Objectives

- Describe a successful two-step approach to advance care planning
- Review goals and positive outcomes of two award-winning complementary programs
  - Community Conversations on Compassionate Care (CCCC)
  - Medical Orders for Life-Sustaining Treatment (MOLST) Paradigm
- Identify available tools on the community web site www.CompassionAndSupport.org
- Develop a workplan to provide advance care planning in your program or practice site

Needs Assessment

Honoring Patient Preferences for EOLC

- Approaching Death: Improving Care at the EOL
  - Institute of Medicine Report, 1997
  - Gaps in care and quality issues
    - location of death, pain management, treatment preferences and hospice admissions
- Community End-of-Life Survey Report
- RIPA/EBCBSRR EOL/Palliative Care Professional Advisory Committee, January 2001
- Regional Variations in Site of Death
- Regional Variations in Cost of Care at EOL
- Functional Health Illiteracy
- Healthcare Professional Communication Skills

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

- 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
  - CompassionNet
- Education and Communication
  - Education for Physicians on End-of-life Care (EPEC)
  - Community web site: www.CompassionAndSupport.org

Advance Care Planning

Compassion, Support and Education along the Continuum
How to Develop an Effective Advance Care Planning Program
Rivington House Conference
June 26, 2009

Patricia Bomba M.D., F.A.C.P.
Vice President and Medical Director, Geriatrics, Excellus BlueCross BlueShield
Chair, MOLST Statewide Implementation Team
Leader, Community-wide End-of-life/Palliative Care Initiative

Advance Directives

Traditional ADs
For All Adults
• New York
  • Health Care Proxy
  • Living Will
  • Organ Donation
  • State-specific forms

Actionable Medical Orders
For Those Who Are Seriously Ill or Near the End of Their Lives
• Do Not Resuscitate (DNR) Order
• Medical Orders for Life Sustaining Treatment (MOLST)
• Physician Orders for Life Sustaining Treatment (POLST) Paradigm

www.CompassionAndSupport.org
www.Polst.org

Community Conversations on Compassionate Care (CCCC)

Community Goals: National Quality Forum

• Document the designated agent (surrogate decision maker) in a Health Care Proxy for every patient in primary, acute and long-term care and in palliative and hospice care.
• Document the patient/surrogate preferences for goals of care, treatment options, and setting of care at first assessment and at frequent intervals as condition changes.
• Convert the patient treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital, i.e., the Medical Orders for Life-Sustaining Treatment—MOLST, a POLST Paradigm Program.
• Make advance directives and surrogacy designations available across care settings
• Develop and promote healthcare and community collaborations to promote advance care planning and completion of advance directives for all individuals.

Traditional Directives Outcomes

• Traditional Advance Directives Outcomes
  • Every adult (18 and older) will complete a Health Care Proxy
  • Every adult will have meaningful discussions about end-of-life
  • Every adult will have access to an easily recognizable document
  • Every adult will have access to educational sessions

MOLST Short Term Outcomes
• Consistent ongoing application of the Medical Orders for Life-Sustaining Treatment (MOLST) program.
• Successful MOLST Community Pilot and adoption of a MOLST as a statewide program.
• Expanded cadre of volunteers prepared to engage in one-to-one and community conversations regarding end-of-life issues, options and the value of advance directives, including the MOLST form.

MOLST Long Term Outcomes:
• Informed & prudent use of life-sustaining & intensive care services.
• Greater efficiencies in health care delivery.
• Improved patient and family satisfaction.
• Reduction in costs associated with medical liability and defensive medicine by providing physicians an efficient framework for discussing end-of-life options.

Five Easy Steps

1. Learn about advance directives
   • NYS Health Care Proxy
2. Remove barriers
3. Motivate yourself
4. Complete your documents
   • 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

NYS Living Will
NYS Health Care Proxy

Medical Orders for Life-Sustaining Treatment (MOLST Program), A POLST Paradigm Program

• Improve the quality of care people receive at the end of life
  • Effective communication of patient wishes
  • Documentation of medical orders on a brightly colored pink form
  • Promise by health care professionals to honor these wishes
• Complements the use of traditional advance directives

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A Project of the Community-Wide End-of-life/Palliative Care Initiative

For Quality Palliative Care & Hospice Care, 2006. Adapted for New York State.
Behavioral Readiness to Complete a Health Care Proxy
- See no need
- Recognize need, but have barriers
- Ready to complete
- Advance Care Directive reflects wishes
- Advance Care Directive needs update

Advance Directives
National Metrics: Completion Rates
- 1991 - Patient Self-Determination Act
  - 20% had a form of Advance Directive (AD)
  - 75% approved of a Living Will
- 2002 - Means to a Better End
  - 15-20% Americans have AD
- 2005 - Pew Research Center for the People and the Press
  - 29% Americans have AD - living wills
- 2008 - AARP survey
  - <40% Americans 35 yo and older have AD

End-of-life Care Community Survey Methodology
- United Marketing Research - conducted interviews
- Random sample of residents living in a 39-county area of upstate New York
- 2,000 adults, 18 and older, interviewed by phone
- Between March 6, 2008 and April 6, 2008
- Selection - random digit dialing (RDD) sample
- Quota sampling approach
  - ensure meaningful number of individuals (about 400)
  - surveyed within each of five regions
  - established for respondents 55 and older - minimize age bias

Disparity between consumer attitudes & actions regarding advance directives

Disparity between consumer attitudes and actions regarding health care proxies

Has your doctor ever talked to you about Health Care Proxies and Living Wills?
How to Develop an Effective Advance Care Planning Program
Rivington House Conference
June 26, 2009

Community Resources
Advance Care Planning
- Advance Care Planning Booklet (English, Spanish)
- Advance Care Planning Poster and Tent card
- Behavioral Readiness “tools”
- Community Conversations on Compassionate Care (CCCC) workshop
- CCCC video
- CCCC video on-line with Five Easy Steps
- Advance Care Planning Facilitator Training
- ACP Clinical Pathways
- CompassandSupport.org Web site

POLST Paradigm Program

History of MOLST Program
- Work initiated Fall 2001
- Created November 2003
- Adapted from Oregon’s POLST
- Combines DNR, DNI, and other LST
- Incorporates NYS law
- Collaboration with NYSDOH – 3/04
- Revised 10/05
- Approved Inpatient DNR form
- Legislation passed 2005
- Community Pilot launched
- Chapter Amendment 2006
- Gov Paterson signed bill 7/8/08
- MOLST consistent with PHL§2977(3)
- Permanent change in EMS scope of practice, 7/08
- MOLST permanent and statewide

MOLST: Next Steps
- MOLST
  - permanent and statewide
  - can be used in the community as DNR and DNI
- Next Steps
  - Statewide expansion
    - SEMAC, SEMSCO
  - NYSDOH
  - Work with OMH and OMRDD
  - Legislation to amend PHL
  - Electronic Workflow
  - Care Management Integration
  - Clinical variation in EOLC and thoughtful ACP discussion

Community Resources
Medical Orders for Life-Sustaining Treatment
- MOLST 8-Step Protocol
- MOLST Guidebook including FAQs
- MOLST Patient & Family Brochure (English, Spanish)
- Sample Facility Policies & Procedures
- Sample Facility Implementation/Education Workplans
- MOLST Training Manual
- MOLST Train-the-Trainer Sessions and Conferences
- MOLST DVD and web-based tools
- MOLST EMS Training
- MOLST Training Center: CPR/DNR; Capacity
- www.CompassionAndSupport.org
- Tube Feeding Guidelines

Website
http://www.CompassionAndSupport.org

Reliable Information: Patients, Families & Professionals
- Advance Care Planning
- Health Care Proxies
- MOLST
- Life-Sustaining Treatment
- Feeding Tubes
- Pain Management
- Hospice & Palliative Care
- Death & Dying
- Spiritual Information
- Pediatrics
- En Espanol

Compass And Support Video Library

Patricia Bomba M.D., F.A.C.P.
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Six Steps to Develop and Implement:
Community-wide End-of-life/Palliative Care Initiative

1. Define Vision, Mission, Values
2. Employ results-oriented approach
3. Design effective, inclusive coalition membership
4. Create effective leadership
5. Demonstrate strong commitment to purpose
6. Monitor performance

Getting Started
- Identify Physician Champion and System Champion
- Demonstrate commitment – begin by doing your own health care proxy
- Learn effective communication skills
- Initiate at your primary practice site
- Establish an advance care planning campaign among employees
- Use tools from the successful CCCC and MOLST Programs

MOLST Program Initiation
- Establish multidisciplinary team
- Engage physician and system champions
- Use the MOLST Training Center
- Develop implementation plan
  - Template at MOLST Training Center
  - MOLST Hospital Implementation Process
  - MOLST LTC Implementation Process
  - Interviews on MOLST video Honoring Patient Preferences
- Develop educational training plan
  - Template at MOLST Training Center
  - Educational Plan for Advance Directives and MOLST

Advance Care Planning:
Life Expectancy of Greater than One Year

Start:
- Physician / Patient Conversation
- Educate about Importance of Advance Directives
- Elicit Patient’s Values and Preferences for End-of-Life Care
- Discuss Palliative Care Options
- Including Hospice
- Consider Introducing the Palliative Care Team
- Work to Overcome Barriers
- Does Patient Have Advance Directives?
  - Yes
  - No
  - Are the Advance Directives Up-to-Date?
  - Encourage Patient to Discuss Wishes with Family
  - Inquire about Organ Donation and/or Autopsy
  - Obtain Copy of Completed Advance Directives
  - Assess Appropriateness of Designated Health Care Agent
  - Motivate Completion of Advance Directives
  - Assess Barriers to Completing Advance Directives
  - Yes
    - Are There Barriers to Completing Advance Directives?
      - No
      - No

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Advance Care Planning
Clinical Pathway <1 year

8-Step MOLST Protocol

1. Prepare for discussion
   - Understand the patient and family
   - Understand the patient's condition and prognosis
   - Retrieve completed Advance Care Directives
   - Determine "Agent" (Spokesperson) or responsible party
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 (POLST) to guide choices and have patient/family share wishes
   - Shared medical decision making
   - Conflict resolution
7. Complete and sign MOLST/POLST
8. Review and revise periodically

Developed for NYS MOLST, Bomba, 2005

Champions

- How to find a champion?
- Who can be a champion?
- What can the champion do?
- How to get staff energized and on board?
- How to get the patients and family on board?

Functional Health Literacy

Definitions

- Literacy - basic ability to read and speak English
- Functional literacy - ability to use reading, writing, and computation skills at a level of proficiency necessary to meet the needs of everyday life situations, function on the job and in society, achieve one's goals, and develop one's knowledge and potential
- Functional health literacy - ability to read, understand, and act on health information.

Consequences

- Poorer health status
- Lack of knowledge about medical care and medical conditions
- Decreased comprehension of medical information
- Lack of understanding and use of preventive services
- Poorer self-reported health
- Poorer compliance rates
- Increased hospitalizations
- Increased health care costs

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Education and Training

- Advance Care Planning Facilitators
  - Traditional advance directives
  - MOLST form and program
  - Goal-based, patient-centered discussions
  - Patient-centered program and process
    - not merely the form
- Program Implementation
  - Facility-based
  - Physician practice – opportunity for process improvement

Community education

Overcoming Functional Health Literacy
Model for Community Education

- Community presentations
  - Videos on DVDs followed by facilitated discussion and Question and Answer period
    - Session 1: Community Conversations on Compassionate Care video with Five Easy Steps for Completing an Advance Directive
    - Session 2: Writing Your Final Chapter
  - Share available community resources; e.g. information on hospice
  - Refer to CompassionAndSupport Website

- CompassionAndSupport Website
  - Videos available on-line for individual use

Advance Care Planning Campaign
Rochester 2002

Advance Care Planning Campaign
Chi Eta Phi Sorority Rochester Chapter

- Healthcare and community collaborative
- Partnership with sixteen Rochester Community Churches and other organizations

Goals:
- Improve quality of care delivered at the end-of-life
- Overcome functional health illiteracy
- Active member of the Community-wide End-of-life/Palliative Care Initiative
- Support short-term and long-term advance care planning community goals
- Key contributor to community outcomes that exceed national metrics
- Sustainable model that can be replicated

Quality Management
Adult Preventive Health Guideline

- Counsel all individuals regarding completion of advance care directives

Advance Directives: Advance Care Planning is a process that requires conversation and results in the completion of an Advance Directive. An Advance Directive allows patient preferences and goals to drive care and to guide shared medical decision making in the event the patient is unable to communicate. Studies have demonstrated that physician counseling markedly increases the completion rate of Advance Directives.

Community Conversations on Compassionate Care
Advance Care Planning Employer Toolkit

- Cover Letter
- Community Conversations on Compassionate Care (CCCC) DVD
- Advance Care Planning Public Service Announcements DVD
- Advance Care Planning Booklet
- Advance Care Planning Brochure
- Advance Care Planning Table Topper
- Advance Care Planning Poster
- Web Bookmark (www.CompassionAndSupport.org)
- Flash Drive – resources to implement an advance care planning employee campaign
Employee Healthcare Decisions Survey Methodology

- Survey to all Health Plan employees
  - Launched via email on February 8, 2008
  - Two reminder emails were sent one week apart
  - 53% response rate (2,315 of 4,343 surveys)
  - 63% in 35-54 age range
  - The margin of error was ±2%

- Results compared
  - 2006 Healthcare Decisions Employee Survey (same 23 question survey)
  - 2002 Healthcare Decisions Employee Survey (shorter 6 question survey)

Completion Rate for Health Care Proxies

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<th>Year</th>
<th>Percent</th>
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<td>2006</td>
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Completion Rate for Health Care Proxies By Region

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When Health Care Proxy Was First Completed

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<td>5+ years ago</td>
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Employee Health Care Decision Survey
Excellus BlueCross BlueShield, April 2008

THANK YOU

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Visit Patient, Family and Professional Resources
www.CompassionAndSupport.org

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