Care Planning Hearing

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eMOLST Aims to Improve Quality & Patient Safety to Achieve the Triple Aim

Thank you for the opportunity to present New York State's work in this area. Advance care planning is a continuous process of planning for future medical care and preparing for the potential situation in which the individual loses the ability to make medical decisions. Two different types of documents exist for different populations.

Given time constraints, my remarks today will focus on **eMOLST** (the electronic version of Medical Orders for Life-Sustaining Treatment) and the **New York State (NYS) eMOLST Registry**.

eMOLST is a statewide multi-tenant web application that can provide an eMOLST form to any provider at any time across NYS instantly.

Our vision for development of eMOLST aligns with the "Triple Aim":

- Improving the patient experience of care, including quality and satisfaction
- Improving the health of populations, by maximizing the quality of life for the seriously ill person, based on the person's values, beliefs and goals for care and providing an extra layer of support for the seriously ill person and their family, loved ones and caregivers
- Reducing the per capita cost of health care by reducing unwanted hospitalizations at the end of life, based on the decisions made by a seriously ill person through a standardized, shared decision making process that is well informed, based on an ethical framework and NYSPHL legal requirements for making decisions to withhold or withdraw life-sustaining treatment with or without a MOLST

Given the comments of other panelists, I would offer the opportunity to work group members to either 1) present an eMOLST demo or 2) enroll interested workgroup members as users, who could then view the eMOLST training site. eMOLST eliminates many of the concerns raised by both work group members and other panelists during the course of the discussion.

In NY, we have learned that sustainable implementation of MOLST and eMOLST requires a multidimensional approach:

- culture change
- provider training
- person/family education & empowerment
- care planning that supports MOLST
- system implementation
- a dedicated MOLST and eMOLST system champion
- a sustainable payment stream based on improved compliance with residents' preferences for care and treatment options

Goals:

- improved person/family satisfaction
- reduced unwanted hospitalizations

Slide #2 National Quality Forum Advance Care Planning Preferred Practices
While advance care planning is about planning for death and the end of life, it is also about planning for potential loss of medical decision-making capacity as a result of acute injury or illness with the possibility of death, but often, recovery.

Advance care planning should be framed as a wellness initiative, as anyone may face a sudden and unexpected acute illness or injury with the potential risk of losing the ability to make medical decisions. Our focus is on choosing the right designated medical decision-maker (health care agent in NYS); discussion of values, beliefs and goals for care; and discussion with family and loved ones, as well as the provider.

Slide #3 Advance Directives vs. Actionable Medical Orders
Advance care planning discussions result in creation of different documents, depending on the needs of the individual.

Everyone 18 years of age and older should have an advance directive that designates the chosen health care agent and a person's values, beliefs and goals. The Community Conversations on Compassionate Care (CCCC) combines storytelling and "Five Easy Steps," based on the behavioral readiness to initiate advance care planning discussion

Seriously ill persons are encouraged to work with the physician and consider completing a MOLST if the person:

- Wants to receive or avoid any or all life-sustaining treatment
- Resides in a long term care facility or requires long term care services
- Might die within the next year

For more information on value of advance directives vs. medical orders and data, view: http://www.compassionandsupport.org/index.php/for_patients_families/advance_care_planning **NYS data**: http://www.compassionandsupport.org/index.php/research_references/research

POLST: An Improvement over Advance Directives, a Cleveland Clinic Journal of Medicine article.

Advance directives must be available whenever the need is triggered by the loss of the ability to make medical decisions via internet-based registries or electronic personal health records

Medical orders must be available in an emergency and across care transitions through a program such as MOLST, since advance directives cannot be followed by emergency personnel in an emergency. **The NYS eMOLST Registry instantly provides a person's current eMOLST form to any authorized system or health professional across the state.**

Slide #4 MOLST is an End-of-life Care Transition Program
MOLST was developed and implemented as an end-of-life care transition program to ensure a seriously ill person's preferences for life-sustaining treatment are clearly indicated as medical

orders and are followed by all health care professionals, including EMS, if the person moves from one location to another to receive care.

EMS cannot follow advance directives, but can follow medical orders in accordance with protocols. MOLST must be completed correctly and not contain incompatible orders.

eMOLST ensures that patient goals for care and preferences for care and treatment can be honored at any time and across all care settings and followed as medical orders by all healthcare professionals.

Slide #5 History of MOLST/eMOLST
NYS Public Health Law did not permit surrogates to make medical decisions in the absence of "clear and convincing" evidence of a person's wishes until June 1, 2010, when Family Health Care Decisions Act (FHCDA) went into effect. **A major change in eMOLST was required with passage of FHCDA; the eMOLST system is built to accommodate change.** Subsequent updates reflect user feedback.

Slide #6 Defining eMOLST vs. NYS eMOLST Registry
eMOLST is a secure web-based application allows enrolled users to complete the eMOLST form and document the discussion in the correct MOLST Chart Documentation Form (CDF) and/or mandated OPWDD Checklist for Persons with Developmental Disabilities who lack capacity.

- The CDFs document the person's goals for care, pertinent discussion, and the ethical/legal requirements.
- Forms are created as pdf documents that can be printed for the patient and a paper-based medical record, stored in an EMR via link to eMOLST, and become part of the NYS eMOLST registry.

The **NYS eMOLST Registry** is an electronic database centrally housing MOLST forms and CDFs to allow 24/7 access in an emergency.

- The NYS eMOLST Registry instantly provides a person's current eMOLST form to any authorized system or health professional across the state.
- Unlike most EMRs, the NYS eMOLST Registry does not need to have a per-facility installation, or per-facility maintenance.

Slide #7 Pathways for eMOLST Use

- The application creates, digitally signs, stores, and provides access to MOLST forms.
- The NYS eMOLST Registry is centrally hosted and is a singular statewide multi-tenant system.
- Each organization uses the same eMOLST registry.
- There is a system and infrastructure that supports it and will support everyone in the state who needs to use it.

Slide #8 The 8-Step MOLST Protocol
The 8-Step MOLST Protocol is a standardized process, designed to educate and assist health care professionals with thoughtful MOLST discussions. This standardized process focuses on the seriously ill person's values, beliefs and goals for care guiding the choice of treatment

preferences using a shared, informed medical decision-making process. The process is integrated into eMOLST.

Slide #9 MOLST Instructions and Checklists
The ethical framework for making decisions to withhold and/or withdraw life-sustaining treatment and the legal requirements under NYSPHL vary based on who makes the decision and where the decision is made. The seven checklists are integrated into eMOLST.

Slide #10 MOLST and MOLST CDFs
MOLST forms and CDFs are created as pdf documents that can be printed for the patient and a paper-based medical record, stored in an EMR via link to eMOLST, and become part of the NYS eMOLST registry.

Slide #11
The following screenshots give a glimpse of eMOLST.

An enrolled user signs in with their unique user name and password. The level of access in eMOLST user is assigned based on clinical and/or administrative roles at the time of enrollment. Some health care professionals participate in the discussion; in NY only physicians can sign the MOLST; some providers need access to read only; and those involved in QA/QI activities, but not in direct patient care, are assigned administrative access to de-identified aggregate data only.

Slide #12
A list of active patients in the registry is accessible on the "My Patients" list. An enrolled user can search with first name, last name, date of birth and gender OR via eMOLST #. Notifications track actions taken on "My Patients."

Slide #13
Multiple providers can serve as "custodians" for a person's eMOLST form. When a person moves to a new care setting, the new provider attests to caring for the person. Persons who are no longer being cared for can be removed from "custodianship;" this results in removal from the list of "My Patients." When a person dies, the eMOLST is marked as deceased. "Form History" tracks all providers who have accessed the eMOLST form.

Slide #14
A summary of the person's values, beliefs and goals for care discussion can be reviewed and validated with the patient or designated medical decision-maker before moving forward to discussing specific medical orders.

Slide #15
Consent for page 1 and page 2 is separate in NY's MOLST and eMOLST to accommodate NYSDOH regulations that require asking a person being admitted to a nursing home on the day of admission, a time when a lengthy discussion is not feasible. If the same designated medical decision maker makes decisions, eMOLST auto populates the fields.

Slide #16 Electronic Signature
An eMOLST form is electronically signed. Consistent with NYSPHL, physicians are the only eMOLST users with access and ability to electronically sign. The user's unique eMOLST password, correct answer to question and image are required.

Slide #17 MOLST Form
The MOLST form is immediately available.

Slide #18 Review and Renewal of eMOLST Form
NY's MOLST is required under law to be reviewed periodically, and also:

- If the person moves from one location to another to receive care; or
- If the person has a major change in health status (for better or worse); or
- If the person or medical decision-maker changes his or her mind about treatment

eMOLST makes it easier for the provider to review the current set of MOLST orders and record the outcome of the review. If the form is voided and a new form is completed, the process is easy and efficient, allowing more time for discussion.

Slide #19 eMOLST web page
This web page contains tools and resources providers and facilities need to get started: http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center/emolst