Impact of a Health Plan's Twenty-Year Commitment to Palliative Care

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No Conflicts of Interest to Disclose

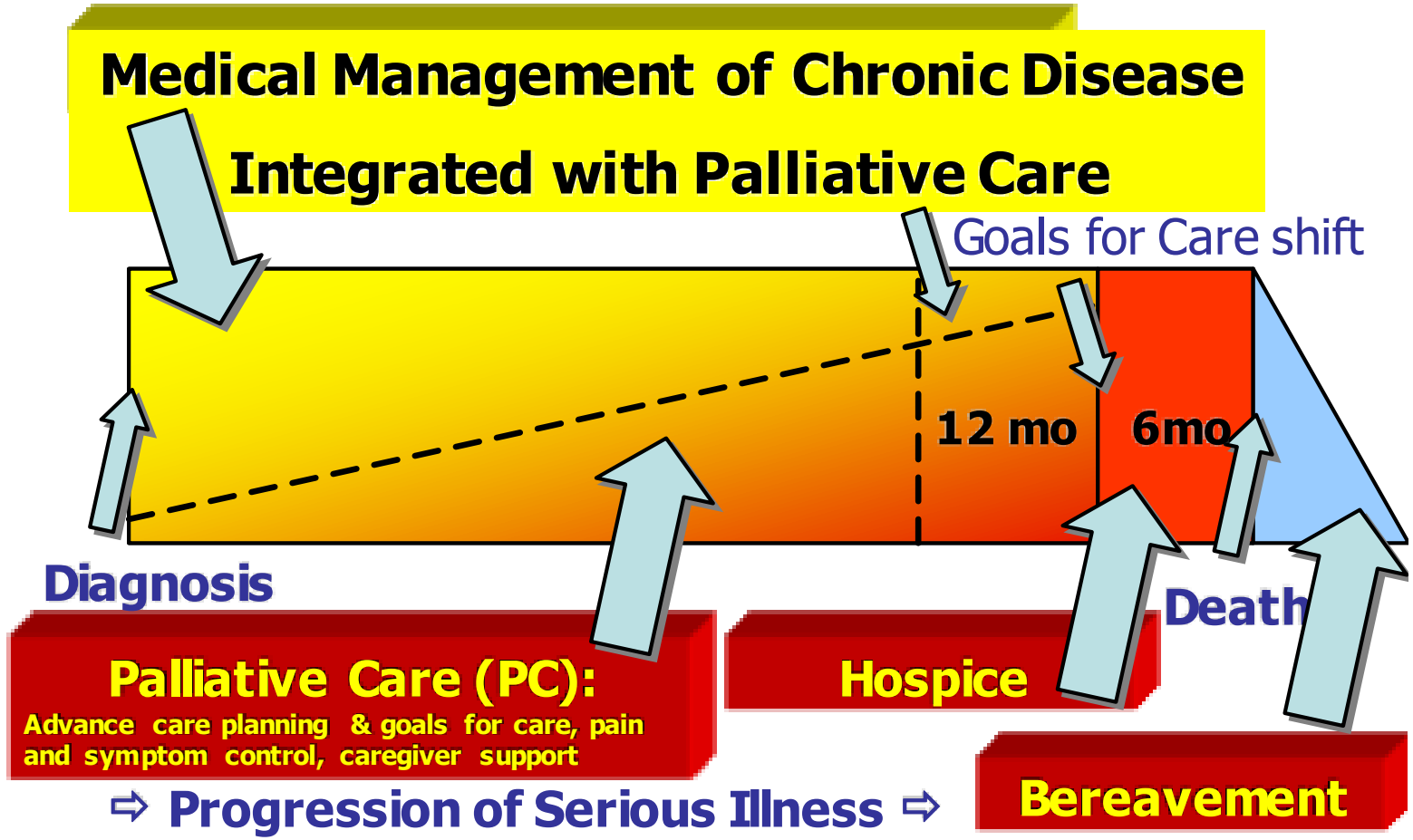
Personal Story

Palliative Care

Team based holistic care: medical, psychosocial, cultural, spiritual, legal

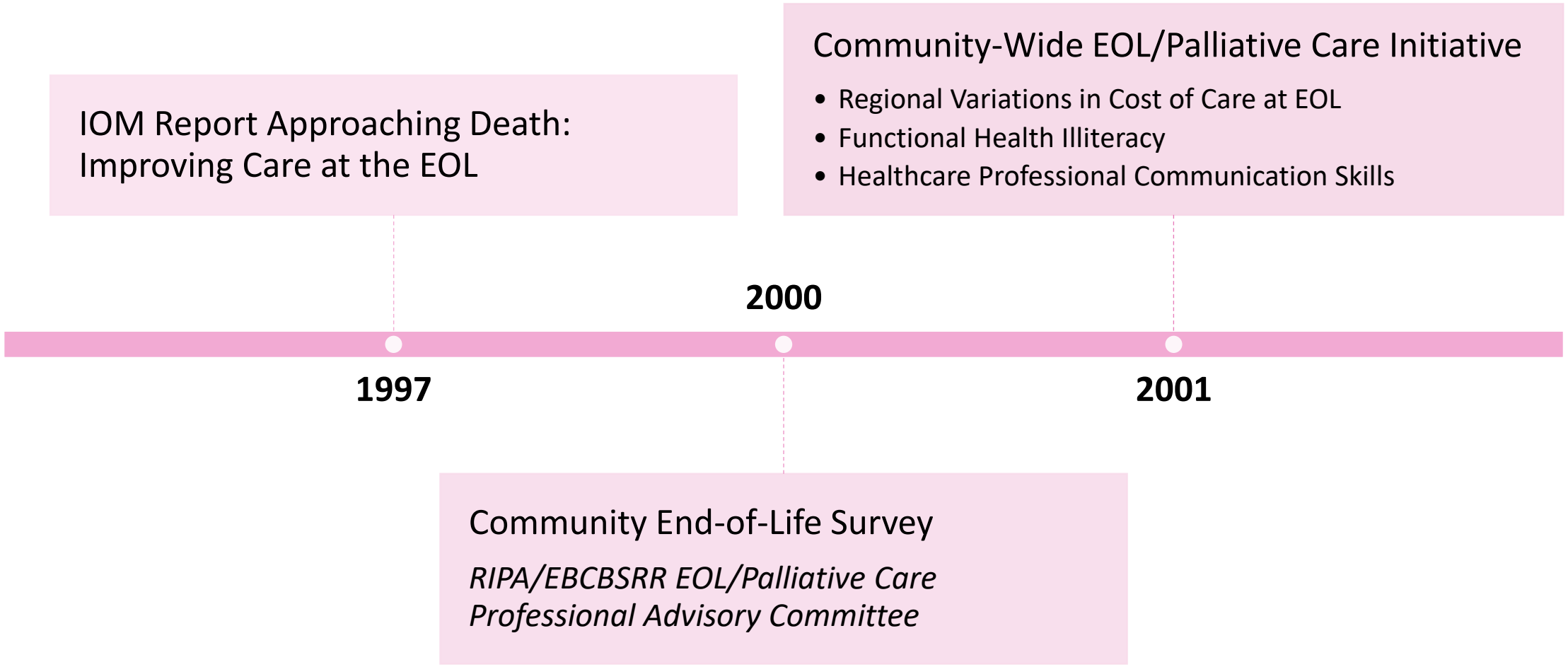
- Three Key Pillars
  - Advance Care Planning
    - Advance directives (HCP)
    - Medical orders (MOLST)
  - Pain & symptom management
  - Caregiver education & support

"Best Care" Model for Patients with Serious Illness



Community Needs Assessment

Honoring Patient Preferences for EOLC and Palliative Care



Community-wide End-of-life/Palliative Care Initiative

Launch, 2001 – Commitment to Leadership, Sustainable Integration into Core Functions, Data Collection
Future – Value Based Payment, Digital Transformation and Enhancement, Sustainability

Advance Care Planning

- Community Conversations on Compassionate Care

Honoring Preferences

- Medical Orders for Life-Sustaining Treatment (MOLST)
- Tube Feeding/PEG Tubes Guidelines for Adults

Pain Management and Palliative Care

- Community Principles of Pain Management (CPPM) & Guidelines for Opioid Use Disorder added
- CompassionNet

Community Education and Professional Training

- Sister web sites, videos, presentations www.CompassionAndSupport.org & www.MOLST.org
- Education for Physicians on End-of-life Care (EPEC)
- ECHO MOLST, Conferences, webinars, etc.

Advance Care Planning
A Population Health Approach

Advance Directives

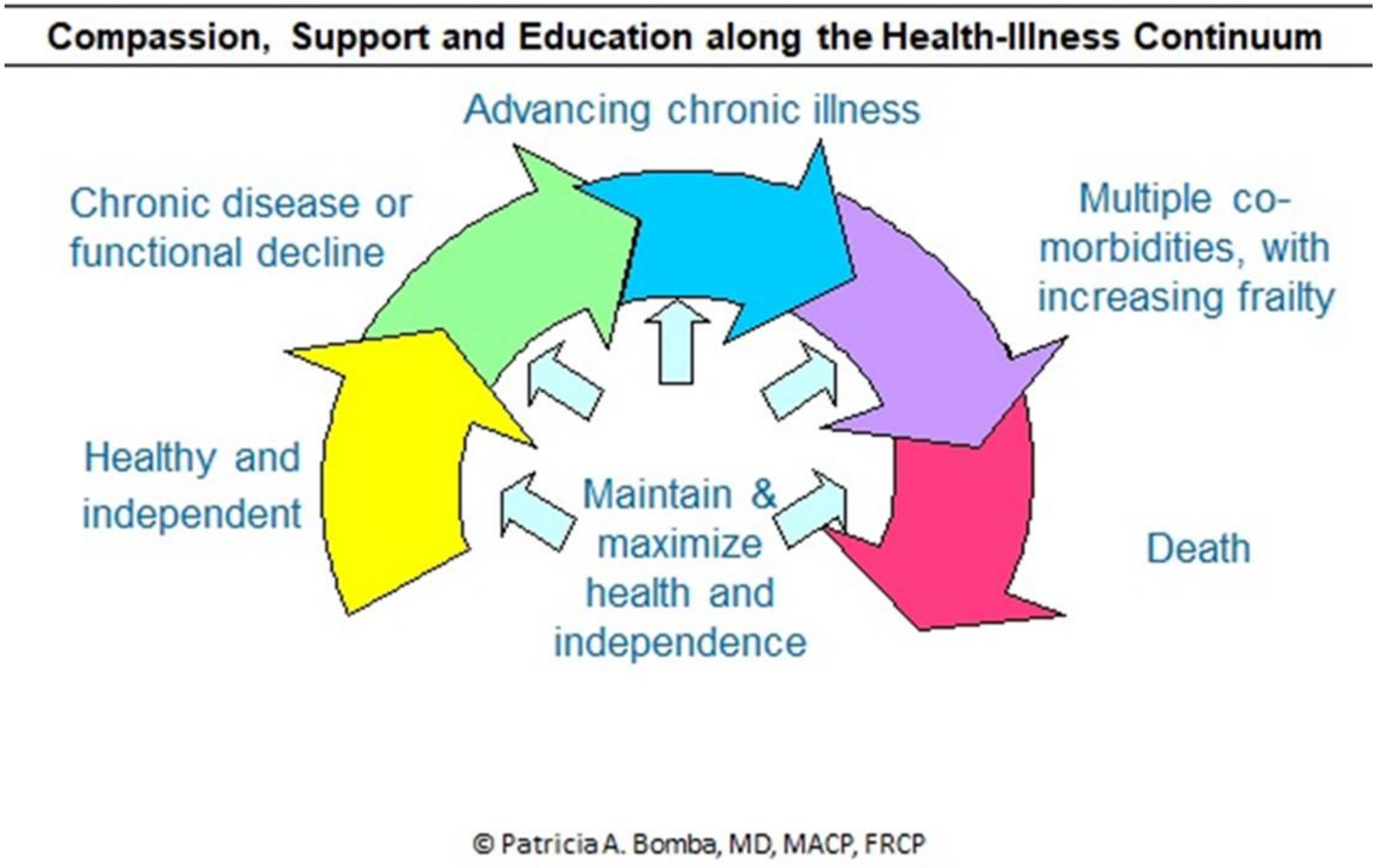
(18 and older)

- Health Care Proxy
- Living Will

Medical Orders (MOLST)

(Advanced illness/frailty)

- Resuscitation
- Respiratory Support
- Hospitalization
- Life-Sustaining Treatment



Characteristics	Medical Orders	Advance Directives
Population	For seriously ill with advanced illness, advanced frailty	All adults
Timeframe	**Current care**	Future care
Who completes the form	Physicians, NPs, PAs	Patients
Resulting form	Medical Orders (MOLST)	Advance Directives
Health Care Agent or Surrogate role	Can engage in discussion if patient lacks capacity	Cannot complete
Portability	Physicians, NPs, PAs	Patient/family responsibility
Periodic review	Physicians, NPs, PAs	Patient/family responsibility

Differences Between Medical Orders and Advance Directives

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

Adapted from Bomba PA, Black J. The POLST: An improvement over traditional advance directives. Cleveland Clinic Journal of Medicine. 2012; 79(7): 457-64

Who is Appropriate for Medical Orders

1. Patients whose physician, NP or PA would not be surprised if they die in the next year
2. Patients who live in a nursing home or receive long-term care services at home or assisted living
3. Patients who want to avoid or receive any or all life-sustaining treatment today
4. Patients who have one or more advanced chronic conditions or a new diagnosis with a poor prognosis
5. Patients who have had two or more unplanned hospital admissions in the last 12 months, coupled with increasing frailty, decreasing functionality, progressive weight loss or lack of social support

Shared Informed Medical Decision Making

- Will treatment make a difference?
- What are the benefits & burdens?
- Is there hope of recovery?
  - If so, what will life be like afterward?
- What does the patient value? What are the patient's goals for care?

Tricia's Story

Bill & Debbie's Story

Joanne's Story

Lee's Story

Lucia's Story

Community Conversations on Compassionate Care

Storytelling and Five Easy Steps

Should choose the right "trusted person" –a Health Care Agent.
Share "what matters most".
Put it in writing. Complete a Health Care Proxy.
Talk to loved ones.
Learn how to make medical decisions.

Advance Care Planning: All Adults ≥ 18 Years Old

Sudore, R, et.al. (2017) Defining ACP for Adults: A Consensus Definition from a Multidisciplinary Delphi Panel. J Pain & Symptom Management, 53(5),

Medical Orders for Life-Sustaining Treatment (MOLST)

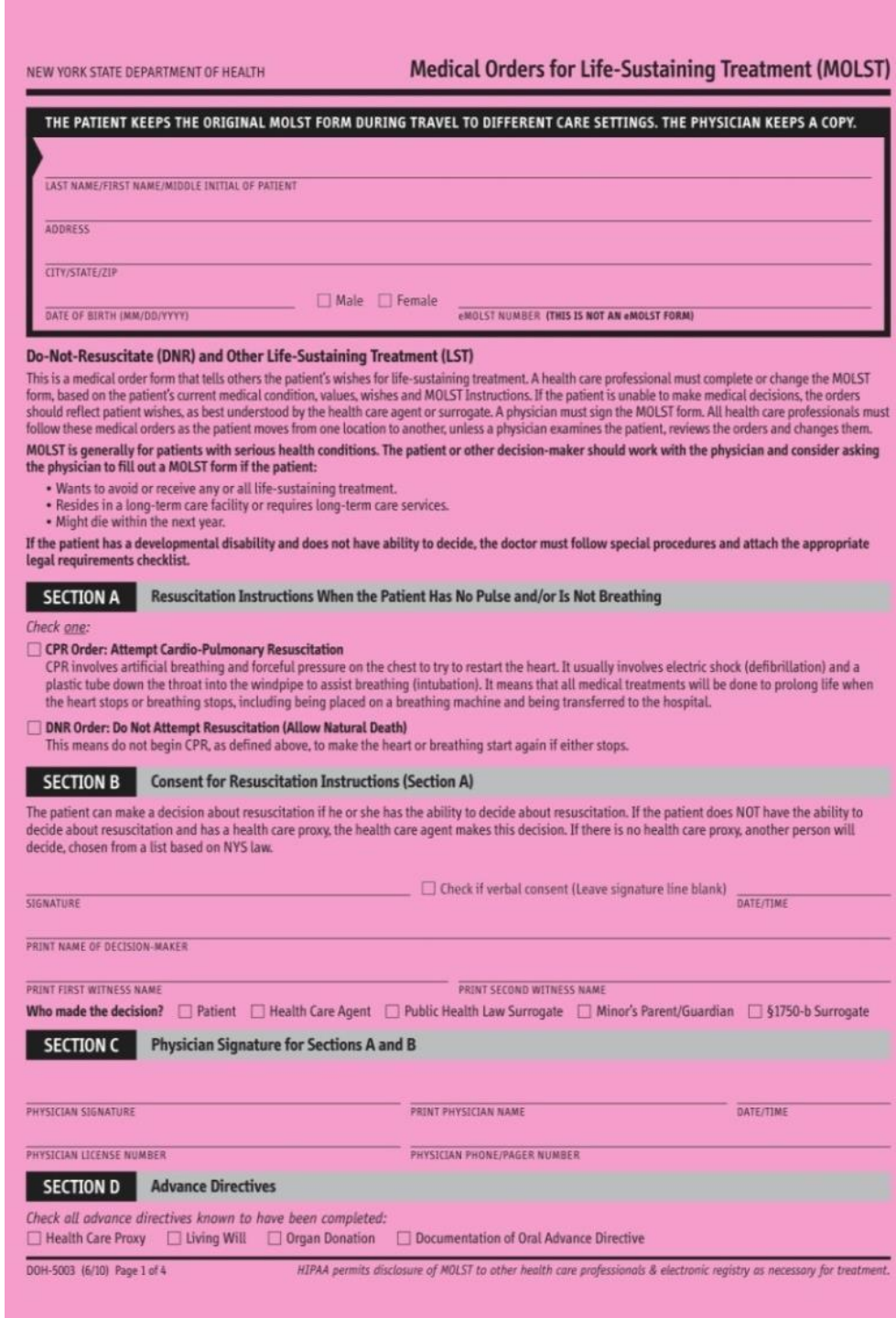
NY's Endorsed POLST Program

Applying Shared Decision Making

Patients with Advanced Illness and Advanced Frailty

Medical Orders for Life-Sustaining Treatment (MOLST)

- Standardized communication process
- Patient health status, prognosis, values & goals for care
- Shared medical decision-making
- Ethical-legal requirements (PHL: HCP & FHCDA and SCPA §1750-b)
- Physician, NP, PA (as of 6/17/2020): authority & accountability
- Physician Accountability: Patients with I/DD who lack capacity
- Documentation of discussion
- Result: portable medical orders
  - reflect resident preferences for LST they wish to receive and/or avoid
  - common community-wide form
  - **ONLY** form EMS can follow DNR, DNI and Do Not Hospitalize
  - **ALL** health care professionals **MUST** follow MOLST
- Palliative care plan and caregiver support



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.*

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, quality improvement
8. Dedicated system and physician champion
9. *Leverage existing payment stream (CPT codes 99497 and 99498) to encourage upstream shared, informed, decision making* (effective 2016)*
10. Standardized interoperable online completion and retrieval system available in all care settings to ensure accuracy and accessibility (i.e. NYSeMOLSTregistry.com)*

FUTURE: Sustainable payment stream based on improved compliance with patient goals, preferences for care & treatment, improved patient/family satisfaction, reduced *unwanted* hospitalizations/ED visits

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

Culture Change

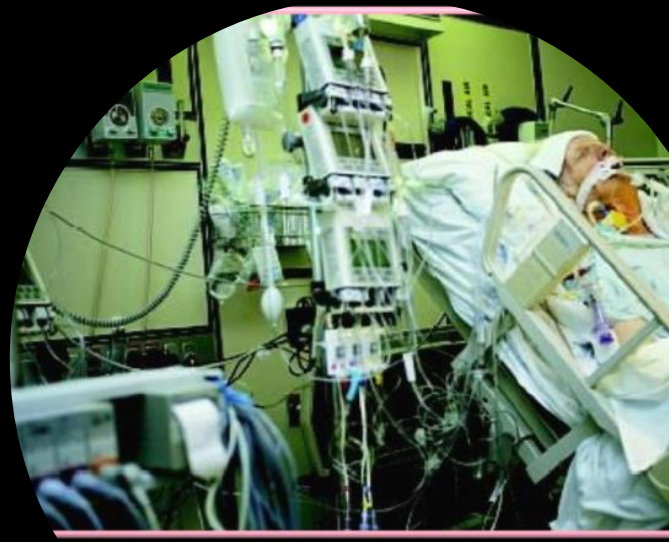
Early Thoughtful Discussions

Health Status, Prognosis, Values, Beliefs, Goals

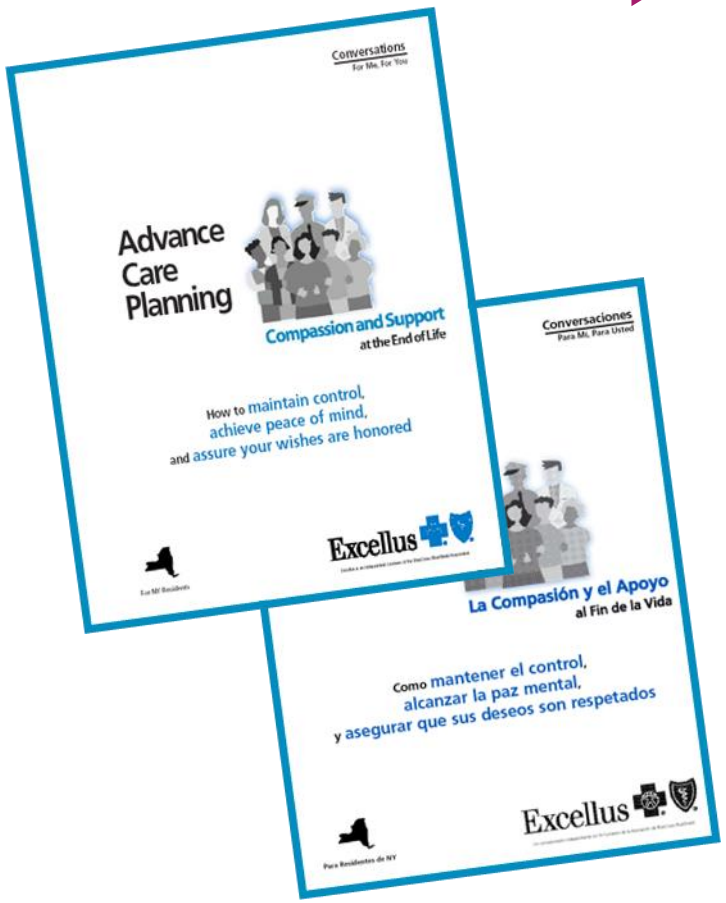
Shared Decision Making

Preferences Based on Goals

Care Plan Based on MOLST



Advance Care Planning Campaign
Spiritual Leaders, Rochester NY, 2002



Community Partners in Advance Care Planning

Professional Training: 8-Step MOLST Protocol, Ethical-Legal Requirements, Prognosis, Capacity Determination, Shared Decision-Making, Communication Skills, Symptom Management & Care Plan to Support MOLST, Leveraging CPT Codes, System Implementation, ACP Toolkits, eMOLST

Patient, Family, & Caregiver

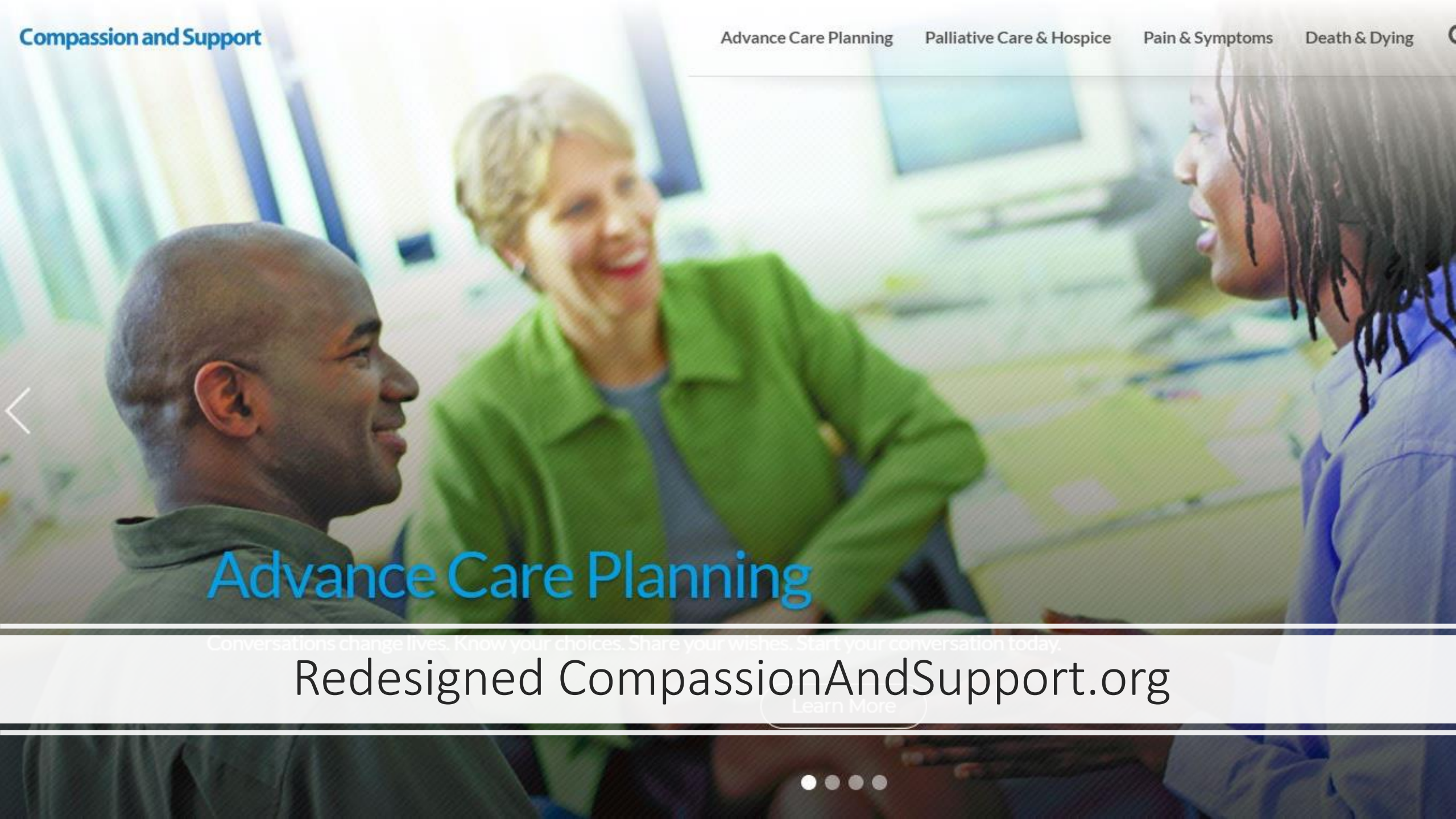
Education, Engagement & Empowerment

System Implementation

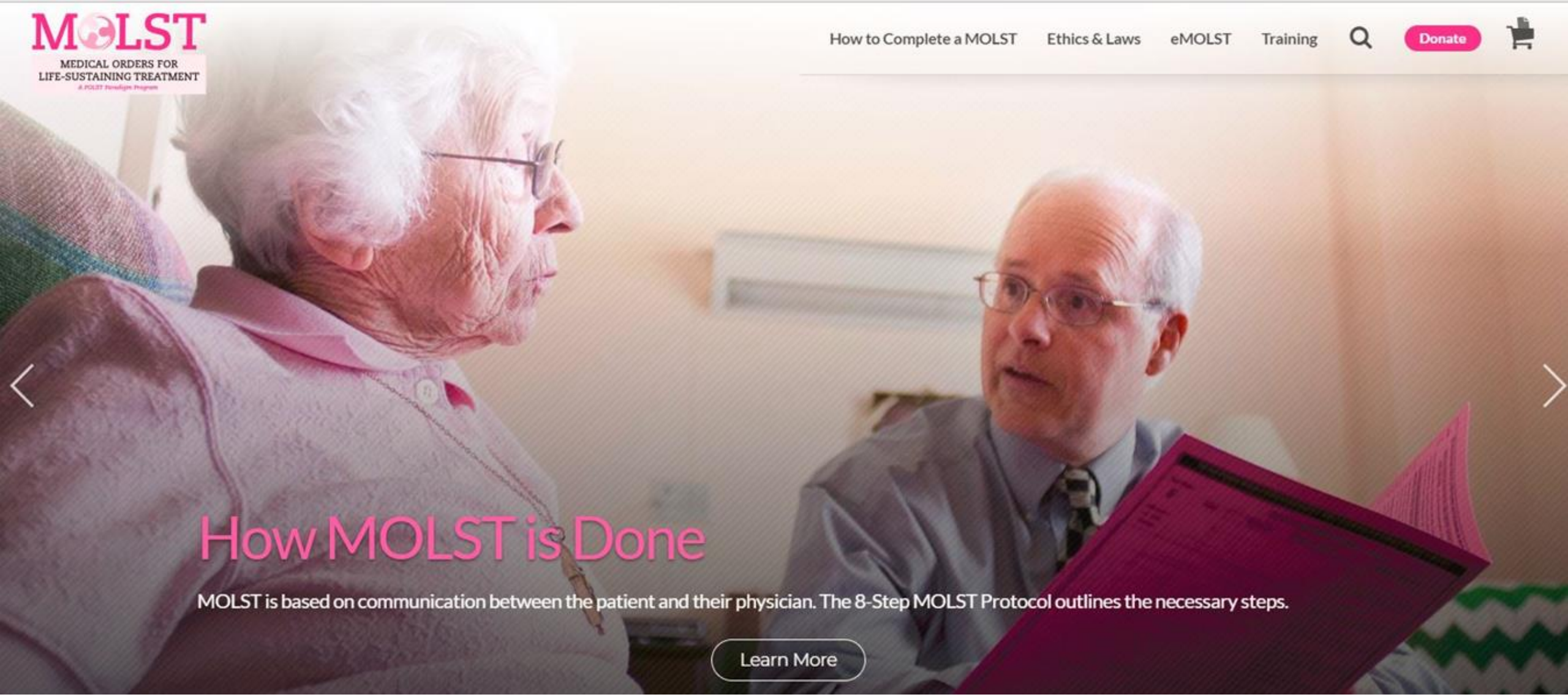
Legislative Advocacy

NYSeMOLSTregistry.com

- Secure website, free public health service, available statewide, patient-centered, integration with EMRs available but *not* required
    - Standardized process for **online** MOLST completion
    - Combines 8-Step MOLST Protocol & 7 Checklists
    - **Registry** of NYeMOLST forms across NYS
    - Provider can print a PDF of MOLST form
- Improves quality, patient safety, accuracy and provides access to MOLST & discussion in an emergency
- eMOLST is a risk management tool.
- Promotes coordinated, person-centered care by improving workflow **within and across** facilities



Redesigned CompassionAndSupport.org



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