



*How to Develop an Effective Advance Care Planning Program
Rivington House Conference
June 26, 2009*







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Chair, MOLST Statewide Implementation Team
Leader, Community-wide End-of-life/Palliative Care Initiative*

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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

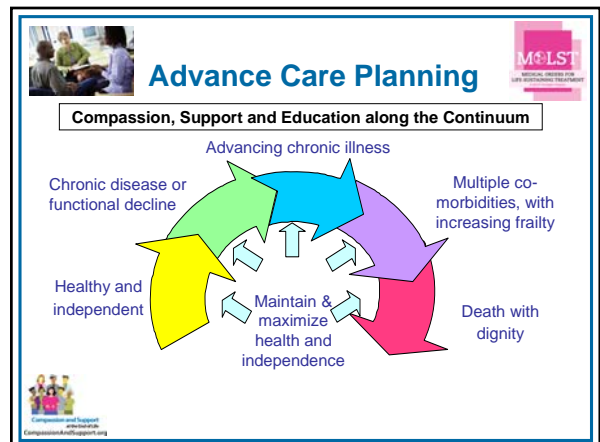


Community-wide End-of-life/ Palliative Care Initiative



- 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

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

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Advance Directives

Traditional ADs

For All Adults
Community Conversations on Compassionate Care (CCCC)

- New York
- Health Care Proxy
- Living Will
- Organ Donation
- State-specific forms

www.CompassionAndSupport.org
www.CaringInfo.org

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


www.CompassionAndSupport.org
www.Polst.org




Advance Care Planning 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.

National Quality Forum, Framework and Preferred Practices for Quality Palliative Care & Hospice Care, 2006, Adapted for New York State

Advance Care Planning Outcomes Traditional Directives and MOLST

- **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 uniform 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.




Community Conversations on Compassionate Care Five Easy Steps

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



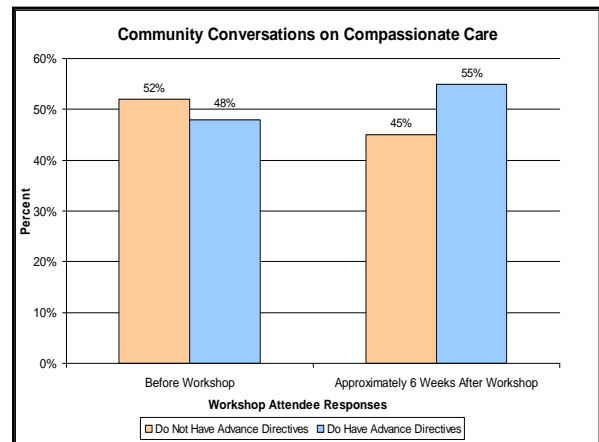
[CCCC video on-line with Five Easy Steps](#)




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

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

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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

Bomba, Doniger, Vermilyea, 2002.


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 Endⁱ
 - 15-20% Americans have AD
- 2005 - Pew Research Center for the People and the Pressⁱⁱ
 - 29% - Americans have AD - living wills
- 2008-AARP surveyⁱⁱⁱ
 - <40% -Americans 35 yo and older have AD

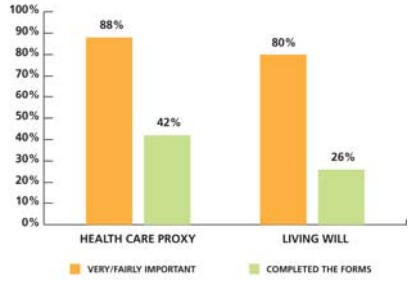
ⁱ Means to a Better End: A Report on Dying in America Today, November 2002
ⁱⁱ The Pew Research Center for the People and the Press. More Americans Discussing and Planning End-of-life Treatment. January 5, 2006
ⁱⁱⁱ http://assets.aarp.org/occenter/ill/setting_ready.pdf

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

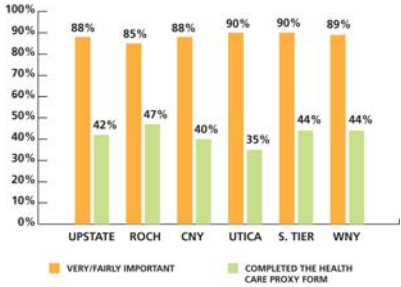
Disparity between consumer attitudes & actions regarding advance directives



Category	Very/Fairly Important	Completed the Forms
HEALTH CARE PROXY	88%	42%
LIVING WILL	80%	26%

End-of-Life Care Survey of Upstate New Yorkers: Advance Care Planning Values and Actions, Excellus BlueCross BlueShield, April 2008

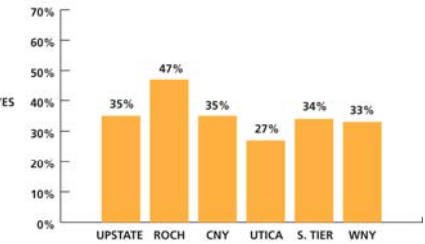
Disparity between consumer attitudes and actions regarding health care proxies



Region	Very/Fairly Important	Completed the Health Care Proxy Form
UPSTATE	88%	42%
ROCH	85%	47%
CNY	88%	40%
UTICA	90%	35%
S. TIER	90%	44%
WNY	89%	44%

End-of-Life Care Survey of Upstate New Yorkers: Advance Care Planning Values and Actions, Summary Report, 2008

Has your doctor ever talked to you about Health Care Proxies and Living Wills?




Region	Yes
UPSTATE	35%
ROCH	47%
CNY	35%
UTICA	27%
S. TIER	34%
WNY	33%


End-of-Life Care Survey of Upstate New Yorkers: Advance Care Planning Values and Actions, Summary Report, 2008

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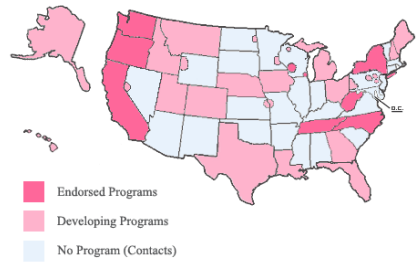
Community Resources Advance Care Planning



- 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
- CompassionAndSupport.org Web site




POLST Paradigm Program





■ Endorsed Programs
■ Developing Programs
■ No Program (Contacts)


Paradigm of communication, documentation, and system responsiveness
 POLST Paradigm Program, June 2009. www.polst.org




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

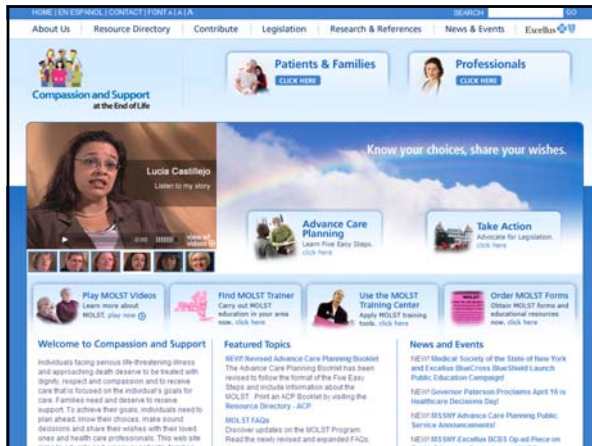
[Compassion And Support Video Library](#)



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**Six Steps to Develop and Implement:
 Community-wide End-of-life/Palliative Care Initiative**

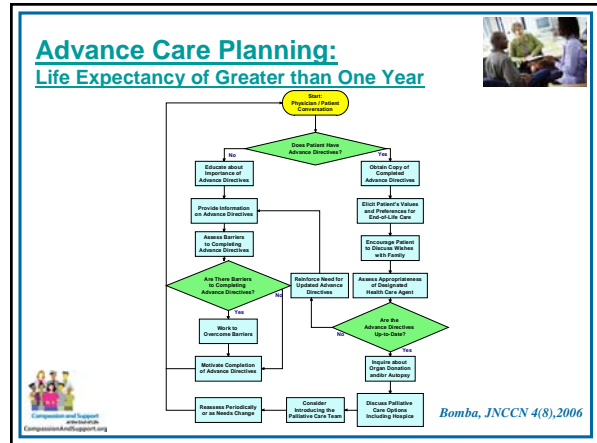
1. Define Vision, Mission, Values
2. Employ results-oriented approach
3. Design effective, inclusive coalition membership
4. Create effective leadership
5. Demonstrate strong commitment to purpose
6. Monitor performance



http://www.compassionandsupport.org/index.php/about_us

Getting Started

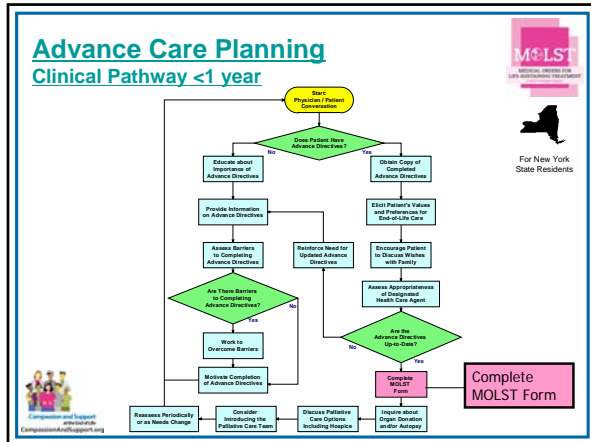
- Identify Physician Champion and System Champion
- Demonstrate commitment – begin by doing your own health care proxy
- Learn effective communication skills
- Initiate at your primary practice site
- Establish an advance care planning campaign among employees
- Use tools from the successful CCCC and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

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- ### 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.

- ### Functional Health Literacy 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




Overcoming Functional Health Literacy 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




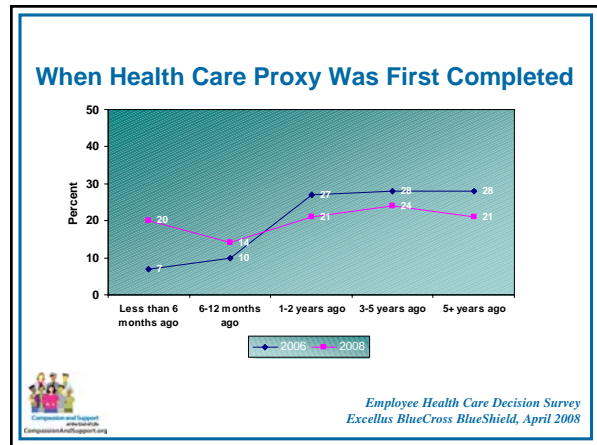
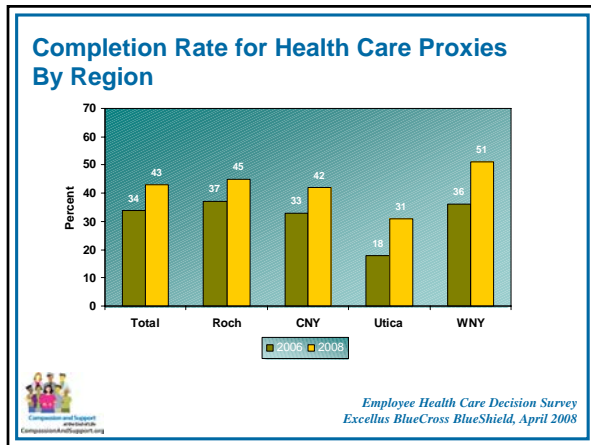
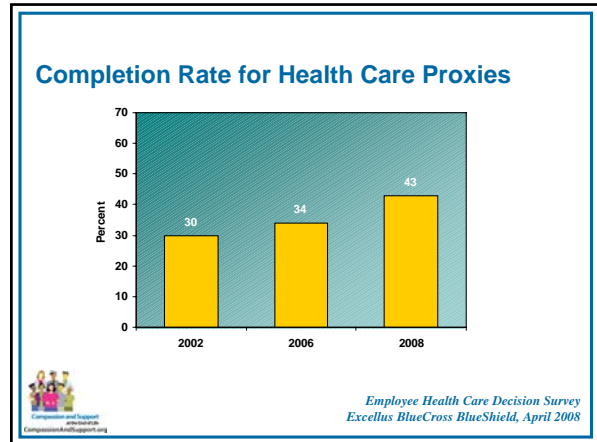
- Cover Letter
- Excellus BCBS Employee Healthcare Decisions Survey (2008) Summary Report
- Community Conversations on Compassionate Care (CCCC) DVD
- Advance Care Planning Public Service Announcements DVD
- Advance Care Planning Booklet
- Advance Care Planning Brochure
- Advance Care Planning Table Topper
- Advance Care Planning Poster
- Web Bookmark (www.CompassionAndSupport.org)
- Flash Drive – resources to implement an advance care planning employee campaign



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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 $\pm 2\%$
- Results compared
 - 2006 Healthcare Decisions Employee Survey (same 23 question survey)
 - 2002 Healthcare Decisions Employee Survey (shorter 6 question survey)

THANK YOU

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





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