

Advance Care Planning RFI

Purpose:

The purpose of this Request for Information (RFI) is to gather input about the advance care planning process and for the possible redesign of the Medical Orders for Life Sustaining Treatment (MOLST), nonhospital Do Not Resuscitate (DNR), and Health Care Proxy forms. The New York State Department of Health (the Department) is initiating a comprehensive review of the advance care planning process, including any necessary changes to New York State documents used during this process. Additionally, recent amendments to Public Health Law allow nurse practitioners to issue orders to withhold or withdraw life-sustaining treatment, including MOLST. To appropriately reflect this change, the MOLST form must be updated to include nurse practitioners. This RFI seeks recommendations for changes to the Health Care Proxy, nonhospital DNR, and MOLST forms, as well as comments on the use of the forms in practice. Healthcare providers, administrators, associations, and the public are encouraged to submit responses.

Background:

Advance care planning is the process of communicating and documenting your wishes for medical treatment in the event that you are no longer able to speak for yourself. During this process you may fill out a Health Care Proxy form, and you may consent to your physician or nurse practitioner issuing MOLST, or nonhospital Do Not Resuscitate (DNR) orders. New York State encourages that anyone over the age of eighteen consider designating a health care agent, using a health care proxy. Persons with an advanced illness or who reside in a skilled nursing facility should be encouraged to complete a MOLST or nonhospital DNR. MOLST and DNR are medical orders that are an important part of the advance care planning process.

The advance care planning conversation has many benefits, including a reduction in hospitalization at the end of life, increased utilization of hospice services, increased likelihood that a patient will die in their preferred setting, and higher satisfaction with quality of care. Even with the proven benefits of having the conversation, national statistics show that 89 percent of Americans say doctors should discuss end-of-life care issues with their patients but only 17 percent say they have had such discussions with a health care provider.

The Governor's 2018 State of the State commitment to increasing awareness of advance care planning and the recent changes to Public Health Law provide a unique opportunity to gather recommendations and general comments on the advance care planning process and the use of its related documents.

Information Request:

The Department is seeking information from healthcare providers, administrators, associations, and the public. Please review the questionnaire and include your responses and recommendations. Respondents are asked to use the template provided and to submit their response in Microsoft Word.

This RFI is for planning purposes only and should not be interpreted as obligations on the part of the Department. The Department will not pay for the preparation of any information submitted or for the use of that information.

The information provided will be analyzed and may appear in reports. Respondents are advised that the Department is under no obligation to acknowledge receipt of the information or provide feedback to respondents with respect to any information submitted. No proprietary, classified, confidential, or sensitive information should be included in your response. The Department reserves the right to use any non-proprietary technical information in any resultant solicitation(s).

Please send response and recommendations to ALTCteam@health.ny.gov with the subject "ACP Review." Responses are due by **November 16, 2018**. Information in addition to the prescribed questions is welcome. Your time and input are greatly appreciated.

Advance Care Planning Use Questionnaire

- 1) Please provide your contact information, including the name of your organization (if applicable), name of contact person, title, phone number, and e-mail address.

Questions for Healthcare Providers Only

- 2) Do you assist individuals in filling out a Health Care Proxy, Nonhospital DNR, and/or MOLST?
 - a. If yes, who do you typically assist in filling out forms? For example, are the majority that fill them out over 65, over 85, female, male, recently diagnosed with an illness, etc.?
 - b. If yes, which form do you use most often?
- 3) Do you regularly have advance care planning conversations with patients?
 - a. If so, how often do you initiate advance care planning conversations?
 - b. If so, who do you typically have the conversation with? For example, are the majority that you have the conversation with over 65, over 85, female, male, do caregivers bring it up first, recently diagnosed with an illness, etc.?
- 4) Explain the barriers to regularly discussing advance care planning with your patients.
- 5) How easy is it to learn if a patient has a Health Care Proxy, DNR, or MOLST?
- 6) How easy is it to access advance care planning documents during a health emergency?
- 7) Do you track the use of the Health Care Proxy, MOLST, and nonhospital DNRs in your organization? If so, how do you track the use and do you find the documents utilized often and appropriately?
- 8) What are the most common errors made in completion of the Health Care Proxy, MOLST, and nonhospital DNR?
- 9) Do you or your organization offer advance care planning education for patients, public, and/or health care providers? If so, would you be interested in having a contact for you or your organization listed on a NYS Department of Health Advance Care Planning website?

Questions for All Respondents

- 10) If you have discussed end-of-life wishes and advance care planning with family members, friends, and/or your health care provider, how easy or difficult was it to begin the conversation? What changes would make these forms easier for patients.
- 11) Are the current advance care planning forms (MOLST, Health Care Proxy, DNR) easy to understand? Please explain.
- 12) If you have a Health Care Proxy, MOLST, or nonhospital DNR, who initiated the conversation and when? Were you satisfied with how that conversation went?

- 13) What types of material or educational tools would be useful to you in having the conversation around advance care planning?
- 14) How easy is it for you to fill out and understand the Health Care Proxy form?
- 15) Is there any language or other changes you would like to see to the Health Care Proxy? Please explain.
- 16) How easy is it for you to fill out and understand the MOLST?
- 17) Is there any language or other changes you would like to see to the MOLST? Please explain.
- 18) What do you believe are some of the reasons why more people are not having the conversation on advance care planning?

Documents for Reference

<https://www.health.ny.gov/forms/doh-5003.pdf> MOLST Form DOH-5003, Version 6/2010
<https://www.health.ny.gov/forms/doh-3474.pdf> Non-hospital Do Not Resuscitate Form DOH-3474, Version 4/2009

The Health Care Proxy information and forms are available from this page:

https://www.health.ny.gov/professionals/patients/health_care_proxy/

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<https://www.health.ny.gov/publications/1430.pdf> English Version 11/2017

<https://www.health.ny.gov/publications/1401.pdf> Chinese

<https://www.health.ny.gov/publications/1431.pdf> Spanish

<https://www.health.ny.gov/publications/1408.pdf> Haitian Creole

<https://www.health.ny.gov/publications/1409.pdf> Italian

<https://www.health.ny.gov/publications/1410.pdf> Korean

<https://www.health.ny.gov/publications/1402.pdf> Russian