Digital Transformation of MOLST: Getting Started and Ensuring Sustainability
Speakers

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Nothing to Disclose
Objectives

• Identify value of early advance care planning, MOLST/eMOLST implementation in Post-Acute, Long Term Care & the long term care continuum

• List steps and create a work plan that streamlines adoption of new innovative technology & leverage new CPT codes

• Produce a work plan for implementation and sustainability of MOLST/eMOLST using existing educational & other resources
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
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?”
Value of MOLST/eMOLST in Healthcare

• Promoting value in healthcare encourages hospitals and other providers to reduce waste and unnecessary care while maintaining high quality of care.

• Hospital Compare: individual hospital results for payment and death(mortality) measures together

• MOLST/eMOLST: reduce unwanted hospitalizations/ED visits
Dedicated Physician & System Champions Align with Health Systems 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
- State Health Innovation Plan
- IOM Dying in America Recommendations
MOLST/eMOLST: End-of-life Care Transitions Program

Hospital

LTC

Office

A Project of the Community-Wide End-of-life/Palliative Care Initiative
IOM Report Dying in America

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

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

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

- **Goals for Care shift**
  - 6mo
  - 12 mo

- **Hospice**
  - Bereavement

⇒ Progression of Serious Illness ⇒
Key Recommendations
Policies and Payment Systems Actions

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

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

- **NY MOLST**: Medical Orders for Life-Sustaining Treatment
National POLST Paradigm Programs  *As of 2006

- **Endorsed Programs**
- **Developing Programs**
- **No Program (Contacts)**
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
Advance Care Planning

Compassion, Support and Education along the Health-Illness Continuum

Advancing chronic illness

Chronic disease or functional decline

Healthy and independent

Maintain & maximize health and independence

Multiple co-morbidities, with increasing frailty

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

CompassionAndSupport.org
POLST.org
<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><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>
</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>
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Key Recommendations
Policies and Payment Systems Actions

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

• NY’s eMOLST highlighted in IOM Report

Released September 17, 2014. Report available: www.nap.edu
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.
8-Step MOLST Protocol

1. Prepare for discussion
   - Understand patient’s health status, prognosis & ability to consent
   - Retrieve completed Advance Directives
   - Determine decision-maker and NYSPHL legal requirements, based on who makes decision and setting

2. Determine what the patient and family know
   - re: condition, prognosis

3. Explore goals, hopes and expectations

4. Suggest realistic goals

5. Respond empathetically

6. Use MOLST to guide choices and finalize patient wishes
   - Shared, informed medical decision-making
   - Conflict resolution

7. Complete and sign MOLST
   - Follow NYSPHL and document conversation

8. Review and revise periodically

Developed for NYS MOLST, Bomba, 2005; revised 2011
AFTER FHCDA: MOLST Instructions and Checklists

Ethical Framework/Legal Requirements

- **Checklist #1** - Adult patients with medical decision-making capacity *(any setting)*
- **Checklist #2** - Adult patients without medical decision-making capacity who have a health care proxy *(any setting)*
- **Checklist #3** - Adult hospital or nursing home patients without medical decision-making capacity who do **not** have a health care proxy, and decision-maker **is** a Public Health Law Surrogate *(surrogate selected from the surrogate list)*
- **Checklist #4** - Adult hospital or nursing home patients without medical decision-making capacity who do **not** have a health care proxy **or** a Public Health Law Surrogate
- **Checklist #5** - Adult patients without medical decision-making capacity who do not have a health care proxy, and the MOLST form is being completed in the **community**.
- **Checklist for Minor Patients** - *(any setting)*
- **Checklist for Developmentally Disabled who lack capacity** – *(any setting)* **must** travel with the patient’s MOLST

eMOLST Produces MOLST and MOLST Chart Documentation Form

Align with NYSDOH Checklists
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

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

Dr. Kim Petrone
Physician at St. Ann's Community

Dr. Patricia Bomba, eMOLST Program Director

CompassionAndSupport YouTube Channel
Effective Implementation Requires a Multidimensional Approach
*Recommended by the 2014 IOM Dying in America report

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)
Culture Change

- Thoughtful Discussions
- Values, Beliefs, Goals
- Shared Decision Making
- Preferences Based on Goals
- Care Plan Based on MOLST
Professional Training: Physicians, Health Care Professionals, Others
Public Education, Engagement and Empowerment

Real Stories
Educational Resources

MOLST Conferences
Community Talks

MOLST General Instructions
NYSDOH MOLST Checklists
8-Step MOLST Protocol

1. Prepare for discussion
   - Understand patient’s health status, prognosis & ability to consent
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Developed for NYS MOLST, Bomba, 2005; revised 2011
Care Plan Supports MOLST
System Implementation

- Policies and Procedures
- Workflow: Current and Future
- Identification of Patients using a population health approach to screening:
  - Advance care planning for everyone 18 years and older
  - Appropriate for POLST Paradigm
- Staffing considerations
- Operational considerations
- Quality Improvement:
  - Use Plan-Do-Study-Act (PDSA) cycles
  - Develop a work plan, timelines, accountability
  - Plan – Execute - Sustain
System Implementation
Advance Care Planning Clinical Pathway (Work Flow)
Life Expectancy of Greater than One Year

Start: Physician / Patient Conversation

Does Patient Have Advance Directives?

Yes
Obtain Copy of Completed Advance Directives

No
Educate about Importance of Advance Directives

Provide Information on Advance Directives

Assess Barriers to Completing Advance Directives

Are There Barriers to Completing Advance Directives?

Yes
Reinforce Need for Updated Advance Directives

No
Are the Advance Directives Up-to-Date?

Yes
Assess Appropriateness of Designated Health Care Agent

No
Inquire about Organ Donation and/or Autopsy

Work to Overcome Barriers

Motivate Completion of Advance Directives

Reassess Periodically or as Needs Change

Yes
Consider Introducing the Palliative Care Team

Discuss Palliative Care Options Including Hospice

Elicit Patient’s Values and Preferences for End-of-Life Care

Encourage Patient to Discuss Wishes with Family

Bomba, JNCCN 4(8), 2006

http://www.compassionandsupport.org/index.php/for_professionals/advanced_care_planning - _professionals/life_expectancy_greater_than_1
System Implementation
Advance Care Planning Clinical Pathway (Work Flow)
Life Expectancy of Less than One Year

Start:
Physician / Patient
Conversation
Educate about Importance of Advance Directives
Obtain Copy of Completed Advance Directives
Elicit Patient’s Values and Preferences for End-of-Life Care
Assess Barriers to Completing Advance Directives
Reinforce Need for Updated Advance Directives
Encourage Patient to Discuss Wishes with Family

Are There Barriers to Completing Advance Directives?
No
Yes
Work to Overcome Barriers
Motivate Completion of Advance Directives

Are the Advance Directives Up-to-Date?
No
Yes
Complete MOLST Form

Consider Introducing the Palliative Care Team
Discuss Palliative Care Options Including Hospice
Inquire about Organ Donation and/or Autopsy

Reassess Periodically or as Needs Change

For New York State Residents

http://www.compassionandsupport.org/index.php/for_professionals/advanced_care_planning_-_professionals/life_expectancy_less_than_1_year

Bomba, JNCCN 4(8), 2006
Built-In Quality Measures

• Completion of ACP process
  – includes properly completed MOLST, as well as documentation of the process

• MOLST
  – Medical orders properly completed, storage & retrieval
  – Document discussion and process

• eMOLST Analytics
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
Digital Transformation
NYSeMOLSTregistry.com

MOLST Chart Documentation Form
Align with NYSDOH Checklists
Thank You

• Thank you for your visionary leadership and support of the multiple dimensions needed to ensure proper implementation of Advance Care Planning and the digital transformation of MOLST to eMOLST.

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