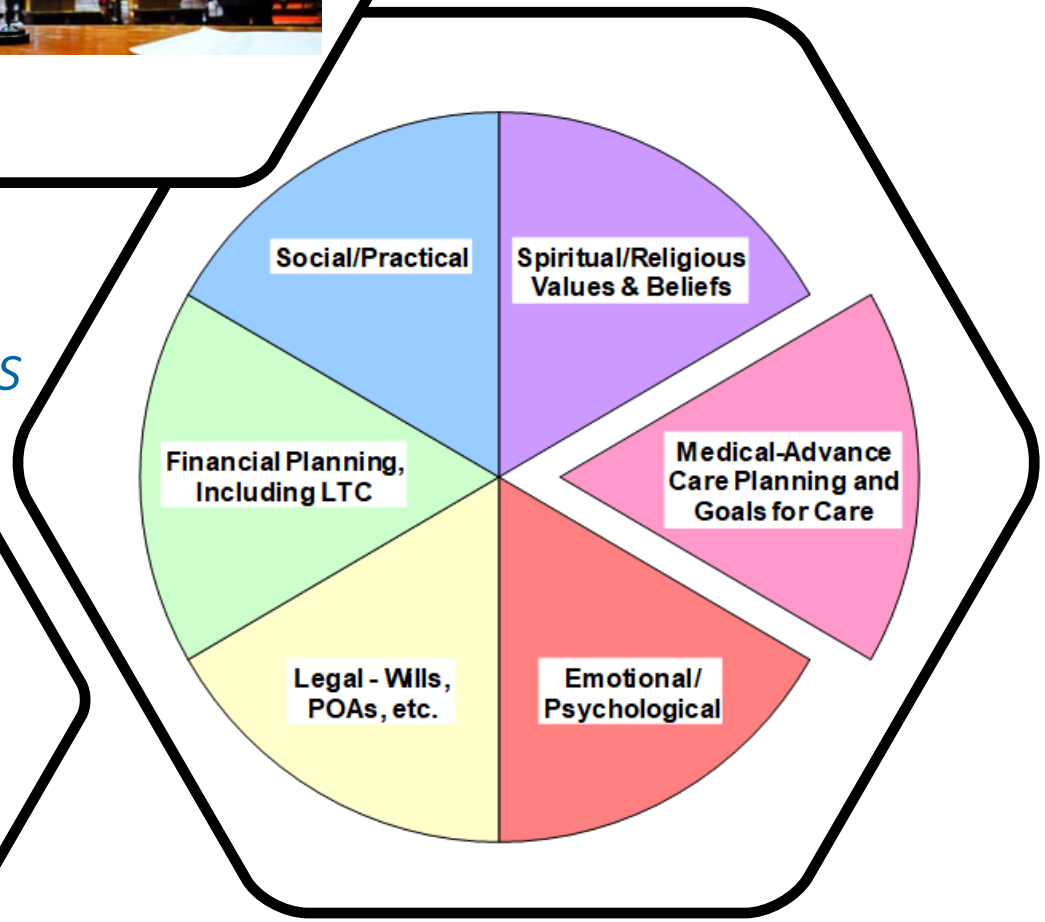
Advance Care Planning is a Right
A Medical-Legal Perspective:
Fifty States, Fifty Forms, Fifty Public Health Laws



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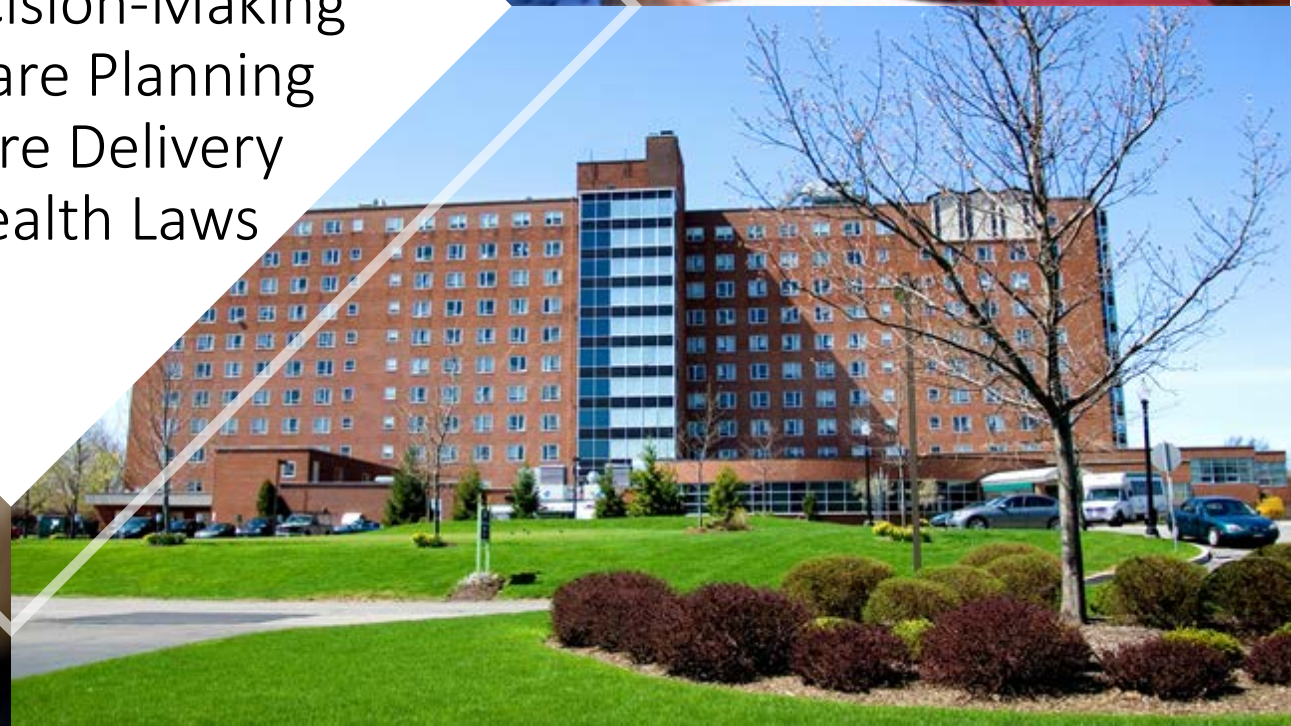
No Conflicts of Interest

Variations Impact Evidence Base

Medical Decision-Making
Advance Care Planning
Health Care Delivery
Public Health Laws



Advance Care Planning – A Key Pillar of Palliative Care
A Population Health Approach – A NY Case Study

Advance Directives

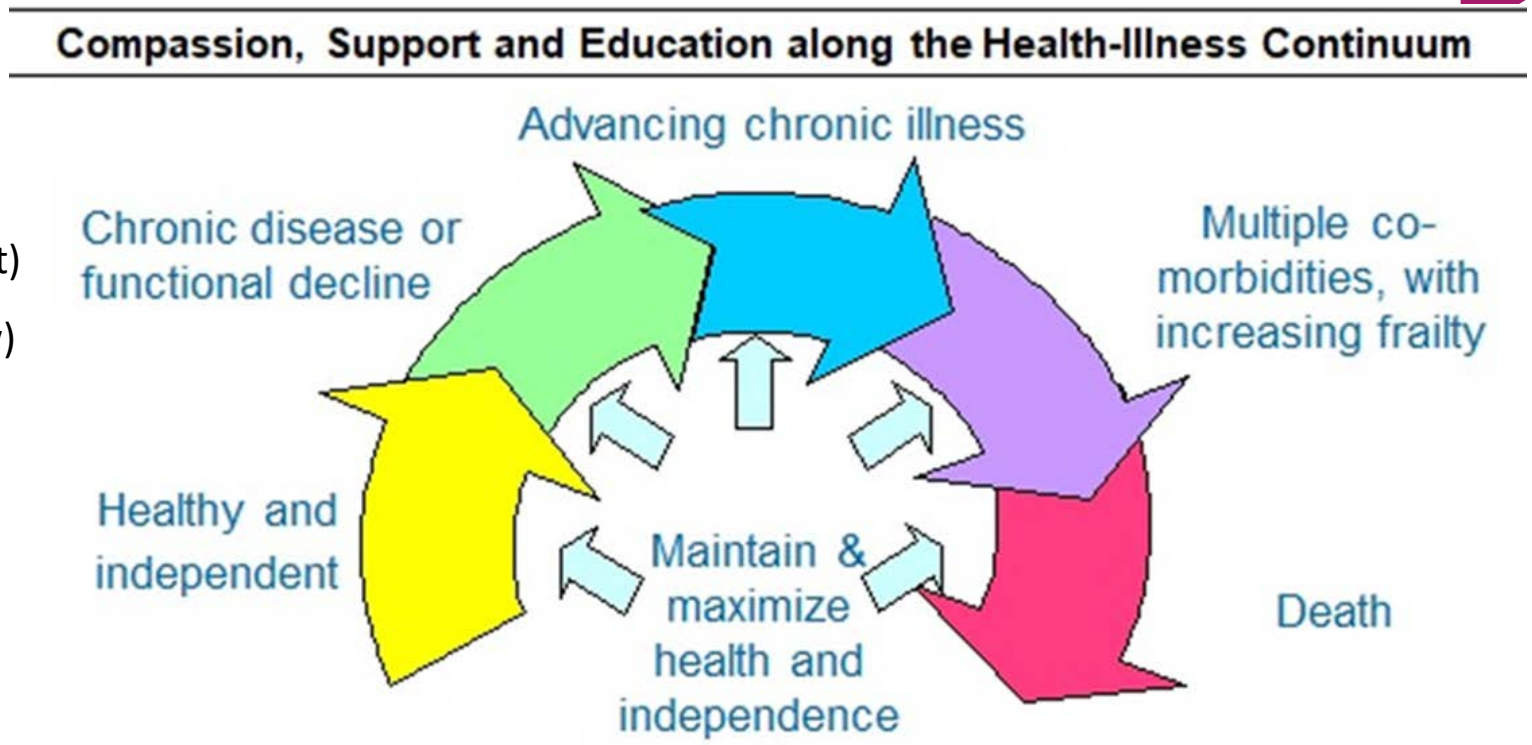
(18 and older)

- Health Care Proxy (legal document)
- Living Will (recognized by case law)

Medical Orders (MOLST)

(Advanced illness/frailty)

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



Tricia's Story

Bill & Debbie's Story

Joanne's Story

Lee's Story

Lucia's Story

Community Conversations on Compassionate Care

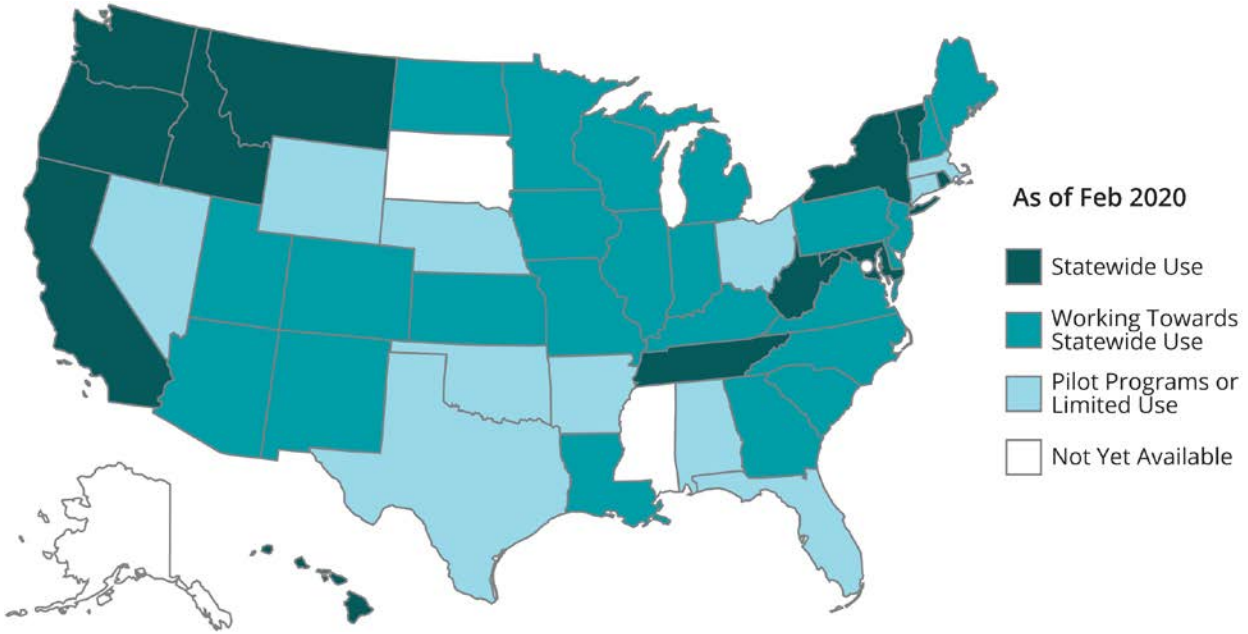
Should choose the right "trusted person" –a Health Care Agent.
Share "what matters most".
Put it in writing. Complete a Health Care Proxy.
Talk to loved ones.
Learn how to make medical decisions.

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),

National POLST: Completion is Voluntary.

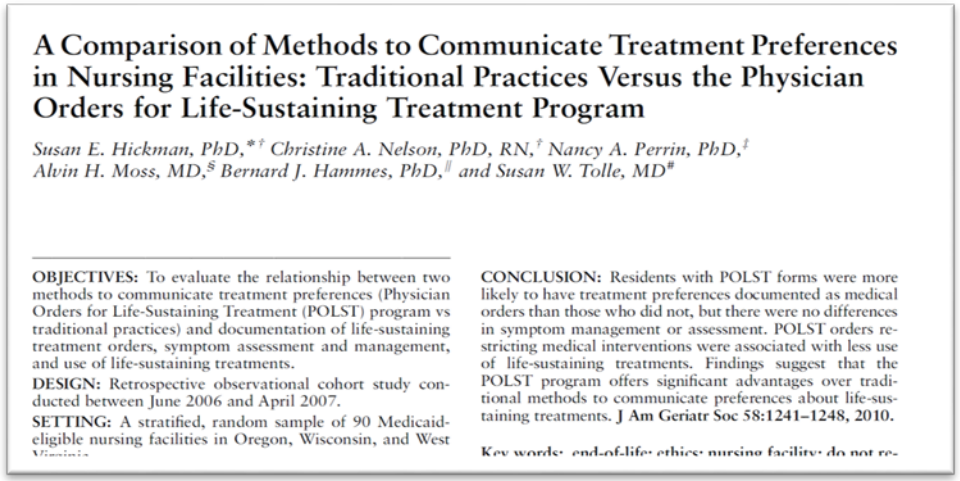
Screening to Ensure Appropriateness is Essential.



Appropriate Population

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 (typically of advanced age)
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

POLST and Goal Concordant Care



A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program

Susan E. Hickman, PhD,† Christine A. Nelson, PhD, RN,† Nancy A. Perrin, PhD,‡ Alvin H. Moss, MD,§ Bernard J. Hammes, PhD,‖ and Susan W. Tolle, MD#*

OBJECTIVES: To evaluate the relationship between two methods to communicate treatment preferences (Physician Orders for Life-Sustaining Treatment (POLST) program vs traditional practices) and documentation of life-sustaining treatment orders, symptom assessment and management, and use of life-sustaining treatments.

DESIGN: Retrospective observational cohort study conducted between June 2006 and April 2007.

SETTING: A stratified, random sample of 90 Medicaid-eligible nursing facilities in Oregon, Wisconsin, and West

CONCLUSION: Residents with POLST forms were more likely to have treatment preferences documented as medical orders than those who did not, but there were no differences in symptom management or assessment. POLST orders restricting medical interventions were associated with less use of life-sustaining treatments. Findings suggest that the POLST program offers significant advantages over traditional methods to communicate preferences about life-sustaining treatments. **J Am Geriatr Soc 58:1241–1248, 2010.**

Key words: end-of-life; ethics; nursing facility; do not re-

Setting = Nursing Home
Key finding = POLST Comfort Care orders associated with fewer treatments in comparison to POLST Full Treatment and no POLST.
Concordance = 94%.

Setting = Hospital
Key finding = POLST Comfort Care orders associated with fewer inpatient treatments in comparison to POLST Full Treatment.
Concordance = 62%

Research

JAMA | Original Investigation | CARING FOR THE CRITICALLY ILL PATIENT

Association of Physician Orders for Life-Sustaining Treatment With ICU Admission Among Patients Hospitalized Near the End of Life

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IMPORTANCE Patients with chronic illness frequently use Physician Orders for Life-Sustaining Treatment (POLST) to document treatment limitations.

OBJECTIVES To evaluate the association between POLST order for medical interventions and intensive care unit (ICU) admission for patients hospitalized near the end of life.

DESIGN, SETTING, AND PARTICIPANTS Retrospective cohort study of patients with POLSTs and with chronic illness who died between January 1, 2010, and December 31, 2017, and were hospitalized 6 months or less before death in a 2-hospital academic health care system.

EXPOSURES POLST order for medical interventions ("comfort measures only" vs "limited additional interventions" vs "full treatment"), age, race/ethnicity, education, days from POLST

Editorial page 934
Supplemental content
CME Quiz at jamanetwork.com/learning and CME Questions page 994

Ethical-Legal Requirements for End-of-life Decisions Three NY Public Health Laws and SCPA §1750-b

Developed for NYS MOLST, Bomba, 2005; revised 2011

Lessons Learned from NY Goal Concordance Requires

- Screen
- Assess capacity
- Evaluate understanding of prognosis & health status
- Patient's goals
- Palliative care plan
  - ✓ Pain & symptoms
  - ✓ 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
   - Conflict resolution
7. **Complete and sign MOLST**
   - Follow PHL and document conversation
8. Review and revise periodically

NYSDOH & OPWDD MOLST Checklists

- **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

NYSeMOLSTregistry.com

Definition

- Secure website, free public health service, available statewide, person-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
- Promotes coordinated, person-centered care by improving workflow **within and across** facilities

Data (as of September 30, 2020)

- Approximately 50,000 live patients in eMOLST
- Average age: 82
- Resuscitation Preferences: 82% DNR; 18% CPR
- Intubation & Ventilation: 72% DNI; 19% Trial; 9% Intubate
- Hospitalization: Do Not Send 21%; Send 44%; Decision Deferred 35%

Value of Advance Care Planning and NY eMOLST During COVID-19 Crisis

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

Culture Change

Key Points

1. **Should** choose a trusted person if capacity is lost and engage family & loved ones are critically important elements.
2. Foster **culture change**: normalize ACP similar to legal and financial planning for future care planning.
3. Build **patient-centered systems** that ensure access to discussions, “what matters most” to the patient, patient goals, advance directives & medical orders (when appropriate) across care transitions.
4. Establish metrics for a population health based approach for advance directives ***vs.*** medical orders.
5. **Bottom line**: ACP is complex and right. Measure “what matters most” to patients and families.