Recognizing the Value of Advance Care Planning and MOLST/eMOLST

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CompassionAndSupport.org

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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

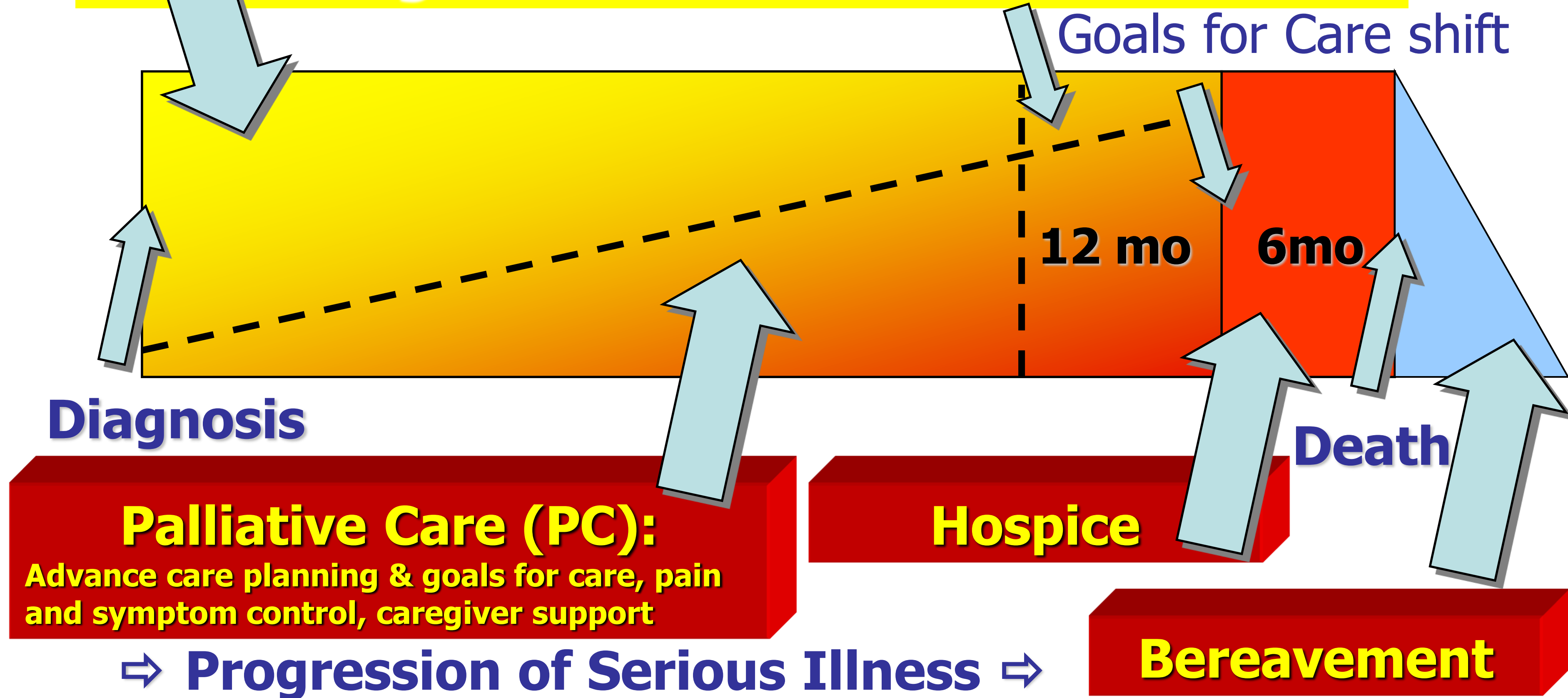
- aims to relieve suffering and improve quality of life for patients with advanced illness and their families
- offered simultaneously with all other appropriate medical treatment from the time of diagnosis
- focuses on quality of life and provides an extra layer of support for patients and families

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



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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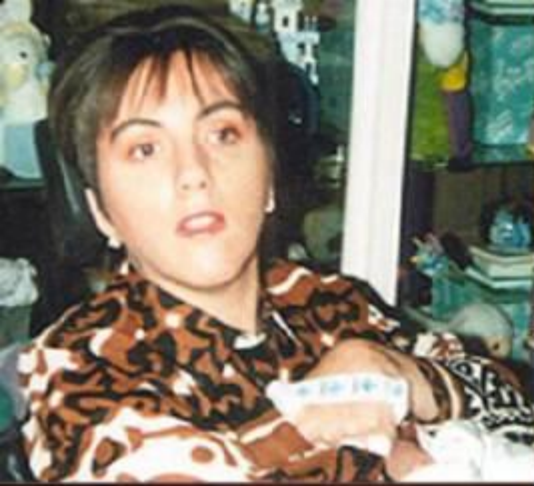

Advance Directives and Actionable Medical Orders

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

CompassionAndSupport.org
POLST.org

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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!
- **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

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.

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

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

My Name is ...
Andrew

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

P♁LST
physician orders for life-sustaining treatment paradigm

Research: Site of Death vs. Treatment Requested

MOLST
MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT
A POLST Paradigm Program

- 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

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

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

NEW YORK STATE DEPARTMENT OF HEALTH

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

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SECTION B Consent for Resuscitation Instructions (Section A)

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PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

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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.*

- 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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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?

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?

Compassion and Support
at the End of Life
CompassionAndSupport.org

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

Compassion and Support at the End of Life
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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

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

ENDORSED®
www.POLST.org

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

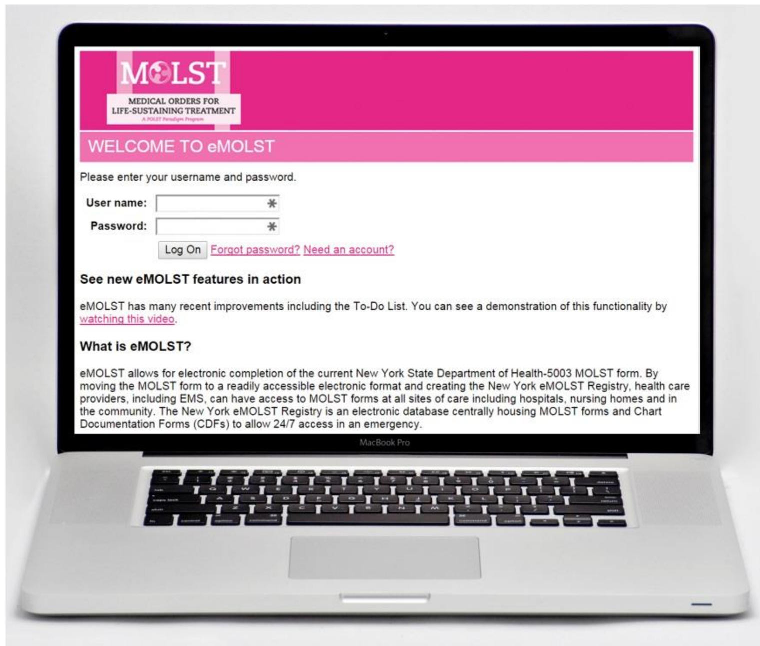
eMOLST Aligns with New Value-Based, Accountable Care Models

- 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

eMOLST Program Director: Patricia.Bomba@lifethc.com

eMOLST Administrator: Katie.Orem@excellus.com

Questions?

Katie Orem, MPH

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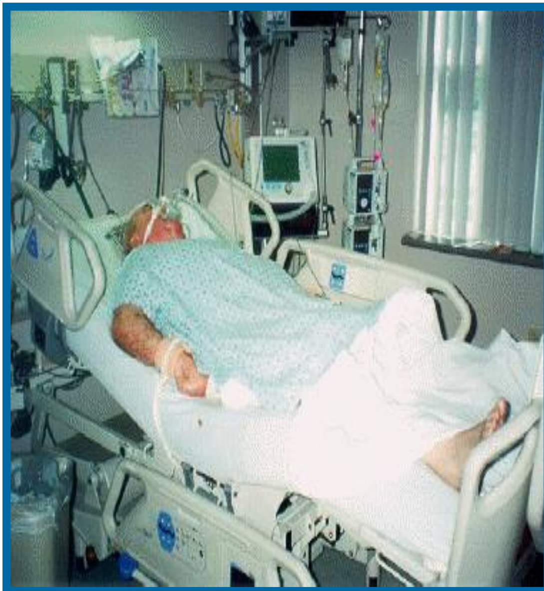
MOLST:
End-of-life Care Transitions Program

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

"All the News That's Fit to Print"

The New York Times

Today, humid and cloudy, high 87. Tonight, thunderstorms, low 74. Tomorrow, afternoon storms, high 87. Weather map, Page 20.

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Insurance Coverage for End-of-Life Talks May Finally Overcome Politics

From Page 1

their families understand the consequences, the pros and cons and options so they can make the best decision for them."

Now, some doctors conduct such conversations for free or shoehorn them into other medical visits. Dr. Joseph Hinterberger, a family physician here in Dundee, wants to avoid situations in which he has had to decide for incapacitated patients who had no family or stated preferences.

Recently, he spent an unreimbursed hour with Mary Pat Pennell, a retired community college dean, walking through advance directive forms. Ms. Pennell, 80, who sold her blueberry farm and lives with a roommate and four cats, quickly said she would not want to be resuscitated if her heart or lungs stopped. But she took longer to weigh options if she was breathing but otherwise unresponsive.

"I'd like to be as comfortable as I can possibly be," she said at first. "I don't want to choke, and I don't want to throw up."

With reimbursement, "I'd do one of these a day," said Dr. Hinterberger, whose 3,000 patients in the Finger Lakes region range from college professors to Mennonite farmers who tie horse-and-buggies to his parking lot's hitching post.

If Medicare covers end-of-life counseling, that could profoundly affect the American way of dying, experts said. But the impact would depend on how much doctors were paid, the allowed frequency of conversations, whether psychologists or other nonphysicians could conduct them, and whether the conversations must be in person or could include phone calls with long-distance family members. Paying for only one session and completion of advance directives would have limited value, experts said.

"This notion that somehow a single conversation and the completion of a document is really an important intervention to the outcome of care is, I think, a legal illusion," said Dr. Diane E. Meier, director of the Center to Advance Palliative Care. "It has to be a series of recurring conversations over years."

End-of-life planning remains controversial. After Sarah Palin's "death panel" label killed efforts to include it in the Affordable Care Act in 2009, Medicare added it to a 2010 regulation, allowing the federal program to cover

HEATHER AINSWORTH FOR THE NEW YORK TIMES

Dr. Joseph Hinterberger discussed end-of-life care with Mary Ann Zebrowski. If reimbursed, "I'd do one of these a day," he said.

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 rescind 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 steps.

"We are seeing more insurers who are reimbursing for these important conversations," said Susan Pisano, a spokeswoman for America's 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 $35 per conversation, face to face or by phone, conducted by doctors, nurses, social workers and others. And Cambia Health Solutions, which covers 2.2 million patients in Idaho, Oregon, Utah and Washington, started a program including end-of-life conversations and training in conducting them.

Excellus Blue Cross Blue Shield of New York does something similar, and its medical director, Dr. Patricia Bomba, has spearheaded the development of New York's advance directive system. Doctors can be reimbursed $150 for an hourlong conversation to complete the form, and $350 for two hours.

Dr. Hinterberger learned of Excellus's coverage when he called recently to ask about end-of-life discussions, but even if he undergoes Excellus's training to qualify for reimbursement, most of his older patients have only Medicare.

End-of-life planning has also resurfaced in Congress. Two recent bipartisan bills would have Medicare cover such conversations, and a third, introduced by Senator Tom Coburn, Republican of Oklahoma, would pay Medicare patients for completing advance directives.

But few people think the bills can pass.

"The politics are tough," said Dr. Phillip Rodgers, co-chairman of public policy for the American Academy of Hospice and Palliative Medicine. "People are so careful about getting anywhere close to the idea that somebody might be denying lifesaving care."

Burke Balch, director of the Powell Center for Medical Ethics at the National Right to Life Committee, said in a statement that many doctors believed in "hastening death for those deemed to have a 'poor quality of life.'" If Medicare covers advance care planning, he said, that plus cost-saving motivations will pressure patients "to reject life-preserving treatment."

Doctors deny that.

"Honestly, sometimes I'm making an argument that treatment is not as bad as you think because of our ability to mitigate side effects," said Dr. Thomas Gribbin, a Grand Rapids, Mich., oncologist who recently persuaded two Michigan insurers to cover end-of-life conversations.

It is unclear if advance care planning saves money, but some studies suggest that it reduces hospitalizations. Many people prefer to die at home or in hospices, so cost-saving can be an inadvertent result, said Dr. William McDade, president of the Illinois State Medical Society, which asked the A.M.A. to create codes for the discussions.

The conversations do not lock people into decisions, and studies show that some change their minds in a crisis.

But evidence suggests that discussions can make a difference. One study found that cancer patients who previously discussed end-of-life preferences with doctors more often received care matching those wishes. Other studies suggest planning lowers stress in patients and families.

Reimbursement rates for talking are much lower than for medical procedures. But doctors say that without compensation, there is pressure to keep appointments short to squeeze in more patients. "Not to be crass about this, you're just giving that service away," Dr. Rodgers said.

Recently, Dr. Hinterberger took time from other patients and his duties at Schuyler Hospital in Montour Falls, N.Y., to conduct end-of-life conversations in his frank, casual style.

He told Ms. Pennell that if she experienced severe pneumonia or a serious accident, doctors might consider putting her on a ventilator or inserting a feeding tube. She could stipulate that she wanted only pain relief, essentially instructing doctors to "just kiss me and tell me you love me," he said. Or she could ask for short-term interventions in case "you perk back up." Or she could indicate, "I want everything. Just do it, do it," he said.

"The middle option," she eventually decided.

When Janice Ryan, 89, a former protective services worker with a bone marrow disorder, said she wanted nothing "unless I can recover and feel wonderful," Dr. Hinterberger gently suggested allowing doctors to try.

"Give the doc some options," said her husband, Dick, a retired professor. She agreed, but added, "I want quality of life; I don't want to just be a vegetable."

Dr. Hinterberger spent 40 minutes with Helen Hurley, 83, whose lung disease requires her to use nasal tubes connected to an oxygen tank she carries in a flowered bag. Then she tired, asking to finish the discussion in future visits, "a little at a time."

But Mary Ann Zebrowski, 75, a retired vineyard worker with diabetes and arrhythmia, had a lot to say. She described her husband's collapse in 2008, saying she was glad he had been resuscitated, but felt pressured to agree to a feeding tube because a doctor said, "What are you trying to do, kill your husband?" She eventually decided to remove the tube and let him die.

She said she wanted no feeding tube for herself, but short trials of other measures. Afterward, she seemed relieved, saying, "I just don't want to put my kids through having to make these decisions."

"All the News That's Fit to Print"

The New York Times

Late Edition

Today, sunny to partly cloudy, seasonable, high 76. Tonight, clear to partly cloudy, cool, low 57. Tomorrow, sunny to partly cloudy, cooler, high 68. Weather map, Page A30.

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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

eMOLST Feedback: Physician

Why eMOLST? Accessibility

Dr. Patricia Bomba, eMOLST Program Director

Compassion and Support at the End of Life

Patients & Families

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Professionals

CLICK HERE

Know your choices, share your wishes.

Advance Care Planning

Learn Five Easy Steps. click here

NATIONAL HEALTHCARE DECISIONS DAY
★ your decisions matter ★

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Welcome to Compassion and Support

Listen to Dr Bomba's Introduction

Individuals facing serious life-threatening illness and approaching death deserve to be treated with dignity, respect and compassion and to receive care that is focused on the individual's goals for care. Families need and deserve to receive support. To achieve their goals, individuals need to plan ahead, know their choices, make sound decisions and share their wishes with their loved ones and health care professionals. This web site aims to educate and empower patients, families, health care and other professionals to accomplish this goal.

Featured Topics

David Klein's interview (part 1) about his wife's death and the importance of advance care planning. Part two of the interview.

Enhanced NHDD Page

NEW Spanish Advance Care Planning Booklet

Updated ORDER FORM

MOLST Brochures (English+Spanish) are back in stock! Order Now

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News and Events

Article on eMOLST published in the NYSBA Health Law Journal

Article on POLST published in the Cleveland Clinic Journal of Medicine

MOLST Conference! 9/20/12 in Plattsburgh, NY. Register now! Registration Flyer

Check out our YouTube Channel

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Questions?

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Reference Slides

MOLST
MEDICAL ORDERS FOR
LIFE-SUSTAINING TREATMENT
A POLST Paradigm Program

Deaths Among Seniors

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

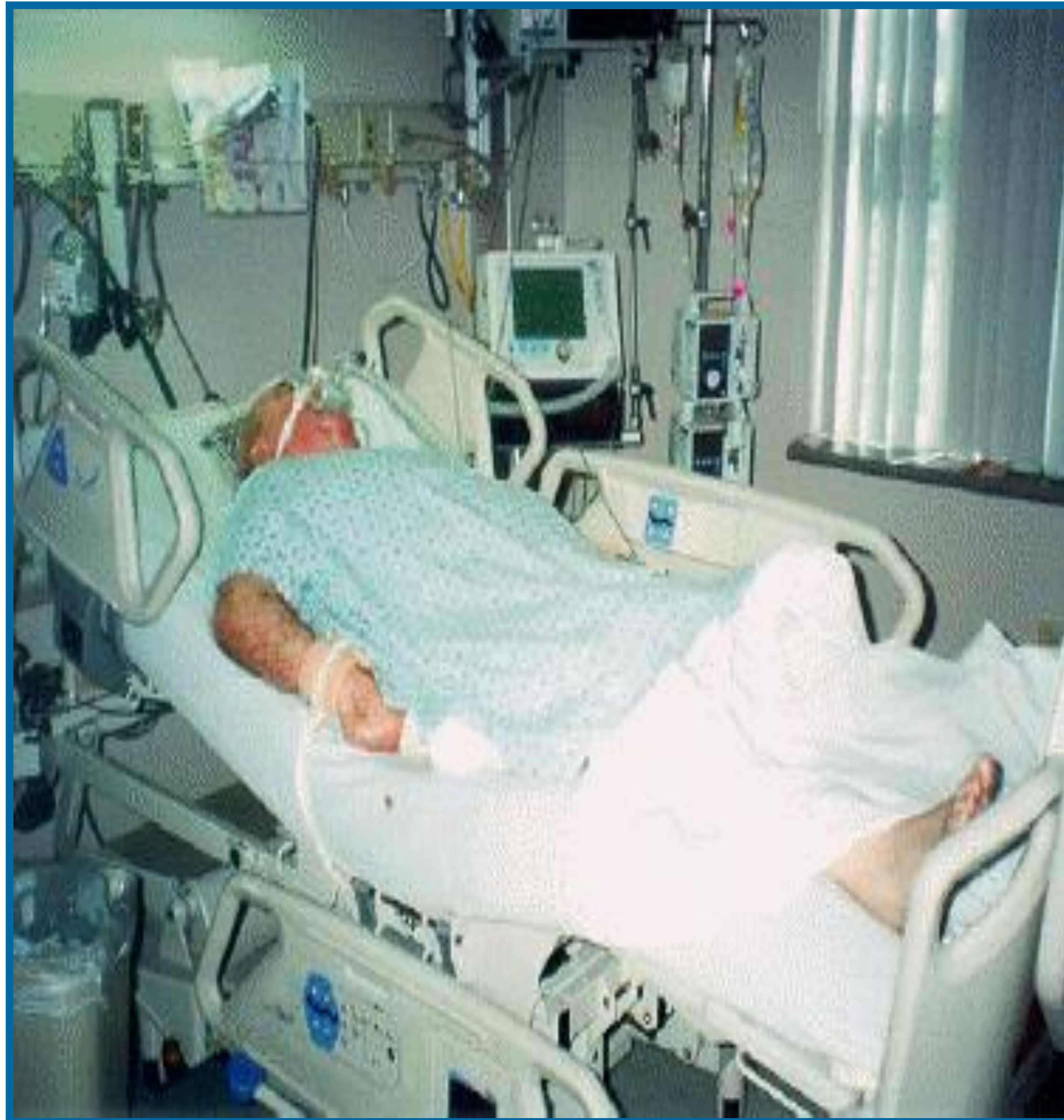
- Estimates suggest that 35% of all New Yorkers 65+ die in the hospital**

- Regional Variation, Medicare Data***

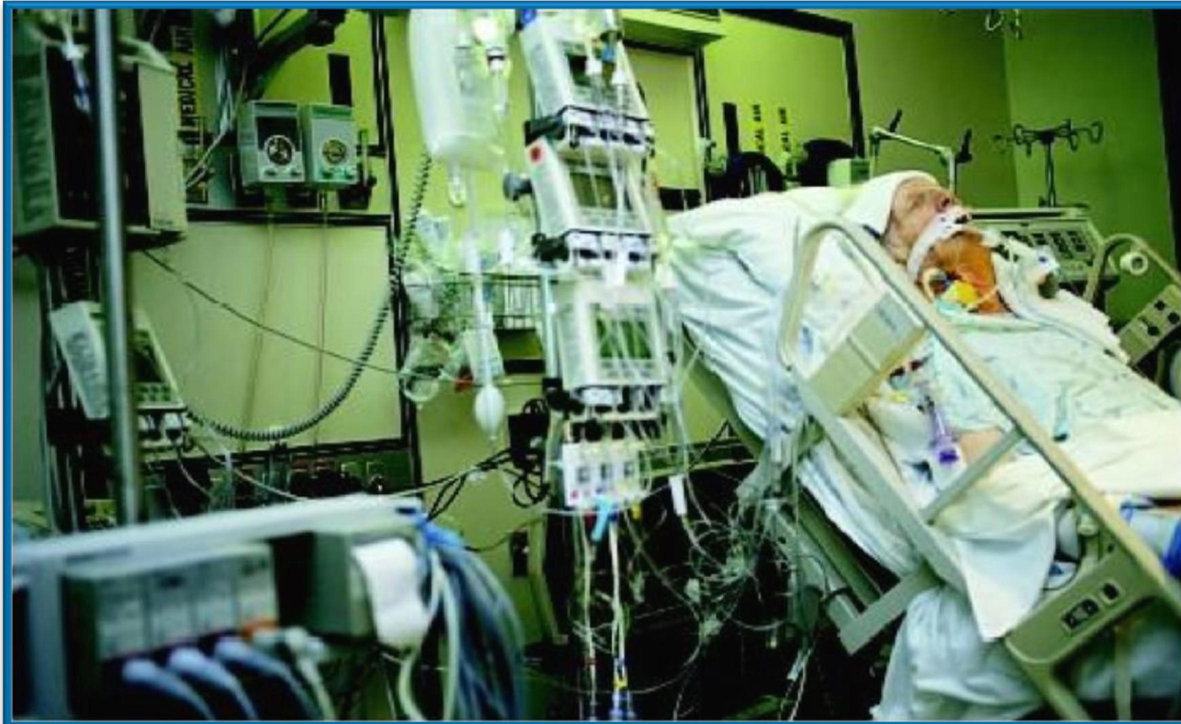
**In Sickness and in Health, Where States are No.1*
Wall Street Journal, June 9, 2014
**America's Health Rankings
***Dartmouth Atlas

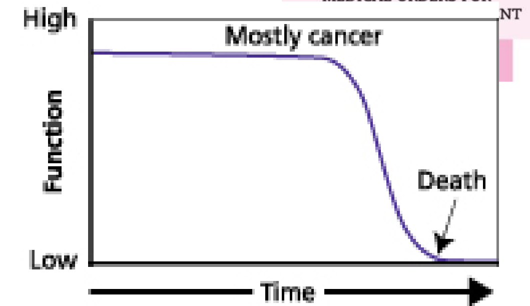
How Americans Die

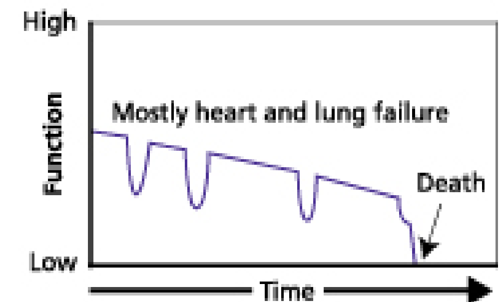
MOLST
MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT
A POLST Paradigm Program

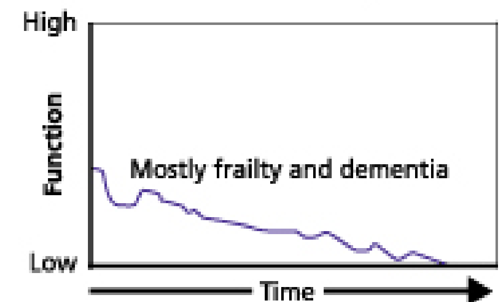


What Do Common Ways of Dying Look Like?









How Americans Wish to Die

Medicare payments in last year of life account for ¼ of all Medicare spending

35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%

1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006

Year

Adjusted costs *
Unadjusted costs
Percent died

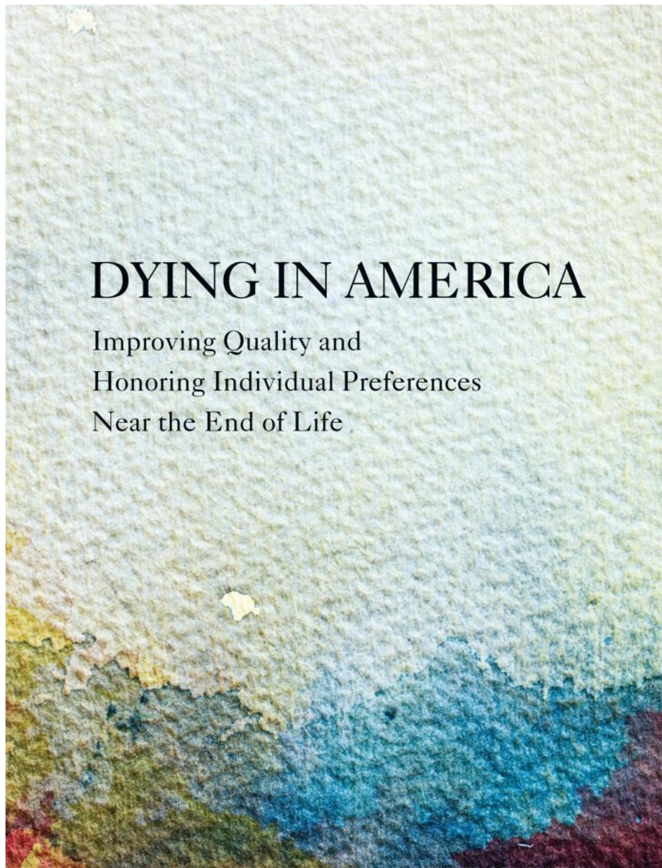
Data from: Riley G, Lubitz J. "Long-Term Trends in Medicare Payments in the Last Year of Life." Health Services Research, 2010; 565-576.

“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

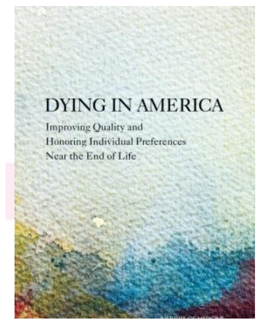


- Major gaps in care near end of life
- Urgent attention needed from numerous stakeholder groups
- Patient-centered, family-oriented approach to care near the end of life should be a high national priority
- Compassionate, affordable, and effective care is an achievable goal

Released September 17, 2014

Report available: www.nap.edu

Five Key Areas

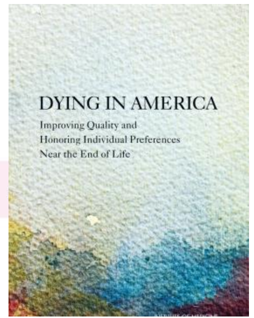


- Delivery of person-centered, family-oriented care
- Clinician-patient communication and advance care planning
- Professional education and development
- Policies and payment systems
- Public education and engagement

Released September 17, 2014

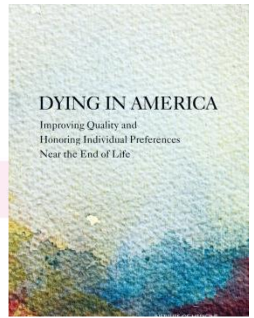
Report available: www.nap.edu

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)

Early Palliative Care for Patients With Metastatic Non-Small Cell Lung Cancer
NEJM. 2010;363:733-742

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.

National Quality Forum, Framework and Preferred Practices for Palliative & Hospice Care Quality, 2006, Adapted for New York State

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)

National Quality Forum, Framework and Preferred Practices
for Palliative & Hospice Care Quality, 2006, Adapted for New York State