Advance Care Planning to Drive Improvements in Quality, Satisfaction and Outcomes Through Palliative Care

Speakers

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Health Care Proxy Readiness

Choose your current stage of readiness:

1. I see no need to fill out a Health Care Proxy form.
2. I see the need to fill out my Health Care Proxy form, but I have barriers or reasons why I have not done it.
3. I am ready to fill out a Health Care Proxy form or I have already started.
4. I already filled out my Health Care Proxy form and it reflects my wishes.
5. I already filled out my Health Care Proxy form but it needs to be changed.

MOLST Utilization and MOLST Interest

Answer Yes or No.

- I use the MOLST form.
- I use the 8-Step MOLST Protocol.
- I am interested in implementing eMOLST.
Policies and Procedures (P&P)

**Choose the description of your health system’s policies and procedures re: advance care planning and MOLST:**

1. A comprehensive P&P covering Advance Care Planning, Advance Directives, MOLST, Health Care Proxy Law, Family Healthcare Decisions Act, Surrogate Court Procedure’s Act (SCPA) § 1750-b for adult patients, minor patients, vulnerable individuals (persons with developmental disabilities, mental illness, vulnerable adults without surrogates, etc.)
2. Multiple separate P&P, including MOLST
3. Multiple separate P&P, not including MOLST
4. I’m not sure

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- Care Transitions: Advance Care Planning and MOLST/eMOLST
- CMS Special Innovation Project: Transforming End of Life Care

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Objectives

- Review value of advance care planning, a key pillar of palliative care
- Define the difference between advance directives and medical orders (MOLST)
- Examine why there are failures in following MOLST orders and review recommendations for improvement, including eMOLST
- Define and demonstrate eMOLST, a tool to assist patients and providers with end of life decisions
- Discuss how eMOLST improves quality and patient safety, ensures accessibility, and achieves the triple aim

Deaths Among Seniors

- New York is ranked #1 in hospital deaths among seniors* (worst in the country)

- Estimates suggest that 35% of all New Yorkers 65+ die in the hospital**

- Regional Variation, Medicare Data***

*In Sickness and in Health, Where States are No. 1
Wall Street Journal, June 9, 2014

**America’s Health Rankings

***Dartmouth Atlas

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How Americans Die

How Americans Wish to Die

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Medicare payments in last year of life account for $\frac{1}{4}$ of all Medicare spending


"30% of health care is unnecessary or harmful"

How do we shift the cultural mindset from “more treatment is better” to “the right treatment and care, and no more?”

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Palliative Care

Interdisciplinary care
- aims to relieve suffering and improve quality of life for patients with advanced illness and their families
- offered simultaneously with all other appropriate medical treatment from the time of diagnosis
- focuses on quality of life and provides an extra layer of support for patients and families

Three Key Pillars with Psychosocial & Spiritual Support
- Advance Care Planning and Goals for Care
  - Step 1: Community Conversations on Compassionate Care*
  - Step 2: Medical Orders for Life-Sustaining Treatment (MOLST)*
- Pain and Symptom Management
- Caregiver Support

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

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Continuum of Care Model for Patients with Serious Illness

**Medical Management of Chronic Disease**

*Integrated with Palliative Care*

**Palliative Care (PC):**
Advance care planning & goals for care, pain and symptom control, caregiver support

**Hospice**

⇒ **Diagnosis**

⇒ **Progression of Serious Illness** ⇒

⇒ **Bereavement**

⇒ **Death**

⇒ **Goals for Care shift**

⇒ **12 mo**

⇒ **6 mo**

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**Key Recommendations**

**Policies and Payment Systems**

- Provide financial incentives to patients and clinicians to discuss EOL issues, document preferences, provide appropriate services & care

- Require EHRs incorporate advance care planning to improve communication of individuals' wishes across time, settings, and providers
  - NY’s eMOLST highlighted in IOM Report

- Encourage states to develop & implement a POLST Paradigm Program

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Definitions

- **National POLST Paradigm**: process of communication & shared decision making results in POLST; has established endorsement requirements
- **POLST**: Physician Orders for Life Sustaining Treatment - different states use different names to describe the state POLST program: such as MOLST, POST, LaPOST, MOST
- **MOLST**: New York State’s Endorsed POLST paradigm program

Advance Care Planning

- Whole process of discussion of end-of-life care, clarification of related values and goals, and embodiment of preferences through written documents and medical orders
- Start at any time
- Revisit periodically
- Becomes more focused as health status changes

2014 IOM Report Dying in America
Report available: www.nap.edu
Advance Care Planning

Ideal Conversations

- Occur with a person’s health care agent and primary clinician, along with other members of the clinical team
- Are recorded and updated as needed
- Allow for flexible decision making in the context of the patient’s current medical situation.

2014 IOM Report Dying in America
Report available: www.nap.edu

Advance Care Planning

Compassion, Support and Education along the Health-Illness Continuum

Chronic disease or functional decline

Maintain & maximize health and independence

Death

Advancing chronic illness

Multiple co-morbidities, with increasing frailty

Healthy and independent

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Advance Directives and Actionable Medical Orders

Traditional ADs
For All Adults

- New York
  - Health Care Proxy
  - Living Will
- Organ Donation
- State-specific forms: e.g. Durable POA for Healthcare

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) Program
- Physician Orders for Life Sustaining Treatment (POLST) Paradigm Programs

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

CompassionAndSupport.org
CaringInfo.org
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Advance Care Planning: Life Expectancy of Greater than One Year

Bomba, P.A., Vermilyea, D. Integrating POLST Into Palliative Care Guidelines JNCCN. 2006; 4:8, 819 – 829

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Medical Orders for Life-Sustaining Treatment (MOLST) Program – More Than a Form

Standardized clinical process
- discussion of patient’s goals for care
- shared medical decision-making between health care professionals and seriously ill patients

Result: a set of medical orders
- reflect the patient’s preference for life-sustaining treatment they wish to receive or avoid
- common community-wide form

Advance Care Planning:
Life Expectancy of Less than One Year

Bomba, P.A., Vermilyea, D. Integrating POLST Into Palliative Care Guidelines JNCCN. 2006; 4:8, 819 – 829

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MOLST: Who Should Have One?

- Generally for patients with serious health conditions
- Wants to avoid or receive 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

Medicare Wellness Visit

- Does my patient have a health care proxy?
- Do I have a copy of the health care proxy?
- Has the patient shared their values, beliefs and goals for their care?
- Has the person spoken with their family?
- Is my patient appropriate for MOLST?
MOLST Screening Questions

- Does the person express a desire to avoid or receive any or all life-sustaining treatment?
- Does the person live in a nursing home or receive long term care services at home or in an ALF?
- Would you be surprised if the person dies in the next year?
- Does this person have one or more advanced chronic condition or a serious new illness with a poor prognosis?
- Does this patient have decreased function, frailty, progressive weight loss, >= 2 unplanned admissions in last 12 months, have inadequate social supports, or need more help at home?

Questions to Help an Individual Prepare for a MOLST Discussion

- What do you understand about your current health condition?
- What do you expect for the future?
- What makes life worth living?
- What is important to you?
- What matters most to you?
- How do you define quality of life?
- Would you trade quality of life for more time?
- Would you trade time for quality of life?
eMOLST: Digital Transformation of NY MOLST an End-of-life Care Transition Program
HANYS Webinar
April 14, 2016

Lead By Example. Start Your Conversation Today!

“There’s no easy way I can tell you this, so I’m sending you to someone who can.”

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Ethics Case #1

- Resident admitted to rehab facility from hospital S/P CVA with aphasia & feeding tube insertion 10/7/14
- HCP “done” in hospital
  - 1 of 6 children listed as HCA; others alternate
  - no signature or mark
  - no documentation on form that patient unable to sign
  - medical record: no documentation of patient’s capacity to choose HCA; documented patient able to follow instructions
  - type of aphasia unclear
- No MOLST; no documentation of discussion of patient values, beliefs or goals for care

Ethics Case #1

- Suffered catastrophic CVA in rehab
- Transferred to custodial care
- Resident not alert; HCP not valid
- **Goals for care**: shift from longevity to quality of life
- **Conflict**: Family request removal of feeding tube; 1 of 6 children does not agree with decision & would sue
- Facility unable to resolve conflict
- Referred to legal
- Resident receiving hospice services; feeding tube in but not tolerating due to vomiting
Ethics Case #2

- 82 yo woman with multiple medical problems and frailty receives all care in one health system

- Hospitalized in early December; transferred to NH for rehab. **MOLST done at SNF**: CPR, DNI, No feeding tube; MD signature illegible, no license # or printed name; no documentation of discussion or capacity available at transfer.

- Hospitalized in January in different system; no medical records

- **Admission orders**: DNR, DNI; no documentation of discussion, capacity determination

- Family unaware of MOLST or DNR/DNI order

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Ethics Case #2

- Patient develops acute respiratory insufficiency, hypoxia & lacks ability to make decisions

- **Family discussion**: family asserts patient did not have capacity to make decisions in early December or at time of admission; family unaware of MOLST or DNR/DNI

- Family asks to rescind DNR, DNI. **Patient intubated**.

- **Clinical assessment**: successful vent wean unlikely

- Family alleges person centered values & beliefs: DNI acceptable, terminal wean off ventilator is not

- **Staff moral distress**: disregard of patient preferences & requests Ethics Consultation
Ethics Case #3

- 88-year-old woman sent from NH to ER
- Dementia, paralysis of all four extremities from strokes, a horrible sacral bed sore, osteomyelitis, septic shock, and respiratory failure.
- No family; no health care agent
- Transfer papers: Nonhospital DNR order; no MOLST
- ER: Patient intubated and admitted to MICU
- Medical staff: “The poor woman was in extremis and doing her utmost to cast off her earthly shackles.”

Why There Are Failure in Following MOLST Orders

- Clinicians, patients, families are unaware of their obligations to follow MOLST and implications of failure to follow MOLST
- Advance care planning is not recognized as a dynamic process, including MOLST
  - Emphasis should be on communication
  - Forms are the end of the process
Why There Are Failure in Following MOLST Orders

- Attention is given to the discussion, but ADs or MOLST are not completed or done incorrectly (incompatible orders)
- Avoiding early discussions
- Focusing on interventions, rather that personal values, beliefs and goals for care #WhatMattersMost
- Wrong Health Care Agent is chosen


Why There Are Failure in Following MOLST Orders

- Lack of understanding of the differences between advance directives (HCP, LW) and medical orders (MOLST)
- Failure to assess and document capacity & other legal requirements
- Lack of accessibility to MOLST and documentation of the discussion

Recommendations

- Strengthen clinician training
- Encourage public education and engagement in advance care planning
- Expand use of eMOLST

New York eMOLST: Definitions

- **Form**: Refers to MOLST form and the Chart Documentation Form (CDF) that documents the key elements of the discussion and process
- **Users**: persons with different clinical and administrative roles with regards to creating, updating, or accessing MOLST forms or other registry content
- **EMR**: Electronic Medical Record
- **EHR**: Electronic Health Record
- **Registry**: Electronic database centrally housing MOLST forms and CDFs to allow 24/7 access in an emergency
- **eMOLST**: electronic form completion system for MOLST & NYeMOLST Registry
New York eMOLST

- An electronic system that guides clinicians and patients through a thoughtful discussion and MOLST process.
- eMOLST makes sure MOLST is completed correctly and ensures it is accessible.
- Allows the clinician to print a copy of the eMOLST form on bright pink paper for the patient.
- Serves as the registry of NY eMOLST forms to make sure a copy of the medical orders and the discussion are available in an emergency.
- eMOLST is web-based, available statewide and accessed at NYSeMOLSTregistry.com.

8-Step MOLST Protocol

1. Prepare for discussion
   - Understand patient’s health status, prognosis & ability to consent
   - Retrieve completed Advance Directives
   - Determine decision-maker and NYSPHL legal requirements, based on who makes decision and setting
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 to guide choices and finalize patient wishes
   - Shared, informed medical decision-making
   - Conflict resolution
7. Complete and sign MOLST
   - Follow NYSPHL and document conversation
8. Review and revise periodically

Developed for NYS MOLST, Bomba, 2005; revised 2011
AFTER FHCDA: MOLST Instructions and Checklists
Ethical Framework/Legal Requirements

- **Checklist #1** - Adult patients with medical decision-making capacity (any setting)
- **Checklist #2** - Adult patients without medical decision-making capacity who have a health care proxy (any setting)
- **Checklist #3** - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is a Public Health Law Surrogate (surrogate selected from the surrogate list)
- **Checklist #4** - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy or a Public Health Law Surrogate
- **Checklist #5** - Adult patients without medical decision-making capacity who do not have a health care proxy, and the MOLST form is being completed in the community.
- **Checklist for Minor Patients** - (any setting)
- **Checklist for Developmentally Disabled who lack capacity** – (any setting) must travel with the patient’s MOLST

http://www.nyhealth.gov/professionals/patients/patient_rights/molst/

eMOLST Produces MOLST Form and MOLST Chart Documentation Form

Align with NYSDOH Checklists

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Care Plan to Support MOLST

- MOLST guides treatment in an emergency
- All patients are treated with dignity, respect and comfort measures
- Person-centered palliative care plan based on patient choice
  - Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled
  - Treatments available for pain and symptoms
    - Effective pain management
    - Shortness of breath: oxygen and morphine
    - Nausea, vomiting, etc.
  - No feeding tube or No IV fluids
    - Offer food/fluids as tolerated using careful hand feeding
- Family, caregiver and staff education

Why NYeMOLST?

eMOLST Improves Quality & Patient Safety, Reduces Harm and Achieves the Triple Aim
Research: Oregon POLST Registry
Site of Death vs. Treatment Requested

- Death records: 58,000 people who died of natural causes in 2010 and 2011 in OR
- Nearly 31% of people who died: POLST forms entered in OR’s POLST Registry
- Compared location of death with treatment requested
  - 6.4% of people with POLST forms who selected "comfort measures only" died in hospital
  - 34.2% of people without POLST forms in the registry died in the hospital


eMOLST Feedback: NYSDOH Attorney

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Why eMOLST? Accessibility

Dr. Patricia Bomba, eMOLST Program Director

eMOLST: Digital Transformation Ensures Accessibility Across Care Transitions

Hospital  LTC  Office

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

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Why eMOLST?

- Adds value
- Improves quality outcomes & patient safety
- Improves legal outcomes
- Reduces risk of survey deficiencies
- Improves provider satisfaction
- Assures accessibility
- Provides a system-based solution
- Achieves the triple aim

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eMOLST Case, CNY, 2014

- Elderly gentleman with multiple medical problems, including COPD with recurrent acute respiratory exacerbations & recurrent hospitalizations
- Has Health Care Proxy, MOLST form
- Presents to ER with acute respiratory insufficiency; MOLST form left on refrigerator
- Patient evaluated & treated
- Plan: intubation & mechanical ventilation and transfer to SUNY Upstate
- MD in ER signed into eMOLST – goals for care: functionality, remain at home; MOLST: DNR & DNI
- Patient admitted, treated conservatively, discharged home

eMOLST Aligns with New Value-Based, Accountable Care Models

- **Improves quality**: discussion of personal-centered values, beliefs and goals for care drives choice of life-sustaining treatment
- **Honors individual preferences**: provides MOLST orders and copy of discussion across care transitions
- Reduce unnecessary and unwanted hospitalizations, ED use, service utilization and expense
Where eMOLST Aligns With NYS Health System Priorities

- Palliative Care
- Advance Care Planning
- Quality, Patient Safety & Risk Management
- Compliance with NYS PHL
- Care Transitions
- Reducing Readmissions
- Accountable Care Organizations
- Innovative Payment Models
- Medicaid Redesign: DSRIP, FIDA, Health Homes
- NY State Health Innovation Plan
- IOM Dying in America Recommendations

Potential Barrier to eMOLST and Thoughtful MOLST Discussions

MOLST Takes Time
- Person-centered goals for care discussion
  - May require more than 1 session to complete
- Shared, informed medical decision making process
- Ethical framework/legal requirements
- Completion of form
- Family awareness of person’s decision
  - Face-to-face
  - Non face-to-face
- Care Plan to support MOLST
- Goals and preferences may change
  - Discussion and MOLST form change
- **ACP CPT Codes Overcomes Barrier**: Inadequate reimbursement for time spent
- Consider office workflow transformation
CMS Approves
Advance Care Planning CPT Codes

- **Two new codes**: 99497 and 99498
- Reimbursement to health care professionals for providing advance care planning services to Medicare and Medicaid members
- Advance care planning is an integral component of the practice of medicine
- Overcomes a key barrier
- Effective January 1, 2016

eMOLST Demo

eMOLST Training Site:
https://training.nysemolstregistry.com/Login

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New York eMOLST

- If you would like your health system’s: hospital, nursing home, physician office, palliative care/hospice program to implement and have your patients’ MOLST forms included in NY’s eMOLST registry, visit NYSeMOLSTregistry.com.

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New York Advance Care Planning, MOLST and eMOLST Educational Resources

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Reliable Information for 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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Community Conversations on Compassionate Care

Advance Care Planning Tools & Resources

- Advance Care Planning Booklet (English, Spanish)
- Advance Care Planning Brochure, Poster and Table Topper
- Advance Care Planning Facilitator Training
- Advance Care Planning Clinical Pathways
- Behavioral Readiness “tools”
- Community Conversations on Compassionate Care (CCCC) workshop; standardized PowerPoint
- Community Conversations on Compassionate Care (CCCC) videos
- Advance Care Planning Public Service Announcements videos
- CCCC video on-line with Five Easy Steps
- Compassion And Support YouTube Channel
- On-line resources at CompassionAndSupport.org

Community Conversations on Compassionate Care

Advance Care Planning Booklets

CompassionAndSupport.org

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MOLST Tools & Resources

- MOLST 8-Step Protocol
- NYSDOH Legal Requirements Checklists & OPWDD Checklist
- MOLST Chart Documentation Forms
- NYSDOH MOLST General Instructions & Glossary
- MOLST FAQs
- MOLST Patient & Family Brochure
- Sample Facility Policies & Procedures
- Sample Facility Implementation & Education Work Plans
- MOLST & FHCDA webinar series (on-line)
- MOLST Train-the-Trainer Sessions
- MOLST Conferences
- Compassion And Support YouTube Channel: MOLST Videos
- MOLST for Professionals; MOLST for Patients & Families
- MOLST Training Center: CompassAndSupport.org – New York State repository for MOLST resources
  
CompassAndSupport.org

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CompassAndSupport.org
Additional MOLST/eMOLST Resources

- **eMOLST Overview (5:37)**  
  https://youtu.be/MjL8Qz944IU?list=PLCSvowXDKV5IEJX39GHvbs8ekkfNXec55

- **NYSDOH Attorney's Perspective on eMOLST (1:38)**  

- **eMOLST webinar sponsored by IPRO and includes Q & A (2:00)**  
  https://qualitynet.webex.com/qualitynet/ldr.php?RCID=f2c519e24280cba7863dab9ad1bf68ea

- **Advantages of eMOLST: A Nursing Home Physician's Perspective (7:24)**  
  https://youtu.be/jn47FlYsxss?list=PLCSvowXDKV5IEJX39GHvbs8ekkfNXec55

Patricia Bomba MD, FACP  
Vice President and Medical Director, Geriatrics, Excellus BlueCross BlueShield  
Chair, MOLST Statewide Implementation Team & eMOLST Program Director

Sara Butterfield  
Project Lead for the CMS Special Innovation Project, Transforming End of Life Care  
Lead, Atlantic Quality Innovation Network QIN_QIO for the CMS 11th Scope of Work
Additional MOLST/eMOLST Resources

- Thoughtful MOLST Discussions in Hospital
  https://youtu.be/gKseJkuuFuK?list=PLCSvowXDKV5LzLqQGqdQ-n3ocGn8LWZ2

- Thoughtful MOLST Discussions in Nursing Home
  https://youtu.be/LYAT43hXxwg?list=PLCSvowXDKV5LzLqQGqdQ-n3ocGn8LWZ2

- Thoughtful MOLST Discussions in Additional Clinical Settings Planned
  Physician Office, Home, Vulnerable Populations

  - "Writing Your Final Chapter: Know Your Choices. Share Your Wishes" has 5 real patient stories (2 before, 3 after MOLST); originally released in 2007 & revised to comply with FHCPDA.
  - It is an excellent resource for staff, patient, family caregiver education; it can be used as a staff "lunch and learn."

Additional MOLST/eMOLST Resources

- "New CPT Codes for Advance Care Planning and MOLST Discussions" (1:00) webinar posted on YouTube
  https://youtu.be/VCV26ZyGgwY

- Link to a MMLIC Dateline Special Edition, includes NYSBA Health Law Journal article co-authored by Jonathan Karmel, JD, NYSDOH, and Pat Bomba, MD, FACP; three additional cases are included: here.
For up-to-date information, subscribe to NY MOLST Update.
Contact Meg.Greco@excellus.com.

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eMOLST: Digital Transformation of NY MOLST an End-of-life Care Transition Program

HANYS Webinar
April 14, 2016

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Social Media

- YouTube Channel: CompassionAndSupport
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- NHDD Campaign