What Can I Do?
5 Ways to Promote Advance Care Planning

Overview of Advance Care Planning
Differences Between Advance Directives & Medical Orders

Patricia A. Bomba, MD, MACP, FRCP
Vice President & Medical Director, Geriatrics
Excellus BlueCross BlueShield
Chair, MOLST Statewide Implementation Team
MOLST & eMOLST Program Director
Founding Member, National POLST Paradigm
Lead, ECHO MOLST
Patricia.Bomba@lifethc.com
Who will write our final chapter?

Will we die in a manner consistent with the way we lived, which respects our personal values, spiritual beliefs, cultural background & preserves our dignity?
Advance Care Planning Conversations

- Occur with a person, their health care agent and primary clinician, and other members of the clinical team
- Are recorded and updated as needed
- Allow for flexible decision making in the context of the patient’s current medical situation.

Advance Directives

(18 and older)

- Health Care Proxy
- Living Will

Medical Orders (MOLST)

(Advanced illness/frailty)

- Resuscitation
- Respiratory Support
- Hospitalization
- Life-Sustaining Treatment
Community Conversations on Compassionate Care

Storytelling and **Five Easy Steps**

1. Learn about advance directives
   - NYS Health Care Proxy
   - Living Will

2. Remove barriers

3. Motivate yourself
   - Stories
   - View C CCC videos

4. Complete your HCP
   - Have a conversation
   - Choose the right HCA
   - Discuss what matters
   - Understand LST
   - Put it in writing
   - Share copies

5. Review and Update
Value of Advance Care Planning
Complete a Health Care Proxy and Family Discussion

Yes: Patient Wishes Honored. Family at Peace

No: Patient and Family Suffered
Advance Care Planning:
For Everyone 18 years and Older
Who is Appropriate for MOLST

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
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 & FHCDCA 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
- Palliative care plan and caregiver support
8-Step MOLST Protocol

1. Prepare for discussion
   - Understand patient’s health status, prognosis & ability to consent
   - Retrieve completed Advance Directives
   - Determine decision-maker & PHL legal requirements

2. Determine what the patient/family know

3. Explore goals, hopes and expectations

4. Suggest realistic goals

5. Respond empathetically

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

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

8. Review and revise periodically

Developed for NYS MOLST, Bomba, 2005; revised 2011
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); includes hospice

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 (+/- hospice eligible)

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/
Patient Values, Beliefs, Goals for Care, Expectations

Identify patient’s personal values and beliefs
• What makes life worth living
• What matters most

Recognize patient’s personal goals for care
• Longevity
• Functional Preservation
• Comfort Care

Patient’s personal goals align with

Does COVID-19 or other emergency change this?
Shared, Informed Medical Decision Making

- Will treatment make a difference?
- What are the burdens and benefits?
- Is there hope of recovery?
- What does the patient value?
Resuscitation Preferences

- Define CPR
- Success rate of CPR
- Advanced illness ≤ 2.0%
- Moderate frailty-terminal illness: <2%
- Reality of COVID-19
Respiratory Support

• Intubation & mechanical ventilation
• Noninvasive ventilation
• Trial period
  • determine if there is benefit
  • based on the patient’s current goals for care
Hospitalization/Transfer Preferences
Care Plan

- Palliation
  - Pain and symptom management
- Caregiver Support & Education
  - Family
  - Loved Ones
  - Staff
Flow of Emergency Care: Standard Medical Care
Flow of Emergency Care: MOLST
End-of-life Conversations Pre-COVID-19

- Face-to-face
- Include family, medical decision-maker
- Team-based approach within scope of practice
- Authority & accountability
- May require a series of conversations
Shift to Telemedicine
Digital Transformation
eMOLST: Best Practice

NYSeMOLSTregistry.com
NYSeMOLSTregistry.com

- Secure website
  1. Standardized process for **online** MOLST completion
  2. **Registry** of NYeMOLST forms across NYS
- Improves quality, patient safety, accuracy and access to MOLST & discussion in an emergency
- Guides MDs/NPs/PAs & patients/decision-makers using a standardized process
  - Allows a team approach “within scope of practice”
  - Provider can print a PDF of MOLST form
- Promotes coordinated, person-centered care by improving workflow within and across facilities
- eMOLST is a free public health service available statewide, accessed at [NYSeMOLSTregistry.com](http://NYSeMOLSTregistry.com)
Advance Care Planning

Conversations change lives. Know your choices. Share your wishes. Start your conversation today.

Redesigned CompassionAndSupport.org

Learn More
How MOLST is Done

MOLST is based on communication between the patient, family, and provider. The 8-Step MOLST Protocol outlines the necessary steps.

Subscribe to NY MOLST Update on MOLST.org
Community Partners in Advance Care Planning
Advance Care Planning is a Plan for Living!

“You matter because you are you. You matter to the last moment of your life and we’ll do all we can not only to help you die peacefully, but also to live until you die.”

Dame Cicely Saunders
Personal Story