbody>
<tr>
<td>Population</td>
<td>For the seriously ill</td>
<td>All adults</td>
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<tr>
<td>Timeframe</td>
<td><strong>Current care</strong></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>
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<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>
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</tbody>
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Standard of Care

Advance Directives
- Health Care Proxy
- Living Will
- Organ Donation

Medical Orders
- DNR
- MOLST
Flow of Emergency Care: Standard of Care
Flow of Emergency Care: MOLST
MOLST/eMOLST: End-of-life Care Transitions Program

Hospital

LTC

Office

A Project of the Community-Wide End-of-life/Palliative Care Initiative
Which patients are appropriate for MOLST?

• Patients who might die in the next year
• Patients who live in a nursing home or receive long-term care services at home or in the community
• Patients who have specific life-sustaining treatments that they want to avoid/receive today, typically coupled w/advanced age
• Patients with one or more advanced chronic conditions or a serious new illness with a poor prognosis
• Patients with frailty, progressive weight loss, >= 2 unplanned admissions in last 12 months, inadequate social supports, or need more help at home
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

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
Incorporating Dialysis into MOLST Discussions

Recommendations in the Shared Decision Making in the Appropriate Initiation of and Withdrawal from Dialysis, 2nd edition clinical practice guideline

Establishing a shared decision making relationship

Recommendation No. 1
Develop a physician–patient relationship for shared decision making.

Informing patients

Recommendation No. 2
Fully inform AKI, stage 4 and 5 CKD, and ESRD patients about their diagnosis, prognosis, and all treatment options.

Recommendation No. 3
Give all patients with AKI, stage 5 CKD, or ESRD an estimate of prognosis specific to their overall condition.

Facilitating advance care planning

Recommendation No. 4
Institute advance care planning. Make a decision to not initiate or to discontinue dialysis.

Recommendation No. 5
If appropriate, forgo (withhold initiating or withdraw ongoing) dialysis for patients with AKI, CKD, or ESRD in certain well-defined situations. Medical management incorporating palliative care is an integral part of the decision to forgo dialysis in AKI, CKD, or ESRD, and attention to a patient’s comfort and quality of life while dying should be addressed directly or managed by palliative care consultation and referral to a hospice program (see Recommendation No. 9 on palliative care services).

Abbreviations: AKI = acute kidney injury; CKD = chronic kidney disease; ESRD = end stage renal disease.

Recommendation No. 6
Consider forgoing dialysis for AKI, CKD, or ESRD patients who have a very poor prognosis or for whom dialysis cannot be provided safely.

Resolving conflicts about what dialysis decisions to make

Recommendation No. 7
Consider a time-limited trial of dialysis for patients who require dialysis but who have an uncertain prognosis, or for whom a consensus cannot be reached about providing dialysis.

Recommendation No. 8
Establish a systematic due process approach for conflict resolution if there is disagreement about what decision should be made with regard to dialysis.

Providing effective palliative care

Recommendation No. 9
To improve patient-centered outcomes, offer palliative care services and interventions to all AKI, CKD, and ESRD patients who suffer from the burdens of their disease.

Recommendation No. 10
Use a systematic approach to communicate about diagnosis, prognosis, treatment options, and goals of care.


Key Takeaways Specific to AKI, CKD & ESRD

• Use palliative care, including advance care planning, with all AKI, CKD and ESRD patients
• Inform all patients with AKI, stage 4 & 5 CKD or ESRD about diagnosis, estimated prognosis and treatment options specific to their condition
• Consider withholding or withdrawing dialysis for patients with a poor prognosis or for whom dialysis cannot be provided safely
• Consider trials to determine patient benefit when prognosis is uncertain or where consensus about dialysis cannot be reached
• Use established processes for conflict resolution
• Medical management with palliative care is critical to foregoing dialysis
• Emphasize quality of life, patient goals, comfort, and use hospice when appropriate
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 are the goals of care?
Avoid Language with Unintended Consequences

• Do you want us to do “everything”?

• Will you agree to discontinue care?

• It’s time we talk about pulling back

• I think we should stop aggressive/heroic therapy

• Despite trying these treatments for several days, and around the clock, expert care, he is unfortunately too sick to respond.

• We will change goals of care to respect her wishes

• We will intensify care; his comfort and dignity are our highest priorities

• Let’s discontinue treatments that are not providing benefit.
Communication Pearls: Clarifying Hopes and Fears

• What does your illness mean to you?
• What do you hope we can accomplish with our medical care?
• What are your greatest hopes about your health?
• What are your greatest fears?
• How can I help you best today?
• How can I help you and your family cope?
Conflict over Treatment

• Unresolved conflicts are problematic and lead to suffering
• Physicians and NPs are needed to clarify prognosis, provide advice on treatment choices in light of goals, and resolve differences
• Engage addtl. team members who specialize in identifying patient goals and navigating family conflict
• Decisions should be based on:
  – Patient’s health status & prognosis
  – Patient’s values, beliefs and goals
  – Goals for treatment
  – Informed medical decision making
  – Informed consent
Reasons for Conflict

• Inappropriate health care agent / surrogate
• Misunderstandings
• Personal factors
• Values conflict
• Poor conversations
• Intervention-based MOLST discussions (compared with patient-centered, goals-based discussions)
• Lack of physician/NP engagement in process
• Lack of documentation
Hoping and Preparing

• "Let's hope for the best..."
  – Join in the search for medical options
  – Open exploration of improbable / experimental therapy
  – Ensure fully informed consent
• "...and prepare for the worst."
  – Make sure affairs (financial/personal) are settled
  – Think about unfinished business
  – Open spiritual and existential issues
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 Supports MOLST
Review & Renew

- According to policies & procedures of your organization or facility, not to exceed 90 days
- When the patient has a change in health status, prognosis, or goals
- When the patient changes care settings
- When the patient changes his/her mind
- MOLST remains legal & valid even if not reviewed/renewed on time
Resources

• eMOLST
  – Template project plan; tools; staff support during implementation and ongoing

• MOLST.org

• CompassionAndSupport.org

• ECHO MOLST: Honoring Patient Preferences

• Print materials
  – Advance Care Planning Booklet (rev 2019)
  – MOLST Brochures
  – Pain Management Patient Guides
New York eMOLST

• An electronic system that guides clinicians and patients through a thoughtful discussion and MOLST process
• Integrates 8-Step MOLST Protocol & NYSDOH Checklists
• Allows a team approach within scope of practice
• Creates MOLST & correct MOLST Chart Documentation Forms
• eMOLST ensures MOLST quality, accuracy, accessibility
• Allows the clinician to print a copy of the eMOLST form on bright pink paper for the patient
• Workflow remains the same; EMS needs a copy of eMOLST
• Serves as the registry of NY eMOLST forms to make sure a copy of medical orders & discussion are available in an emergency.
• eMOLST is free, available statewide and accessed at NYSeMOLSTregistry.com.
eMOLST Produces MOLST and MOLST Chart Documentation Form

Align with NYSDOH Checklists
eMOLST and OPWDD MOLST Legal Requirements Checklist for Individuals with DD

LAST NAME FIRST NAME DATE OF BIRTH

Step 6 – Notification: At least 10 hours prior to the implementation of a decision to withdraw LST, or at the earliest possible time:

- The person will not be notified
- The person will be notified
- if the person is notified
  - if the person is notified

Step 3 – Confirm individual’s lack of capacity to make health care decisions. Either the attending physician or the person’s legal guardian or surrogate must sign the MOE form.

MOE blank form must be signed

Step 6 – Does the individual have any concerns about his/her future health care? If yes, an employee must be present to explain any concerns to the individual.

Attending Physician

Note: The MOLST checklist has been revised by the Department of Health (DOH). Revised 3/18/2013

Address

Step 1 – Identification of Appropriate 1750-b Surrogate from Prioritized List. Check appropriate category and add name of surrogate.

Step 2 – 1750-b surrogate has a conversation or series of conversations with the attending physician regarding possible treatment options and goals for care. Following these discussions, the 1750-b surrogate makes a decision to withdraw or withhold LST, either orally or in writing.

Specify the LST that is requested to be withdrawn or withheld:

- 1. Living Will
- 2. Do Not Resuscitate (DNR)
- 3. Intubation
- 4. IVs
- 5. Antibiotics
- 6. Pain Management
- 7. Surrogate Decision Making Committee (SDMC, Article 80)

Decision made orally

- Written – Attending Physician

- Signature of attending physician:

Decision made in writing (must be dated, signed by surrogate, signed by 1 witness and given to attending physician):
eMOLST Improves Quality Outcomes

- **Safe** – built-in quality controls for correct orders; does not allow for incongruous medical orders
- **Effective** – enables providers to follow clinical steps and meet legal requirements
- **Patient-centered** - goals for care guide choice of interventions
- **Timely** – web-based; assures accessibility across care transitions, including documentation of discussion
- **Efficient** – more time for discussion; less time for documentation, while ensuring accuracy
- **Equitable** – integrates needs of adults, minors, developmentally disabled who lack medical decision-making capacity; can be used in all clinical care settings
eMOLST Improves Legal Outcomes

• Improves compliance with NYS Public Health Law (FHCDA, §1750-b)
• Ensures accurate documentation
• Reduces potential liability
• Reduces potential for DOH deficiencies
eMOLST Improves Provider Satisfaction

- **Easy to learn, easy to use**
- DOH-approved process for conversion of paper MOLST to eMOLST
- Creates MOLST and MOLST Chart Documentation Form
- Helps providers learn complexities of NYSPHL
- Tracks when “Review and Renewal” is needed
- Implementation tools and resources are available
- eMOLST is **FREE**
eMOLST Provides a System-based Solution for Health Systems

• Improves compliance with NYSPHL: HCP, MOLST, FHCDA, §SCPA 1750-b, PCIA, PCAA

• **QA/QI** – members will be able to access Analytics

• **IT**
  – Can be used with/without EMR; integration available with SSO, SSO with Patient Context and API
  – Web-based solution

• Improve financial outcomes
  – Tracks time spent and documentation required for billing ACP CPT Codes
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: What Can Happen When MOLST is Unavailable but in eMOLST

- 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
Effective 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 (NYSeMOLSTregistry.com)*

*Recommended by the 2014 IOM Dying in America report
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
• Care Plan to support MOLST
• Goals for care, preferences and MOLST may change
  • New ACP CPT Codes Overcomes Barrier: Inadequate reimbursement for time spent
• Consider office workflow transformation
Leverage Advance Care Planning CPT Codes 99497 and 99498

• Reimbursement to physicians and qualified health care professionals for providing advance care planning services to Medicare and Medicaid members

• Time-based
  – 99497: First 30 minutes (16-45 minutes)
  – 99488: Each additional 30 minutes (16-45 additional minutes for a total of 46 – 75 minutes)

• Face-to-face with the patient, family member(s), and/or surrogate

• No active management of the problem(s) is undertaken during the time period reported.

• ACP: integral component of the practice of medicine
References


Additional eMOLST Resources

• If you would like your physician office, hospital, nursing home, palliative care/hospice program to implement and have your patients’ MOLST forms included in NY’s eMOLST registry, visit NYSeMOLSTregistry.com.

• Contacts
  eMOLST Program Director: Patricia.Bomba@lifethc.com
  eMOLST Administrator: Katie.Orem@excellus.com

• eMOLST tools
  NYSeMOLSTregistry.com

• eMOLST Overview (5:37)
  https://youtu.be/MjL8Qz944IU?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=f2c519e24280cba7863dab9ad1bf68ea