Recognizing the Value of Advance Care Planning and MOLST/eMOLST

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CompassionAndSupport.org
Objectives

• Define value of MOLST, a key pillar of palliative care

• Review advance care planning and the difference between advance directives and medical orders

• Discuss the clinical process, the ethical framework, and the shared, informed medical decision-making process for making MOLST decisions

• Recognize the legal requirements for making decisions to WH/WD life-sustaining treatment in NY, with or without MOLST

• Explain how eMOLST improves quality and patient safety, reduces harm and achieves the triple aim
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

Progression of Serious Illness

Hospice

Bereavement

12 mo

6mo

Death
Chronic disease or functional decline

Advancing chronic illness

Multiple co-morbidities, with increasing frailty

Healthy and independent

Maintain & maximize health and independence

Death with dignity

Compassion, Support and Education along the Health-Illness Continuum
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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POLST.org
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!
- In the FLX 90% of people said health care proxy completion was important, but only 47% have done it.
Advance Care Planning

Benefits

- “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!
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!
## 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>

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
Disparity between consumer attitudes & actions regarding health care proxies

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

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

Standardized clinical process

– discussion of patient’s goals for care
– shared medical decision-making between health care professionals and seriously ill patients

Result: a set of medical orders

– reflect the patient’s preference for life-sustaining treatment they wish to receive or avoid
– common community-wide form
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)

<table>
<thead>
<tr>
<th>Person's Name: __________________________________________</th>
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<tbody>
<tr>
<td>Date of Birth: <em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
</tbody>
</table>

Do not resuscitate the person named above.

<table>
<thead>
<tr>
<th>Physician's Signature ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name ______________________________________</td>
</tr>
<tr>
<td>License Number ________________________________</td>
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</tbody>
</table>

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?
MOLST Discussion:
Role of Qualified, Trained Health Care Professionals

• MOLST is based on the patient’s current medical condition, values, and goals for care.

• Completion of the MOLST begins with a conversation or a series of conversations between the patient, the health care agent or the surrogate, and a qualified, trained health care professional
  – defines the patient’s goals for care
  – reviews possible treatment options on the entire MOLST form
  – ensures shared, informed medical decision-making

• Document the conversation in the medical record.

http://www.compassionandsupport.org/index.php/for_professionals/molst/molst_discussion
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?
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

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

- **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

**Barrier:** Inadequate reimbursement for time spent
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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MOLST:
End-of-life Care Transitions Program

Hospital  LTC  Office

A Project of the Community-Wide End-of-life/Palliative Care Initiative
Where MOLST/eMOLST Align With 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
Insurance Coverage for End-of-Life Talks May Finally Overcome Politics

Some insurers are starting to pay for the planning of care.

"voluntary advance care planning" in annual wellness visits. But bowing to political pressure, the Obama administration had Medicare reduce that portion of the regulation. In doing so, Medicare wrote that it had not considered the viewpoints of members of Congress and others who opposed it.

Politically, the issue was dead. But private insurers, often encouraged by doctors, began taking a different view.

We are seeing more insurers who are reimbursing for these important conversations," said Susan Pfister, a spokesman for the American Health Insurance Plans, a trade association. The industry, which usually uses Medicare billing codes, had created its own code under a system that allows that if Medicare does not have one, and more insurance companies are using it or covering the discussions in other ways. This year, for example, Blue Cross Blue Shield of Michigan began paying an average of $1.00 per conversation, face to face or by phone, conducted by doctors, nurses, social workers and others. And Cigna Health Solution, which covers 1.9 million patients in North Carolina, Oregon, Utah and Washington, started a program including end-of-life conversations and training in conducting them.

"The politics are tough," said Dr. Philip Hodges, co-founder of public policy for the American Academy of Family Physicians. "In my experience, it's hard to move things forward in the political process. But if we can get doctors comfortable with these conversations, then maybe we can move things forward in a more meaningful way."

Dr. Hodges is also the president of the American Academy of Family Physicians, which has a program to help doctors talk about advance care planning. The program includes a training module for doctors and nurses, and a set of guidelines for communicating with patients about their preferences for care at the end of life.

Dr. Hodges said that while many doctors are uncomfortable with the idea of discussing advance care planning, he believes that it is important for patients to have these discussions with their doctors.

"It's not just about making life easier for patients at the end of life," he said. "It's about giving them the tools they need to make choices about their care, and to live their lives as they want to live them."
By THE EDITORIAL BOARD SEPT. 4, 2014

Encouraging End-of-Life Talks

There is reason to hope that a degree of sanity may be returning to the touchy issue of advance planning for medical care at the end of life. Just five years ago, Republican politicians, Sarah Palin prominent among them, were falsely charging that President Obama’s health care reforms would create “death panels” that could cut off care for the critically ill to save money on health care costs.

Since then, that claim has been thoroughly debunked and Republicans have moved on to other attacks on the reform law. Now, with little fanfare, some private and public insurers have begun paying doctors to have end-of-life discussions with their patients.

That can only be helpful to consumers. Advance planning ensures that patients make decisions for themselves when they are of sound mind and that all family members are aware of a patient’s wishes, relieving them of the stress of improvising in a crisis. It also gives doctors and nurses critical information about the kind of care desired.

As Pam Belluck reported in The Times on Sunday, private insurers have begun covering “advance care planning” conversations as the number of aging Americans rises and many people want more input into how and where they will spend their final days (at home or in an institution) and what treatment they will receive, ranging from all-out efforts to sustain life to simple pain relief.

Private policies vary in how much they will pay for a planning session. Excellus Blue Cross Blue Shield of New York, for instance, reimburses doctors $150 for an hour-long conversation to help patients complete the state’s advance directive form. Some states, including Colorado and Oregon, have begun covering end-of-life planning for poor people insured by Medicaid. Still to be heard from is Medicare, which covers some 50 million Americans. Clearly, the Centers for Medicare and Medicaid Services, which runs Medicare, should encourage doctors to make end-of-life planning sessions a routine service. By setting a reasonable reimbursement rate Medicare can provide a good example for private insurers to follow.
eMOLST Feedback: NYSDOH

• “I did log on to the eMOLST Training Site, and I did fill out a MOLST form, download it and print it.”

• “I do think eMOLST has all the advantages of using TurboTax vs. trying to do your taxes using paper forms with a pencil.”

• “The electronic form didn't let me make mistakes - it prevented me from filling out the form in a way that was illegal, inconsistent or illogical. I think this is great!”

Jonathan Karmel, JD, NYSDOH Division of Legal Affairs, Legal Counsel
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Why eMOLST? Accessibility
Questions?

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Reference Slides
Deaths Among Seniors

• New York is ranked #1 in hospital deaths among seniors* (worst in the country)

• Estimates suggest that 35% of all New Yorkers 65+ die in the hospital**

• Regional Variation, Medicare Data***/

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*In Sickness and in Health, Where States are No.1
Wall Street Journal, June 9, 2014

**America's Health Rankings

***Dartmouth Atlas
How Americans Die
What Do Common Ways of Dying Look Like?
How Americans Wish to Die
Medicare payments in last year of life account for ¼ 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, IHI
Choose Wisely Campaign
IOM Report Dying in America

- Major gaps in care near end of life
- Urgent attention needed from numerous stakeholder groups
- Patient-centered, family-oriented approach to care near the end of life should be a high national priority
- Compassionate, affordable, and effective care is an achievable goal

Released September 17, 2014
Report available: www.nap.edu
Five Key Areas

• 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

Released September 17, 2014
Report available: www.nap.edu
Key Recommendations

• Quality standards should be developed for clinician-patient communication and advance care planning

• Appropriate provider training, certification and licensure should be developed to strengthen palliative care knowledge and skills of all clinicians

• Fact-based public education that encourages advance care planning and shared, informed medical decision-making
Key Recommendations

• All insurers should cover comprehensive care for individuals with advanced serious illness who are near the end of life

• All insurers should integrate the financing of medical and social services to support quality care consistent with patients’ values and preferences
Impact on Survival and Quality of Life: Early Integration of Palliative Care

• Randomized study of 151 patients with newly diagnosed non-small cell lung cancer
  – Early palliative care plus standard oncologic care or standard oncologic care
  – Quality of life and mood assessed at baseline and at 12 weeks
  – Primary outcome: change in quality of life at 12 weeks

• Outcomes
  – Fewer patients in early palliative care group received aggressive end-of-life care (33% vs. 54%, P=0.05)
  – Median survival longer among patients receiving early palliative care (11.6 months vs. 8.9 months, P=0.02)
Palliative Care and New Value-Based, Accountable Care Models

• Palliative care aligns with new care and innovative payment models
  – Helps to reduce avoidable hospitalizations and ED use
  – Strengthens person-centeredness and consumer engagement and satisfaction
  – Improves coordination along the continuum
  – Avoids unnecessary and unwanted service utilization and expense
Advance Care Planning Preferred Practices
National Quality Forum

- Document the designated agent (surrogate decision maker) in a Health Care Proxy for every patient in primary, acute and long-term care and in palliative and hospice care.

- Document the patient/surrogate preferences for goals of care, treatment options, and setting of care at first assessment and at frequent intervals as condition changes.

- Convert the patient treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital, i.e., the Medical Orders for Life-Sustaining Treatment—MOLST, an endorsed POLST Paradigm Program.

- Make advance directives and surrogacy designations available across care settings: eMOLST, a statewide data source for SHIN-NY.

- Develop and promote healthcare and community collaborations to promote advance care planning and completion of advance directives for all individuals. e.g. Respecting Choices and Community Conversations on Compassionate Care.

Advance Care Planning Preferred Practices
National Quality Forum

- Establish or have access to ethics committees or ethics consultation across care settings to address ethical conflicts at the end of life. (special requirements exist with Family Health Care Decisions Act)

- For minors with decision making capacity, document the child's views and preferences for medical care, including assent for treatment, and give them appropriate weight in decision making. Make appropriate professional staff members available to both the child and the adult decision maker for consultation and intervention when the child's wishes differ from those of the adult decision maker. (aligns with Family Health Care Decisions Act)