Care Transitions Intervention: The Fifth Pillar
A Two-Step Approach to Advance Care Planning:
Community Conversations on Compassionate Care (CCCC)
Medical Orders for Life-Sustaining Treatment (MOLST)

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Advance Care Planning

Compassion, Support and Education along the Continuum

Advancing chronic illness

Chronic disease or functional decline

Healthy and independent

Maintain & maximize health and independence

Multiple co-morbidities, with increasing frailty

Death with dignity

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

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

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Community Conversations on Compassionate Care

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

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

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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Thoughtful EOLC Discussions: Benefits

- Improve quality; reduce cost
- Only 31% of patients with advanced cancer at EOL had had discussions with physicians about EOLC
- Patients who had EOL conversations had significantly lower costs in their final week of life, over $1,000 less
- “Higher costs were associated with worse quality of death”

Arch Intern Med. 2009;169(5):480-488

Thoughtful EOLC Discussions: Benefits

- "End-of-life discussions are associated with less aggressive medical care near death and earlier hospice referrals.”
- “Aggressive care is associated with worse patient quality of life and worse bereavement adjustment.”

Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment
JAMA. 2008;300(14):1665-1673
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: CompassionAndSupport.org

Advance Care Planning Goals & Outcomes

Traditional Advance 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
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; through collaboration with the RHIO
- Develop and promote healthcare and community collaborations to promote advance care planning and completion of advance directives for all individuals; e.g. Respecting Choices and Community Conversations on Compassionate Care

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

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

1 Means to a Better End: A Report on Dying in America Today, November 2002
3 http://assets.aarp.org/rgcenter/il/getting_ready.pdf

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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


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Disparity between consumer attitudes and actions regarding health care proxies

![Bar chart showing the percentage of people who found health care proxies very or fairly important and those who completed health care proxy forms in different regions of New York State.]


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

![Bar chart showing the percentage of people who have discussed health care proxies and living wills with their doctor in different regions of New York State.]


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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 RRHIO and HEAL 5
  - Care Management Integration
  - Clinical variation in EOLC and thoughtful ACP discussion

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September 15-16, 2009

Website
CompassionAndSupport.org

Reliable Information: Patients, Families & Professionals
- Advance Care Planning
- MOLST for Patients/Families
- MOLST Training Center for Professionals
- Life-Sustaining Treatment
- Guidelines for Long Term Feeding Tube Placement
- Pain Management for Patients/Families
- Pain Management for Professionals
- Hospice & Palliative Care
- Death & Dying
- Faith Based Perspectives Patients and Families
- Pediatrics
- En Espanol
- Care Transitions Intervention
- Health Care Reform: focus on HR3200 Section 1233

Compassion And Support Video Library

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