POLST: A National Perspective and Lessons Learned from New York
Presenters

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Vice President & Medical Director, Excellus BlueCross BlueShield
Chair, MOLST Statewide Implementation Team; eMOLST Program Director
Founding Member, National POLST Paradigm

The presenter has nothing to disclose.
Objectives

- Review advance care planning as a communication process, a key pillar of palliative care, and an integral component of the practice of medicine
- Explain the difference between advance directives and medical orders
- Discuss the 8-Step MOLST protocol that outlines a communication process, the ethical framework and shared, informed medical decision-making for end-of-life discussions
- Discuss key barriers and means to overcome those barriers
- Identify challenges, successes and lessons learned from experience in New York, an endorsed 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 25% of all Medicare Spending

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?”
Community Needs Assessment
Honoring Patient Preferences for EOLC

• IOM Report Approaching Death: Improving Care at the EOL, 1997
  – Gaps in care and quality issues
    • location of death, pain management, treatment preferences and hospice admissions

• Community End-of-Life Survey Report, 2001
  – RIPA/EBCBSRR EOL/Palliative Care Professional Advisory Committee, Regional Variations in Site of Death

• Community-Wide End-of-life/Palliative Care Initiative, 2001
  – Regional Variations in Cost of Care at EOL
  – Functional Health Illiteracy
  – Healthcare Professional Communication Skills

i www.iom.edu/CMS/3809/12687.aspx

Community-wide End-of-life/Palliative Care Initiative, 2001

• Advance Care Planning
  – Community Conversations on Compassionate Care

• Honoring Preferences
  – Medical Orders for Life-Sustaining Treatment (MOLST)
  – PEGS

• Pain Management and Palliative Care
  – Community Principles of Pain Management (CPPM) & Guidelines for Opioid Use Disorder added
  – CompassionNet

• Education and Communication
  – Education for Physicians on End-of-life Care (EPEC)

Community web site: www.CompassionAndSupport.org
www.MOLST.org added April 2018

Community-Wide EOL/Palliative Care Initiative, Launch May 2001
2014 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

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

12 mo

6mo

Diagnosis

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

⇒ Progression of Serious Illness ⇒

Hospice

Bereavement

Death
Advance Care Planning

Compassion, Support and Education along the Health-Illness Continuum

Chronic disease or functional decline

Maintain & maximize health and independence

Healthy and independent

Advancing chronic illness

Multiple co-morbidities, with increasing frailty

Death

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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

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 and MOLST.org
CompassionAndSupport.org and POLST.org

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Advance Directives and Actionable Medical Orders

Traditional ADs

For All Adults

Community Conversations on Compassionate Care (CCCC)

- Vermont Advance Directive for Healthcare
- 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
- Clinician Orders for DNR/CPR and other Life Sustaining Treatment (COLST)
- Physician Orders for Life Sustaining Treatment (POLST) Paradigm Programs

VTEthicsNetwork.org
CaringInfo.org

VTEthicsNetwork.org
POLST.org

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Community Conversations on Compassionate Care
Storytelling and **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
Community Conversations on Compassionate Care
How to Choose a Health Care Agent

- Knows me well
- Understands what is important to me
- Will talk about sensitive wishes now
- Will listen to my wishes
- Willing to speak on my behalf
- Would act on my wishes
- Can separate his/her feelings from mine
- Will be available in the future
- Lives close by or willing to come
- Could handle responsibility
- **Can manage conflict resolution**
- Meets legal criteria
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
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
Flow of Emergency Care: Standard Medical Care
Flow of Emergency Care: MOLST or any POLST Paradigm Program
## Differences Between MOLST/POLST and Advance Directives

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>POLST</th>
<th>Advance Directives</th>
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<tr>
<td>Population</td>
<td>For the seriously ill</td>
<td>All adults</td>
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<tr>
<td>Timeframe</td>
<td><strong>Current care</strong></td>
<td>Future care</td>
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<tr>
<td>Who completes the form</td>
<td>Health Care Professionals</td>
<td>Patients</td>
</tr>
<tr>
<td>Resulting form</td>
<td>Medical Orders (POLST)</td>
<td>Advance Directives</td>
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<tr>
<td>Health Care Agent or Surrogate role</td>
<td>Can engage in discussion if patient lacks capacity</td>
<td>Cannot complete</td>
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<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>

Advance Care Planning Screening Questions*

• Does my patient have a health care proxy?
• Do I have a copy of the health care proxy?
• Has the patient shared their values, beliefs and goals for their care?
• Has the person spoken with their family?
• Is my patient appropriate for MOLST?

*Appropriate for Medicare and other Wellness Visits, Hospital, LTC, Hospice pre-admission & admissions
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 the physician 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?
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?
Standardized clinical process
Discussion of patient’s values & goals for care
Shared medical decision-making between health care professionals and seriously ill patients (ethical framework/legal requirements)
Physician/NP Accountability for medical orders
Documentation of discussion

Result: portable medical orders
  - reflect the patient’s preference for life-sustaining treatment they wish to receive and/or avoid
  - common community-wide form
  - **ONLY** form EMS can follow DNR, DNI and Do Not Hospitalize

Professional Training

Thoughtful MOLST Discussions

- Physicians and other clinicians
- *Within scope of practice*
- Communication skills
- 8-Step MOLST Protocol
- MOLST Form, Instructions & FAQs
- Shared, informed medical decision-making
- Evidence-based guidelines: CPR, Long-term Feeding Tube Placement
- Conflict resolution
- Proper documentation
  - “Remember, if you don’t document, it didn’t happen.”
- Leverage ACP CPT codes 99497 and 99498
“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
Effective Communication Skills
Thoughtful MOLST Discussions

• Express yourself clearly
• Ask open-ended questions
• Actively listen
• Reflect: paraphrase the message and communicate understanding back
• Resolve conflicts
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

http://www.nyhealth.gov/professionals/patients/patient_rights/molst/
Care Plan Supports MOLST
Lessons Learned from NY MOLST
Culture Change

• Thoughtful Discussions
• Values, Beliefs, Goals
• Shared Decision Making
• Preferences Based on Goals
• Care Plan Based on MOLST
Why There Are Failure in Following MOLST Orders

• Clinicians, patients, families are unaware of their obligations to follow MOLST and implications of failure to follow MOLST

• Advance care planning is not recognized as a dynamic process, including MOLST
  – Emphasis should be on communication
  – Forms are the end of the process
Why There Are Failures in Following MOLST Orders

• Attention is given to the discussion, but ADs or MOLST are not completed or done incorrectly (incompatible orders)

• Avoiding early discussions or focusing on interventions, rather than personal values, beliefs and goals for care #WhatMattersMost

• Wrong Health Care Agent is chosen

Why There Are Failure in Following MOLST Orders

• Lack of understanding of the differences between advance directives (HCP, LW) and medical orders (MOLST)

• Failure to assess and document capacity & other legal requirements

• Lack of accessibility to MOLST and documentation of the discussion
Ethics Case #1

- 82 yo woman with multiple medical problems and frailty receives all care in one health system

- Hospitalized in early December; transferred to NH for rehab. MOLST “done” at SNF: CPR, DNI, No feeding tube; MD signature illegible, no license # or printed name; no documentation of discussion or capacity available at transfer.

- Hospitalized in January in different system; no medical records

- Admission orders: DNR, DNI; no documentation of discussion, capacity determination

- Family unaware of MOLST or DNR/DNI order
Ethics Case #1

- Patient develops acute respiratory insufficiency, hypoxia & lacks ability to make decisions
- **Family discussion**: family asserts patient did not have capacity to make decisions in early December or at time of admission; family unaware of MOLST or DNR/DNI
- Family asks to rescind DNR, DNI. Patient intubated.
- **Clinical assessment**: successful vent wean unlikely
- Family alleges person centered values & beliefs: DNI acceptable, terminal wean off ventilator is not
- **Staff moral distress**: disregard of patient preferences & requests Ethics Consultation
Ethics Case #2

• 88-year-old woman sent from NH to ER
• Dementia, paralysis of all four extremities from strokes, a horrible sacral bed sore, osteomyelitis, septic shock, and respiratory failure.
• No family; no health care agent
• Transfer papers: Nonhospital DNR order; no MOLST
• ER: Patient intubated and admitted to MICU
• Medical staff: “The poor woman was in extremis and doing her utmost to cast off her earthly shackles.”
Recommendations

• Strengthen clinician training

• Encourage public education and engagement in advance care planning

• Expand use of eMOLST
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

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](http://NYSeMOLSTregistry.com).
8-Step MOLST Protocol

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http://www.nyhealth.gov/professionals/patients/patient_rights/molst/
eMOLST Produces MOLST and MOLST Chart Documentation Form

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

LAST NAME/FIRST NAME DATE OF BIRTH

Step 1 – Identification of Appropriate 1750-b Surgeon from Prioritized List. Check appropriate category and add name of surgeon:

- [ ] Surgeon

If the list is not being used, then the following information should be included

If the list is not being used, then the following information should be included:

- [ ] 1750-b Surgeon

Decision made orally:

[ ] Decision made orally

Witness – Attending Physician

[ ] Decision made in writing (must be dated, signed by surgeon, signed by 2 witnesses and given to attending physician)
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
- **CNY case example**
Why eMOLST: NYSDOH Attorney, Physician Feedback
Quality, Patient Safety and Accessibility
Effective Implementation Requires a Multidimensional Approach

1. Culture change*
2. Professional training of physicians, clinicians & other professionals*
3. Public advance care planning education, engagement & empowerment*
4. Thoughtful discussions*
5. Shared, informed medical decision-making*
6. Care planning that supports MOLST
7. System implementation, policies and procedures, workflow
8. Dedicated system and physician champion
9. Leverage existing payment stream (CPT codes 99497 and 99498) to encourage upstream shared, informed, decision making*
10. Standardized interoperable online completion and retrieval system available in all care settings to ensure accuracy and accessibility (NYSeMOLSTregistry.com)*

*Recommended by the 2014 IOM Dying in America report
Question and Answers

Email questions and comments to Patricia Bomba, MD, MACP
Patricia.Bomba@lifethc.com
Key MOLST Resources

- **Websites:** [MOLST.org](http://MOLST.org) and [CompassionAndSupport.org](http://CompassionAndSupport.org)

  - "Writing Your Final Chapter: Know Your Choices. Share Your Wishes"
  - Original release 2007; revised to comply with FHCDA

- **CompassionAndSupport YouTube Channel** ACP and MOLST playlists
  - [http://www.youtube.com/user/CompassionAndSupport?feature=mhee](http://www.youtube.com/user/CompassionAndSupport?feature=mhee)

- **Thoughtful MOLST Discussions in Hospital & Hospice**
  - [https://youtu.be/gKseJkuuFuk?list=PLCSvowXDKV5LfzLqQGqdQ-n3ocGn8LWZ2](https://youtu.be/gKseJkuuFuk?list=PLCSvowXDKV5LfzLqQGqdQ-n3ocGn8LWZ2)

- **Thoughtful MOLST Discussions in Nursing Home**
  - [https://youtu.be/LYAT43hXxwg?list=PLCSvowXDKV5LfzLqQGqdQ-n3ocGn8LWZ2](https://youtu.be/LYAT43hXxwg?list=PLCSvowXDKV5LfzLqQGqdQ-n3ocGn8LWZ2)


- **MLMIC Dateline Special Edition**, includes NYSBA Health Law Journal article co-authored by J Karmel & P Bomba; 3 additional cases are included

- "New CPT Codes for Advance Care Planning and MOLST Discussions"
  - [https://dl.dropboxusercontent.com/u/69456301/ACP.MOLSTdiscussionsNewCodes.071816.ppt?dl=1](https://dl.dropboxusercontent.com/u/69456301/ACP.MOLSTdiscussionsNewCodes.071816.ppt?dl=1)
Key eMOLST Resources

- Physician offices, hospitals, nursing homes, palliative care/hospice programs can implement and have patients’ MOLST forms included in NY’s eMOLST registry; for further information visit NYSeMOLSTregistry.com.

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

- eMOLST Tools
  NYSeMOLSTregistry.com

- eMOLST Overview (5:37)
  https://youtu.be/MjL8Qz944IU?list=PLCSvvwXDKV5IEJX39GHvbs8ekkfNXec55

- NYSDOH Attorney’s Perspective on eMOLST (1:38)

- Advantages of eMOLST: A Nursing Home Physician’s Perspective (7:24)
  https://youtu.be/jn47FLYsxss?list=PLCSvowXDKV5IEJX39GHvbs8ekkfNXec55

- eMOLST webinar sponsored by IPRO and includes Q & A (2:00)
  https://qualitynet.webex.com/qualitynet/ldr.php?RCID=f2c519e24280cbe7863dab9ad1bf68ea