The NPI will be Required for all HIPAA Standard Transactions on May 23rd: As of May 23, 2008, the NPI will be required for all HIPAA standard transactions. This means:

- For all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, DDE, 276/277, 270/271 and 835), paper claims (UB-04 and CMS-1500) and SPR remittance advice; and

- Reporting of Medicare legacy identifiers in any primary or secondary provider fields will result in the rejection of the transaction.

MLN Matters Number: MM5972
Related Change Request (CR) #: 5972
Related CR Release Date: April 11, 2008
Effective Date: July 1, 2008
Related CR Transmittal #: R1490CP
Implementation Date: July 7, 2008

Prolonged Services (Codes 99354 - 99359)

Note: This article was updated on July 12, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians and other qualified non-physician practitioners (NPP) whose services are billed to Medicare Carriers or Medicare Administrative Contractors (A/B MAC).

What You Need to Know

CR 5972, from which this article is taken, updates the sections of the Medicare Claims Processing Manual that address prolonged services codes, in order to be consistent with changes/deletions in codes and changes in typical/average time units in the American Medical Association Current Terminology Procedural Terminology (CPT) coding system.

Make sure that your billing staffs are aware of the prolonged services CPT code changes as described in Background, below.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2007 American Medical Association.
Background

Since Medicare Claims Processing Manual Chapter 12 (Physicians/Nonphysician Practitioners), Sections 30.6.15.1 Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes) and 30.6.15.2 (Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359) were first written, several code changes, code deletions, and typical/average time units have changed in the American Medical Association (AMA) Current Procedural Terminology (CPT) coding system.

CR 5972, from which this article is taken, updates these sections that address prolonged services codes, in order to be consistent with the AMA CPT coding changes.

These manual changes:

- (In keeping with current Medicare payment policy for physician presence and supporting documentation) define Prolonged Services and explain the required evaluation and management (E&M) companion codes;
- Correct and update the tables for threshold times (reproduced below) to reflect code changes and current typical/average time units associated with the CPT levels of care in code families; and
- In a new Subsection (30.6.15.1 (H)), explain how to report physician visits for counseling and/or coordination of care when the visit is based on time and when the counseling and/or coordination service is prolonged.

A summary of these manual changes follow.

Prolonged Services Definitions

In the **office or other outpatient setting**, Medicare will pay for prolonged physician services (CPT code 99354) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion E&M service as noted in the CPT code. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services with CPT code 99355.

In the **inpatient setting**, Medicare will pay for prolonged physician services (code 99356) (with direct face-to-face patient contact which require one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99357.
Note: You should not separately report prolonged service of less than 30 minutes total duration on a given date, because the work involved is included in the total work of the evaluation & management (E&M) codes.

You may use code 99355 or 99357 to report each additional 30 minutes beyond the first hour of prolonged services, based on the place of service. These codes may be used to report the final 15 – 30 minutes of prolonged service on a given date, if not otherwise billed. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

**Required Companion Codes**

Please remember that prolonged services codes 99354 – 99357 are not paid unless they are accompanied by the companion codes as described here.

The companion E&M codes for 99354 are:
- Office or Other Outpatient visit codes (99201 - 99205, 99212 – 99215),
- Office or Other Outpatient Consultation codes (99241 – 99245),
- Domiciliary, Rest Home, or Custodial Care Services codes (99324 – 99328, 99334 – 99337),
- Home Services codes (99341 - 99345, 99347 – 99350);

The companion E&M codes for 99355 are 99354 and one of its required E&M codes.

The companion E&M codes for 99356 are the Initial Hospital Care and Subsequent Hospital Care codes (99221 - 99223, 99231 – 99233), the Inpatient Consultation codes (99251 – 99255); Nursing Facility Services codes (99304 - 99318).

The companion codes for 99357 are 99356 and one of its required E&M codes.

**Requirement for Physician Presence**

You may count only the duration of direct face-to-face contact with the patient (whether the service was continuous or not) beyond the typical/average time of the visit code billed, to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable.

You cannot bill as prolonged services:
- In the **office setting**, time spent by office staff with the patient, or time the patient remains unaccompanied in the office; or
- In the **hospital** setting, time spent reviewing charts or discussing the patient with house medical staff and not with direct face-to-face contact with the patient or waiting for test results, for changes in the patient’s condition, for end of a therapy, or for use of facilities.
Documentation

Unless you have been selected for medical review, you do not need to send the medical record documentation with the bill for prolonged services. Documentation, however, is required to be in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services that you bill.

You must appropriately and sufficiently document in the medical record that you personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. Make sure that you document the start and end times of the visit, along with the date of service.

Use of the Codes

You can only bill the prolonged services codes if the total duration of all physician or qualified NPP direct face-to-face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes).

Threshold Times for Codes 99354 and 99355 (Office or Other Outpatient Setting)

If the total direct face-to-face time equals or exceeds the threshold time for code 99354, but is less than the threshold time for code 99355, you should bill the E&M visit code and code 99354. No more than one unit of 99354 is acceptable.

If the total direct face-to-face time equals or exceeds the threshold time for code 99355 by no more than 29 minutes, you should bill the visit code 99354 and one unit of code 99355. One additional unit of code 99355 is billed for each additional increment of 30 minutes extended duration.

Table 1 displays threshold times that your carriers and A/B MACs use to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings, including outpatient consultation services and domiciliary, rest home, or custodial care services and home services codes. The AMA CPT coding-derived changes are highlighted and noted in bolded italics.
Table 1
Threshold Time for Prolonged Visit Codes 99354 and/or 99355
Billed with Office/Outpatient and Consultation Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99354</th>
<th>Threshold Time to Bill Codes 99354 and 99355</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>40</td>
<td>85</td>
</tr>
<tr>
<td>99202</td>
<td>20</td>
<td>50</td>
<td>95</td>
</tr>
<tr>
<td>99203</td>
<td>30</td>
<td>60</td>
<td>105</td>
</tr>
<tr>
<td>99204</td>
<td>45</td>
<td>75</td>
<td>120</td>
</tr>
<tr>
<td>99205</td>
<td>60</td>
<td>90</td>
<td>135</td>
</tr>
<tr>
<td>99212</td>
<td>10</td>
<td>40</td>
<td>85</td>
</tr>
<tr>
<td>99213</td>
<td>15</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>99214</td>
<td>25</td>
<td>55</td>
<td>100</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
<td>70</td>
<td>115</td>
</tr>
<tr>
<td>99241</td>
<td>15</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>99242</td>
<td>30</td>
<td>60</td>
<td>105</td>
</tr>
<tr>
<td>99243</td>
<td>40</td>
<td>70</td>
<td>115</td>
</tr>
<tr>
<td>99244</td>
<td>60</td>
<td>90</td>
<td>135</td>
</tr>
<tr>
<td>99245</td>
<td>80</td>
<td>110</td>
<td>155</td>
</tr>
<tr>
<td>99324</td>
<td>20</td>
<td>50</td>
<td>95</td>
</tr>
<tr>
<td>99325</td>
<td>30</td>
<td>60</td>
<td>105</td>
</tr>
<tr>
<td>99326</td>
<td>45</td>
<td>75</td>
<td>120</td>
</tr>
<tr>
<td>99327</td>
<td>60</td>
<td>90</td>
<td>135</td>
</tr>
<tr>
<td>99328</td>
<td>75</td>
<td>105</td>
<td>150</td>
</tr>
<tr>
<td>99334</td>
<td>15</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>99335</td>
<td>25</td>
<td>55</td>
<td>100</td>
</tr>
<tr>
<td>99336</td>
<td>40</td>
<td>70</td>
<td>115</td>
</tr>
<tr>
<td>99337</td>
<td>60</td>
<td>90</td>
<td>135</td>
</tr>
<tr>
<td>99341</td>
<td>20</td>
<td>50</td>
<td>95</td>
</tr>
<tr>
<td>99342</td>
<td>30</td>
<td>60</td>
<td>105</td>
</tr>
<tr>
<td>99343</td>
<td>45</td>
<td>75</td>
<td>120</td>
</tr>
<tr>
<td>99344</td>
<td>60</td>
<td>90</td>
<td>135</td>
</tr>
<tr>
<td>99345</td>
<td>75</td>
<td>105</td>
<td>150</td>
</tr>
<tr>
<td>99347</td>
<td>15</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>99348</td>
<td>25</td>
<td>55</td>
<td>100</td>
</tr>
<tr>
<td>99349</td>
<td>40</td>
<td>70</td>
<td>115</td>
</tr>
<tr>
<td>99350</td>
<td>60</td>
<td>90</td>
<td>135</td>
</tr>
</tbody>
</table>
To get to the threshold time for billing code 99354 and two units of code 99355, add 30 minutes to the threshold time for billing codes 99354 and 99355. For example, when billing code 99205, in order to bill code 99354 and two units of code 99355, the threshold time is 150 minutes.

**Threshold Times for Codes 99356 and 99357 (Inpatient Setting)**

If the total direct face-to-face time equals or exceeds the threshold time for code 99356, but is less than the threshold time for code 99357, you should bill the visit and code 99356.

Medicare contractors will not accept more than one unit of code 99356. If the total direct face-to-face time equals or exceeds the threshold time for code 99356 by no more than 29 minutes, you should bill the visit code 99356 and one unit of code 99357. One additional unit of code 99357 is billed for each additional increment of 30 minutes extended duration.

Table 2 displays the following threshold times that your Medicare contractors uses to determine if the prolonged services codes 99356 and/or 99357 can be billed with the inpatient setting codes. The AMA CPT coding-derived changes are highlighted and noted in bolded italics.

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99356</th>
<th>Threshold Time to Bill Codes 99356 and 99357</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>30</td>
<td>60</td>
<td>105</td>
</tr>
<tr>
<td>99222</td>
<td>50</td>
<td>80</td>
<td>125</td>
</tr>
<tr>
<td>99223</td>
<td>70</td>
<td>100</td>
<td>145</td>
</tr>
<tr>
<td>99231</td>
<td>15</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>99232</td>
<td>25</td>
<td>55</td>
<td>100</td>
</tr>
<tr>
<td>99233</td>
<td>35</td>
<td>65</td>
<td>110</td>
</tr>
<tr>
<td>99251</td>
<td>20</td>
<td>50</td>
<td>95</td>
</tr>
<tr>
<td>99252</td>
<td>40</td>
<td>70</td>
<td>115</td>
</tr>
<tr>
<td>99253</td>
<td>55</td>
<td>85</td>
<td>130</td>
</tr>
<tr>
<td>99254</td>
<td>80</td>
<td>110</td>
<td>155</td>
</tr>
<tr>
<td>99255</td>
<td>110</td>
<td>140</td>
<td>185</td>
</tr>
<tr>
<td>99304</td>
<td>25</td>
<td>55</td>
<td>100</td>
</tr>
<tr>
<td>99305</td>
<td>35</td>
<td>65</td>
<td>110</td>
</tr>
<tr>
<td>99306</td>
<td>45</td>
<td>75</td>
<td>120</td>
</tr>
<tr>
<td>99307</td>
<td>10</td>
<td>40</td>
<td>85</td>
</tr>
<tr>
<td>99308</td>
<td>15</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>99309</td>
<td>25</td>
<td>55</td>
<td>100</td>
</tr>
</tbody>
</table>
### Prolonged Services Associated With E&M Services Based Counseling and/or Coordination of Care (Time-Based)

When an E&M service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or the qualified NPP and the patient in the office/clinic or the floor time in the scenario of an inpatient service, the E&M code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the E&M code) and should not be "rounded" to the next higher level. **Further, in E&M services in which the code level is selected based on time, you may only report prolonged services with the highest code level in that family of codes as the companion code.**

#### Billing Examples

Examples of billable and non-billable prolonged services follow.

- **Billable Prolonged Services**
  
  **EXAMPLE 1**
  
  A physician performed a visit that met the definition of an office visit CPT code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills CPT code 99213 and one unit of code 99354.
  
  **EXAMPLE 2**
  
  A physician performed a visit that met the definition of a domiciliary, rest home care visit CPT code 99327 and the total duration of the direct face-to-face contact (including the visit) was 140 minutes. The physician bills CPT codes 99327, 99354, and one unit of code 99355.
  
  **EXAMPLE 3**
  
  A physician performed an office visit to an established patient that was predominantly counseling, spending 75 minutes (direct face-to-face) with the patient. The physician bills CPT code 99215 and one unit of code 99354.

- **Non-billable Prolonged Services**
  
  **EXAMPLE 1**
  
  A physician performed a visit that met the definition of visit code 99212 and the total duration of the direct face-to-face contact (including the visit) was 35 minutes.

---

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2007 American Medical Association.
The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

EXAMPLE 2
A physician performed a visit that met the definition of code 99213 and, while the patient was in the office receiving treatment for 4 hours, the total duration of the direct face-to-face service of the physician was 40 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

EXAMPLE 3
A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354. The physician must bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.

Finally, you should remember that Medicare contractors will not pay (nor can you bill the patient) for prolonged services codes 99358 and 99359, which do not require any direct patient face-to-face contact (e.g., telephone calls). These are Medicare covered services and payment is included in the payment for other billable services.

Additional Information

You can find more information about billing with prolonged services codes 99354 – 99359 by going to CR 5972, located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1490CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated Medicare Claims Processing Manual Chapter 12 (Physicians/Nonphysician Practitioners), Sections 30.6.15.1 Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes) and 30.6.15.2 (Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359) as an attachment to that CR.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2007 American Medical Association.
BILLING-REIMBURSEMENT FOR THE POLST CONVERSATION

2015 NATIONAL POLST LEADERSHIP CONFERENCE

JUDITH BLACK, MD, MHA
KENNETH BRUMMEL-SMITH, MD
FEBRUARY 6, 2015
Agenda

What Can Health Care Professionals Use Today?
- Private Medicare Fee for Service
- Different Health Plans Models
- Physician Compensation and Quality Metrics

Where Reimbursement Stands at a National Level

Questions and Answers
Bridging the Divide: A Foot in More than One Camp

- Pay for volume
- Fragmented care
- Treating sickness
- Adversarial payers
- Little HIT
- Duplication & waste

- Pay for value
- Accountable care
- Fostering wellness
- Payer partners
- Fully wired systems
- Right care, right setting, right time
WHAT CAN HEALTH CARE PROFESSIONALS USE TODAY?
Billing For Advance Care Planning

If greater than 50% of time is spent in counseling:

<table>
<thead>
<tr>
<th>OP - New Patient</th>
<th>OP - Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes – 99203</td>
<td>15 minutes – 99213</td>
</tr>
<tr>
<td>45 minutes – 99204</td>
<td>25 minutes – 99214</td>
</tr>
<tr>
<td>60 minutes – 99205</td>
<td>40 minutes – 99215</td>
</tr>
<tr>
<td><strong>Home – New patient</strong></td>
<td><strong>Home – Established Patient</strong></td>
</tr>
<tr>
<td>45 minutes – 99343</td>
<td>25 minutes – 99348</td>
</tr>
<tr>
<td>60 minutes – 99344</td>
<td>40 minutes – 99349</td>
</tr>
<tr>
<td>75 minutes - 99345</td>
<td>60 minutes - 99350</td>
</tr>
</tbody>
</table>
Billing For Advance Care Planning

If greater than 50% of time is spent in counseling:

**IP – Admit**
- 30 minutes – 99221
- 50 minutes – 99222
- 70 minutes – 99223

**NH – New patient**
- 25 minutes – 99304
- 35 minutes – 99305
- 45 minutes - 99306

**IP - Established Patient**
- 15 minutes – 99231
- 25 minutes – 99232
- 35 minutes – 99233

**NH – Established Patient**
- 15 minutes – 99308
- 25 minutes – 99309
- 35 minutes - 99310

CMS MLN Number MM5972, 7/12/13
Other Options For Billing For Completing Advance Care Planning

- If the reason for the appointment is advance care planning, the ICD-9 code for counseling (V65.4) can be listed as primary diagnoses with the medical conditions discussed as secondary diagnoses
  - 15 min visit with > 50% of time counseling w/ estb patient = 99213
  - 25 min visit with > 50% of time counseling w/ estb patient = 99214
  - 40 min visit with >50% for time counseling w/ estb patient = 99215

- If advance care planning occurs as part of a regular visit, the ICD-9 code of the primary diagnoses is used and the V65.4 code is the secondary diagnoses (with >50% of time spent on counseling).

V65.4 – Other counseling, not elsewhere classified
Using Prolonged Service Codes

- Medicare pays for prolonged services with direct face-to-face contact
- Has to be billed with a usual companion CPT code
  - E.g., 9920X for new outpatients and 9921X for established outpatients
  - 99354 & 99356 require 1 hour beyond the usual service
  - 99355 & 99357 used for each additional 30 minutes
- Face-to-face
  - 99354 and/or 99355 are used for outpatient/home/domiciliary
  - 99356 and/or 99357 are used for inpatient/nursing home
- Cannot count time spent with nursing, office staff

Non-face-to-face codes (99358, 99359) are rarely paid
Using Prolonged Service Codes

- Must document start time and stop time
- Examples:
  - A physician performed a visit that met definition of CPT code 99213 and total duration of visit (face-to-face) was 65 minutes. Bill 99213 + one unit of 99354.
  - A physician sees an established visit and spends 75 minutes predominantly counseling. Bill 99215 (>50% time spent counseling) + one unit 99354.***
  - A NP sees a nursing home visit established patient that met 99308 (15 min) and spends time talking about POLST for 90 minutes – bill 99308, 99356, and one unit 99357

***If the companion code is predominantly counseling, then it must be the highest in that group)
Category II CPT Codes

- Not separately valued or reimbursable
- Used in Physician Quality Reporting
- May lead to increased income if on a pay-for-performance program
- In 2015 doctors who do not report these measures will be fined 1.5% of their total profit

Codes:
- 1123F: Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in medical record
- 1124F: Advance Care Planning discussed and documented in medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
- 1157F: Advance care plan or similar legal document present in the medical record
- 1158F: Advance care planning discussion documented in the medical record

Blue Health Plan Models

- **Physician Payment/All clinical sites**
  - **BCBS Rhode Island**
    - E&M Codes
    - HCPCS S0257
    - Age or product related? /terminally ill?
    - > 66 years Medicare Special Needs Plan

- **Physician Payment**
  - **BCBS Tennessee**
    - CPTII 1157F, 1158F
    - HCPCS: S0257
  - **BCBS Hawaii**
    - CPTII 1157F, 1158F or ICD-9 V49.86
    - HCPCS: S0257
    - > 75 Years

- **Hospital Incentive Program**
  - **Highmark**
    - CPT II 1123F or CPT 1124F; E&M codes
    - Hospitals accountable for physicians completion
    - Patients discharged to SNF or LTAC

- **Physician payment/All clinical sites**
  - **Excellus**
    - CPT II 1123F or CPT 1124F; E&M codes
    - Physician training for MOLST
    - Commercial, Medicare, Medicaid
Advanced care discussions are covered when the appropriate code is submitted in accordance with policy.

- End-of-life and advance directive issues is an important part of counseling terminally ill patients and their caregivers.
- Reimbursement: E&M Physicians claims with submitted S0257.
- Each physician is allowed to bill for a maximum of two services per patient per year.
- BCBSRI audits quarterly to gauge program effectiveness.
- Reserves the right to recoup any money paid to providers for claims ineligible for payment.
Percentage of 66 years old and older who had each of the following during the measurement year: Advance care planning (advance directive, living will, power of attorney, health care proxy, actionable medical decision maker or surrogate decision maker)

- **Documentation of advance care planning in 2014 must include:**
  - An advance care plan in the medical record **or**
  - Advance care planning discussion with the provider documented and dated **or**
  - Notation that the member has previously executed an advance care plan that meets criteria
Blue Cross Blue Shield Hawaii

Percentage of patients 75 years and older at the end of the measurement period who had an advance care plan and/or an advance care planning discussion with their PCP documented during the measurement period

Codes used:

- 1158F – Advance care plan discussion document in the medical record
- S0257 – Counseling and discussion regarding advance directives or end-of-life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service).
- V49.86 – Do not resuscitate status
Provider-Payer collaboration for Commercial and Medicare Advantage; As part of overall score, hospitals are scored on compliance with generating a POLST/POST/ MOLST for patients discharged to SNF or LTAC

Assess compliance using codes from submitted claims

1123F Advance care planning and documented, advance care plan or surrogate decision maker documented in the medical record

- POLST Discussion with POLST completion

1124F Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

- POLST Discussion without POLST completion
Blue Cross Blue Shield Excellus

Developed in 2009 to support NYMOLST Provider-Payer collaboration for Commercial, Medicare Advantage, Medicaid

Time-based reimbursement with the use of E& M codes

New vs. Established Patient Example:
- 15 min visit with > 50% of time counseling w/ est. patient = 99213
- 25 min visit with > 50% of time counseling w/ est. patient = 99214
- 40 min visit with > 50% for time counseling w/ est. patient = 99215

Prolonged Physician Service Codes
- Face to Face Time 99354-99357
- Non Face to Face Time 99358-99359

Adapted for EBCBS Model – Used for Tracking
- CPTII 1123F: MOLST discussion with MOLST completion
- CPTII 1124F: MOLST discussion without MOLST completion
Tracking Advance Care Planning Discussions and Counseling Discussions as Quality Indicator

• In Lancaster Hospital when physician indicates advance care planning and counseling system has V65.49 populate EPIC screen

• The Coalition for Compassionate Care of California are using the ICD-9 code for counseling(V65.4) for tracking ACP discussion

• October 2013 CPT® Editorial Panel Meeting*
  • End of Life Care-Advance Directive Plan – accepted addition of 9949x7 and 9949x8 and associated guideline and instructions to report services related to end of life-advance directive plan discussion with patients

## Quality Indicator for Physician Compensation

**Percentage of Patients discharged to a SNF or LTAC facility with a POLST, POST or MOLST form completed prior to discharge**

<table>
<thead>
<tr>
<th>Advance Care Planning Codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT II 1123F</td>
<td>1123F - Advance care planning discussed and documented with POLST/MOLST/POST completion</td>
</tr>
<tr>
<td>CPT II 1124F</td>
<td>1124F - Advance care planning discussed and documented without POLST/MOLST/POST completion</td>
</tr>
</tbody>
</table>
Quality Indicator for Physician Compensation

- Physicians group which works in 11 SNF and admits to Lancaster General are being measured on POLST completion for the majority of their LTC residents
- POLST are being scanned into EMR and retrospectively review the EMR charts of all current LTC residents of the practice who are admitted to the hospital
- Preset amount of quality dollars can be earned and POLST completion is one component

<table>
<thead>
<tr>
<th>Performance Level</th>
<th>Performance Metric Score*</th>
<th>% of Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>≥75%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Level II</td>
<td>60-74.9%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Level III</td>
<td>50-59.9%</td>
<td>50%</td>
</tr>
<tr>
<td>Level IV</td>
<td>≤ 49.9%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Where It Stands at a National Level
New Codes for Advance Care Planning 
CY 2015 (CPT Editorial Panel)

99497
- Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
RUC/HPAC Recommended Work RVU 1.50

99498
- Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)
RUC/HPAC Recommended Work RVU 1.40
For CY 2015, CMS assigned a PFS status indicator of “I” to CPT codes 99497 and 99498 for CY 2015.

- “I” means Not valid for Medicare purposes.

Medicare uses another code for the reporting and payment of these services.

“CMS will consider whether to pay for CPT codes 99497 and 99498 after we have had the opportunity to go through notice and comment rulemaking.”
Meaningful Use

- Part of the Health Information Technology for Economic and Clinical Health (HITECH) Act
- HHS provides incentive payments for adoption of HIT
  - Meaningful use of health IT
  - Identify technical capabilities
- Meaningful Use Stages
  - Stage 1 - 2011
  - Stage 2 - 2014
  - Stage 3 - 2016
Contact Information

Judith S. Black, MD, MHA - Senior Medical Director, Senior Markets Highmark Inc.
judith.black@highmark.com

Kenneth Brummel-Smith, MD - Health & Aging Policy Fellow, Charlotte Edwards Maguire Professor and Chair, Department of Geriatrics, Florida State University College of Medicine
ken.brummel-smith@med.fsu.edu
POLST Programs

Building your Coalition and Sustainability

February 6, 2015

2015 NPPTF Annual Meeting

Rick Bassett, MSN, RN, APRN, ACNS-BC, CCRN
Adult Critical Care CNS

Judy Thomas, JD
Executive Director
Coalition for Compassionate Care of California
Overview

• Understand the key role that a coalition plays in having an effective POLST program
• Identify the characteristics of an effective, central organization in leading POLST efforts in your state
• Recognize fundamental principles in achieving sustainability
• Provide summary of key issues/barrier in addressing sustainability
• What are you wanting out of this session?
The Coalition

- What is the value of a Coalition
  - Manage politics
  - Ownership
  - Conduit for information
  - Better input
- Who should be part of the Coalition
  - Representatives of all key stakeholders
- What about
  - Critics of POLST
  - Organizations with proprietary interest
The Central Group

• Entity needs to be identified early on in the process of organizing your POLST efforts
• Important to identify a group that has a mission and vision aligned with POLST and its fundamental elements
  • Forming a new group
    • Some minimal infrastructure will be needed
    • Volunteer service on group is common
    • Consider the need for an Executive Director
  • Utilizing existing group
    • Need to inform them of the purpose and components of the POLST efforts
    • Need consensus from members of the group that they are willing to provide support and oversight for the process
Stakeholders

- Important to identify key process stakeholders in your community/state that will need to be involved
  - Consider the following when identifying stakeholders
    - Who is already on the group?
    - What part of the POSLT process do they represent or have expertise in
      - Community contacts
      - Legislative
      - Grant or sustainability expertise
      - POLST form content expert
      - Others??
    - Who is missing?
Other Considerations

- How to involve hospices and palliative care organizations
- How to avoid burn out with volunteer
- How to address adversity/political issues
- How to engage stakeholders both regionally and statewide
- How to address administrative structural needs
States with organized structures

- Membership?

- Volunteer vs. paid?

- Formal office?

- Oversight of POLST
Idaho’s Coalition Experience

• Formed a coalition about a decade ago that began work on POLST efforts
  • Better Way Coalition
• Coalition was volunteer based with one exception. There was a part time Executive Director
• Coalition merged with the regional hospice group to create better collaboration and synergy across these efforts and interests
  • Idaho End of Life Coalition
• Coalition became well established across the state with four regions and regional representatives
  • Provided a face for each region
  • Sat on the Board of the Coalition
  • Created a formal reporting expectation for each region
  • Provided for better sharing of ideas and more collaboration
• Changed name to Idaho Quality of Life Coalition to better reflect the mission and vision of the Coalition in their name
Idaho’s Coalition Structure

**IQOL Board**

- **Nomination Committee**
  - Board member leader: 
    - Responsible for:
      - Assisting Board in assuring bylaw membership requirements are maintained
      - Seeking and processing nominations for Board and committee positions

- **Education Committee**
  - Board member leader: 
    - Responsible for:
      - Planning and/or coordinating regional and statewide educational offerings
      - Planning and executing the annual IQOL conference

- **Policy Committee**
  - Board member leader: 
    - Responsible for:
      - Providing content oversight and coordination with all stakeholders throughout the State for the Idaho POST
      - Monitoring, assessing and acting upon legislative activities for relevant topics
California’s Coalition Experience

- Started in 1998 as RWJ community-state partnership grantee
- Project of the California Hospital Association
- Independently incorporated in 2010
California’s POLST Infrastructure

• Coalition for Compassionate Care of California
  • Provides day-to-day operations
• POLST Task Force
  • Oversees statewide aspects (policy, form content, messaging, training, quality)
• Local POLST Coalitions
  • About 25
    • Local piloting, education, quality triaging
• Physician Leadership Council
  • Maintain clinical integrity of the POLST program
    • Educate other physicians
• POLST Trainers
Building Sustainability

- Need to assess scope of Central Organization and its responsibilities
  - Anticipated reoccurring expenses
    - Any paid positions
    - Cost of outreach (travel expenses)
    - Cost of community education
      - Pamphlets, brochures
    - Cost of provider education
  - Formality of the POLST program in your state
    - IT infrastructure
    - Form distribution
- Don’t forget value of in-kind contributions
Building Sustainability

- What, who are your partners in purpose and funding?
  - Legislative funding
    - Difficult to obtain
    - Challenging to predict sustainability
  - Grant funding
    - Great for funding specific activities
    - Often only provides limited funds
    - Requires grant application
    - Competitive process
  - Partner with foundation to provide multiyear funding
  - Partner with other entities to share resource
    - Reduce reoccurring burden
    - Can be risky

**OR**

You can grow a money tree
Building Sustainability

• Don’t forget value of in-kind contributions
  • Meeting space, food, printing, postage
  • People’s time
• Critical to document these contributions
  • Grants
  • Foundation $$$
  • Engagement of other in-kind contributors
States with Sustainability Efforts

• What efforts were most successful?

• What resources were required?
California’s Sustainability Efforts

- Grant Funding
- Pay for Services
  - Education
  - Materials
- Membership
- Donations
  - Major donors (non-profits)
  - Individuals
Idaho’s Sustainability Efforts

- With exception to a part-time Executive Director, our coalition is entirely volunteer-based
  - Membership funds
  - Annual conference
  - Regional conferences
  - Grants
  - Support from local foundations
  - Individual donors
  - In-kind support from Idaho SOS office
Conclusion

• Establishing a successful sustainability structure starts with understanding the needs within your state
• Requires that key stakeholders come together to form a formal relationship (i.e. a coalition) that establishes
QUESTIONS
The NY eMOLST is an electronic form completion and process documentation system for the NYS MOLST form that serves as NY's eMOLST Registry. The web-based application includes programming to eliminate errors, guides conversations between clinicians and the medical decision-maker and family, the ethical framework & legal requirements for making decisions regarding CPR and life-sustaining treatment, and documentation of the discussion. eMOLST may be used with paper records, integrated in EMR or hybrid system, allows for electronic signature for providers and for the form to be printed for needed workflow in the paper world.

Excellus BCBS owns the technology platform and the New York eMOLST "core product" and is licensing the New York's eMOLST platform with state-specific customization. Excellus BCBS and Fusion have created this core product that is capable of handling the common issues required of an electronic POLST Paradigm system. This core product is fully operational in New York State and serves as a scalable base for the future needs of any state developing the National POLST Paradigm approach to end-of-life planning.

We have a core team that provides both the subject matter expertise and IT capability. We are confident that our multi-faceted understanding of the problems, barriers and solutions would help a state pilot a very successful and engaging electronic POLST Paradigm Program system.

The core team includes:

- Dr. Patricia Bomba, NY eMOLST Program Director (Patricia.Bomba@lifethc.com)
- Katie Orem, NY eMOLST Administrator (Katie.Orem@excellus.com)
- Greg Smalter, Fusion Productions.

For more information, visit the eMOLST web page in the MOLST Training Center on CompassionAndSupport.org. To schedule a demo and discussion with the core team, contact Dr. Bomba via email or call toll free at 1-877-718-6709.
eMOLST: Improve Quality & Patient Safety, Reduce Harm and Achieve the Triple Aim

Patricia Bomba, M.D., F.A.C.P.

Vice President and Medical Director, Geriatrics
Chair, MOLST Statewide Implementation Team & eMOLST Program Director
Leader, Community-wide End-of-life/Palliative Care Initiative
Chair, National Healthcare Decisions Day New York State Coalition

Patricia.Bomba@lifethc.com
CompassionAndSupport.org
NYeMOLST: Electronic Form and Process Documentation System & Registry

• eMOLST
  – 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
  – Includes programming to eliminate errors
  – Allows electronic signature for providers
  – CDFs document goals for care, discussion, 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

• eMOLST Registry
  – Electronic database centrally housing MOLST forms and CDFs to allow 24/7 access in an emergency
Why eMOLST? Adds Value

• Ensures accessibility in all settings
• Improves quality outcomes
• Improves legal outcomes
• Improves provider satisfaction
• Provides a system-based solution
• “I do think eMOLST has all the advantages of using TurboTax vs. trying to do your taxes using paper forms with a pencil.”*

*Jonathan Karmel, JD, NYSDOH Division of Legal Affairs, Legal Counsel
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
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

MOLST and MOLST Chart Documentation Forms

Align with NYSDOH Checklists
# MY PATIENTS

## LIST OF MY PATIENTS

<table>
<thead>
<tr>
<th>eMOLST NUMBER</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>DOB</th>
<th>eMOLST STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>001-85FYC-WQ4N</td>
<td>Adams</td>
<td>John</td>
<td>08/08/1900</td>
<td>No Form</td>
</tr>
<tr>
<td>001-8RDSJ-MSTC</td>
<td>Arthur</td>
<td>Chester</td>
<td>02/23/1816</td>
<td>Review in 13 Days</td>
</tr>
<tr>
<td>001-3DS87-WQ4N</td>
<td>Delacour</td>
<td>Fleur</td>
<td>04/23/1923</td>
<td>Draft</td>
</tr>
<tr>
<td>585-7LWVV-7K6H</td>
<td>Dog</td>
<td>Goofy</td>
<td>01/01/1901</td>
<td>Due for Review</td>
</tr>
<tr>
<td>001-6VPPT-WQ4N</td>
<td>Snape</td>
<td>Severus</td>
<td>08/08/1888</td>
<td>First Draft</td>
</tr>
</tbody>
</table>

## Search for a Patient

- **First Name:**
- **Last Name:**
- **Gender:**
- **Date of Birth:**

## Lookup by eMOLST Number

A patient's eMOLST number can be found near the top of the paper MOLST form.

**eMOLST Number:**

[Go](#)
PATIENT SUMMARY

Fleur Delacour
emOLST 001-2DSST-WGN

SUMMARY OF ORDERS

Resuscitation instructions:
- Resuscitation Instructions: Do Not Attempt Resuscitation (Allow Natural Death)

Life-Sustaining Treatment:
- Treatment Guidelines: Comfort Measures Only
- Instructions for Intubation and Mechanical Ventilation: Do Not Intubate
- Future Hospitalization/Transfer: Do Not Send to the Hospital
- Feeding Tube: None
- IV Fluids: None
- Antibiotics: Determine Use or Limitation When Infection Occurs
- Other Instructions: Entered

CURRENT SIGNED eMOLST FORM

Form was completed on 10/03/2014 14:15 by koreml.excellus.

CUSTODIANS

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>PHONE NUMBER</th>
<th>HIPAA ENTITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orem</td>
<td>Katie</td>
<td>5854536306</td>
<td>St. Peter's Health Partners Excellus BCBS eMOLST Training</td>
</tr>
<tr>
<td>Bomba</td>
<td>Patricia</td>
<td>(585) 454-1700</td>
<td>Excellus BCBS</td>
</tr>
</tbody>
</table>

HAS THE PATIENT DIED?

Mark as deceased
This will mark the patient as deceased, and remove the patient from your My Patients list, and you will be unable to access this patient’s information or eMOLST forms.

eMOLST HISTORY

SEARCH: Filter results
1 | DISCUSSION

- Patient is minor and has developmental disability: no
- Patient is a minor: no
- : false
- : false
- no proxy, living will, or oral directive, lacks capacity, has PHL surrogate, completed in community: false
- Are you converting information about this patient from a paper MOLST form or a non-hospital DNR?: Yes
- Original date of consent for resuscitation instructions: 01/01/2011
- Original date of consent for life-sustaining treatment: 02/02/2011
- Is the patient a minor?: No
- Is the patient from a Mental Hygiene Facility?: No
- Is the patient from a Correctional Facility?: No
- Does the patient have developmental disabilities without capacity?: No
- Health Status: Severely Frail
- Estimated Prognosis: 6 months to < 1 year
- New Health Care Proxy: Patient lacks capacity to choose health care agent
- Medical decision-making capacity: Lacks ability to understand orders
- Decision-Maker: Public Health Law Surrogate
- Core patient values: Not to be a burden, Quality of life, Support
- Goals of care category: Functional preservation
- Goals for Care: Entered
- Setting: Nursing Home
- Legal Requirements: Checklist #3
- No Health Care Agent or Public Health Law Surrogate and not in hospice care: no

2 | RESUSCITATION INSTRUCTIONS

3 | LIFE-SUSTAINING TREATMENT

4 | PATIENT CONSENT

5 | CHART DOCUMENTATION FORM

6 | SIGNATURE

7 | PRINT
CREATE eMOLST

Goofy Dog
eMOLST# 585-7LWVV-7K6H

NOTICE

The form has changed! Please pay attention to new questions on the form.

1 | DISCUSSION
- Patient is minor and has developmental disability: no
- Patient is a minor: no
- false
- false
- No proxy, living will, or oral directive, lacks capacity, has PHL surrogate, completed in community: false
- Are you converting information about this patient from a paper MOLST form or a non-hospital DNR?: Yes
- Original date of consent for resuscitation instructions: 01/01/2011
- Original date of consent for life-sustaining treatment: 02/02/2011
- Is the patient a minor?: No
- Is the patient from a Mental Hygiene Facility?: No
- Is the patient from a Correctional Facility?: No
- Does the patient have developmental disabilities without capacity?: No
- Health Status: Severely Frail
- Estimated Prognosis: 6 months to < 1 year
- New Health Care Proxy: Patient lacks capacity to choose health care agent
- Medical decision-making capacity: Lacks ability to understand orders
- Decision-Maker: Public Health Law Surrogate
- Core patient values: Not to be a burden, Quality of life, Support
- Goals of care category: Functional preservation
- Goals for Care: Entered
- Setting: Nursing Home
- Legal Requirements: Checklist #3
- No Health Care Agent or Public Health Law Surrogate and not in hospice care: no

2 | RESUSCITATION INSTRUCTIONS
6 | SIGNATURE

By completing the steps and clicking the button below, you are electronically signing the Medical Orders for Life Sustaining Treatment, as summarized above. This eMOLST form contains orders for the following sections: Resuscitation Instructions, Life Sustaining Treatment.

1. Re-enter your eMOLST password: ............

2. In what city did you meet your spouse/significant other? ...........

3. Select your secret image from the choices below:

   ![Options](image1.png) ![Option2](image2.png) ![Option3](image3.png) ![Option4](image4.png) ![Option5](image5.png)

   - EXIT
   - SIGN eMOLST FORM

7 | PRINT
**Medical Orders for Life-Sustaining Treatment (MOLST)**

**Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)**

This is a medical order form that tells others the patient’s wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient’s current medical condition, values, wishes and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders and changes them.

**MOLST** is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician to fill out a MOLST form if the patient:

- 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.

If the patient has a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

**SECTION A** Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

**Check one:**

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**

CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**

This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.
Goofy Dog
eMOLST# 585-7LWV-7K6H

1 | SUMMARY OF ORDERS

**Resuscitation Instructions:**

- Resuscitation Instructions: Do Not Attempt Resuscitation (Allow Natural Death)

**Life-Sustaining Treatment:**

- Treatment Guidelines: Limited Medical Interventions
- Instructions for Intubation and Mechanical Ventilation: Do Not Intubate
- Future Hospitalization/Transfer: Send to the Hospital
- Feeding Tube: None
- IV Fluids: Trial Period
- Antibiotics: Determine Use or Limitation When Infection Occurs
- Other Instructions: Entered
- Life-sustaining treatment selected: no

View PDF

NO CHANGE ✓ | VOID FORM, COMPLETE NEW FORM + | VOID FORM, NO NEW FORM + | EXIT ✈

2 | SIGNATURE

+ Begin with most recent orders selected

3 | PRINT

+ Begin with no orders selected
### TO-DO LIST

#### ATTEST TO NEW PATIENTS

<table>
<thead>
<tr>
<th>eMOLST NUMBER</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>DOB</th>
<th>eMOLST STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>001-9WDQ2-WQ4N</td>
<td>Nightengale</td>
<td>Florence</td>
<td>03/26/1899</td>
<td>Pending Attestation</td>
</tr>
<tr>
<td>001-DS6YQ-MKWN</td>
<td>Kennedy</td>
<td>Jacqueline</td>
<td>03/25/1930</td>
<td>Pending Attestation</td>
</tr>
<tr>
<td>001-FBD43-WQ4N</td>
<td>Washington</td>
<td>Martha</td>
<td>09/01/1900</td>
<td>Pending Attestation</td>
</tr>
</tbody>
</table>

#### REVIEW AND RENEW

<table>
<thead>
<tr>
<th>eMOLST NUMBER</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>DOB</th>
<th>eMOLST STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>585-7LWVV-7K6H</td>
<td>Dog</td>
<td>Goofy</td>
<td>01/01/1901</td>
<td>Due for Review</td>
</tr>
</tbody>
</table>

#### AFFIRM THE DISCUSSIONS AND SIGN NEW FORMS

<table>
<thead>
<tr>
<th>eMOLST NUMBER</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>DOB</th>
<th>eMOLST STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>001-8VPPT-WQ4N</td>
<td>Snape</td>
<td>Severus</td>
<td>08/08/1888</td>
<td>Draft</td>
</tr>
</tbody>
</table>
In This Section

- Advance Care Planning
- MOLST
- MOLST Training Center
  - Frequently Asked Questions
  - 8-Step MOLST Protocol
  - MOLST Chart Documentation Forms for Adult Patients
  - MOLST LIFE Pack
  - eMOLST
  - MOLST and FHCDA Webinar Series
  - EMS MOLST Training
  - Resources for MOLST Trainers
  - Order Free Educational Materials
- Provider Training
- MOLST Updates
- MOLST Videos
- Implementation Resources
- New York State Legislation
- Ethics Review Committee
- Quality Improvement
- Capacity Determination
- Case-Based Discussions
- CPR
- Share a MOLST Case Study
- Feeding Tubes/PEGS

---

eMOLST

Electronic Medical Orders for Life-Sustaining Treatment in New York State

eMOLST is a secure web-based application that allows enrolled users to complete the eMOLST form, MOLST Chart Documentation Form (CDF) and mandated OPWDD Checklist for persons with developmental disabilities who lack capacity. CDFs document the MOLST discussion including the patient's values, beliefs and goals for care, the ethical framework for medical decisions regarding withholding and withdrawing life-sustaining treatment, and legal requirements. Forms are created as pdf documents that can be printed for the patient and paper-based medical records, stored or linked to from an EMR, and become part of the NYS eMOLST registry.

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

eMOLST allows for electronic completion of the current New York State Department of Health-5003 MOLST form. By moving the MOLST form to a readily accessible electronic format and creating the New York eMOLST Registry, health care providers, including EMS, can have access to MOLST forms at all sites of care including hospitals, nursing homes and in the community.

To begin using eMOLST at your organization, please contact Dr. Pat Bomba (patricia.bomba@lifethc.com) and Katie Orem (katie.orem@excellus.com).

Getting Started with eMOLST at Your Organization

- eMOLST Summary & Why do eMOLST?
- eMOLST Program Manual (see page 6 for the "getting started" checklist)
- eMOLST Form Completion (Clinical) Screenshots
- eMOLST Administrative Screenshots
- eMOLST Overview - 5-minute video demonstrating why it's important to implement eMOLST across New York
- eMOLST Enrollment Template - please complete this and send to katie.orem@excellus.com
- eMOLST Paper Conversion Template
eMOLST
The Electronic Medical Orders for Life-Sustaining Treatment

Overview
MOLST is based on effective communication of patient wishes, documentation of medical orders on a bright pink form and a promise by health care professionals to honor these wishes. MOLST is a standardized community-wide form that transitions with patients across all care settings.

As a result of a New York State Department of Health HEAL 5 (Health Care Efficiency and Affordability) grant, a secure web-based application will render an electronic version of the current paper-based New York State Department of Health-5003 MOLST Form that is available to providers through the Rochester Regional Health Information Organization (RHIO).

In keeping with New York State’s vision for open-system solutions, the eMOLST application is being developed following open architectural principles for the benefit of the community and other RHIOs across the state. The long-term vision of this project is to build a New York State eMOLST registry by leveraging interoperability between New York State RHIOs and serve as a model for the nation.

The eMOLST application documents the clinical process, including goals for care discussion, as well as the legal requirements. The eMOLST application upgrades the workflow around completing the information required for a legal medical order with automated user feedback for quality review and notification of missing information and training tools for users. A DOH-5003 MOLST form and a MOLST Chart Documentation Form for adult or minor patients or OPWDD checklist for individuals with developmental disabilities who lack medical decision-making capacity are created.

By moving the MOLST form to a readily accessible electronic format, health care providers, including EMS, will have access to MOLST forms at all sites of care including hospitals, nursing homes and the community. This approach will allow for EMS to view in the event of an emergency and will allow for other systems to view at the time of need, as the document is shared across the care continuum.

Goals and Vision
- Assure Accessibility – Create an electronic registry.
- Improve Quality Assurance – Ensure accuracy of form completion through built-in quality controls
- Build Quality Metrics – Integrate outcome measurement and trend reporting.

eMOLST Application Functions
- eMOLST allows health care professionals to access the application to create, and complete the review and renewal process of eMOLST forms for patients. eMOLST is also available from tablets such as the iPad and Android-powered devices.
- A mobile version of eMOLST is available for the iPhone and Android smart phones, including the ability to access a user’s account, view forms, and complete the review and renewal process.
- The user can keep track of eMOLST forms completed for their patient, and receive messages about which patients are ready for review and renewal of orders.
- Physicians can electronically sign the form.
- A PDF version of the form will be available to print, on pulsar pink paper, for the patient.
- Access and information transmitted through the eMOLST application complies with HIPAA, New York State Department of Health privacy rules and New York State Public Health Law.

For further information about eMOLST, please contact Dr. Patricia Bomba at patricia.bomba@lifethc.com
CompassionAndSupport.org
eMOLST
The Electronic Medical Orders for Life-Sustaining Treatment

Why Do eMOLST?

Implements Quality Outcomes
- **Safe** – built-in quality controls for correct orders; does not allow for incongruous medical orders
- **Effective** – enables providers to follow clinical steps and meet legal requirements
- **Patient-centered** - goals for care guide choice of interventions
- **Timely** – web-based; assures accessibility across care transitions, including documentation of discussion
- **Efficient** – more time for discussion; less time for documentation, while ensuring accuracy
- **Equitable** – integrates needs of adults, minors, developmentally disabled who lack medical decision-making capacity; can be used in all clinical care settings

Implements Legal Outcomes
- Improves compliance with NYS Public Health Law (FHCDA, §1750-b)
- Ensures accurate documentation
- Reduces potential liability
- Reduces potential for DOH deficiencies

Implements Provider Satisfaction
- Easy to learn, easy to use
- DOH-approved process for conversion of paper MOLST to eMOLST
- Creates MOLST and MOLST Chart Documentation Form
- Helps providers learn complexities of NYSPHL
- Tracks when “Review and Renewal” is needed
- Opportunity to link eMOLST training and training for enhanced reimbursement model for thoughtful MOLST discussions

Provides System-based Solution for Health Systems
- Improves compliance of FHCDA, PCIA, PCAA
- QA/QI – members can access Analytics
  - Integrates outcome measurement and trend reporting
  - Allows access to aggregate de-identified data analysis
  - Data can be used for Joint Commission Advanced Certification in Palliative Care
- IT
  - Can be used with/without EHR and conversion
  - Web-based solution
- Improve financial outcomes
  - Meets CMS requirements for reimbursement
  - Tracks time spent and elements required for enhanced reimbursement model for thoughtful MOLST discussion

For further information about eMOLST, contact Dr. Patricia Bomba, eMOLST Program Director, at patricia.bomba@lifethc.com or Katie Orem, MPH, eMOLST Administrator at katie.orem@excellus.com.

CompassionAndSupport.org
Problems with Paper POLST (according to Oregon POLST Registry)

- Missing/Illegible Date Signed, 42.90%
- Missing/Illegible Name, 36.10%
- Missing/Illegible Signature, 28.00%
- Missing/Illegible DOB, 15.20%
- Missing Section A Orders, 2.90%
Errors:
- 12-15% POLST Forms Monthly NRR

Common Errors:
- 36% - no HCP signature
- 40% - no HCP signature date
- Invalid order set

Errors Mean invalid POLST:
- POLST not located during emergency OR EMS cannot follow orders
- Patient may receive inappropriate tx or tx they didn’t want
Solution!

EPOLST:

1. Automatically signs & dates POLST for HCPS
2. Makes it impossible to finalize a form with incongruous orders
PROBLEM #2
WITH PAPER POLST

TIME

- Completion time
  - Writing information already in EMR

- Time to availability by Emergency Personnel (EMS, EDs)
  - Needs to be sent to HIM to be scanned into OHSU EHR
  - Needs to be sent to OPR (fax)
  - Needs to be manually entered into OPR
Solution!

EPOlst:

(1) AUTOMATICALLY COMPLETES FORM WITH PATIENT INFORMATION FROM EMR

(2) AUTOMATICALLY SENDS EPOlst TO OPR ** NO NEED TO SEND TO HIM!
ePOLST and the OPR

- **ePOLST systems:**
  - Compatible with OPR
  - Bi-directional with OPR

- **Upload time to OPR:**
  - 90% of POLST Forms rec’d within **30 days** (paper)
  - ePOLST:
    - Eliminates initial data entry task (increases efficiency)
    - Almost immediate upload time

- **Goals:**
  - Make POLST forms available to EMS and other medical professionals *faster*
  - Ensure POLST orders available when needed
ePOLST at Providence

Overwhelmingly successful

Increased rate of submission over faxing

Significant decrease in submission lag time
Decreased incidence of non-compliance

Error rate decreased from 20% to less than 1%

ePOLST at Providence
<table>
<thead>
<tr>
<th>Time</th>
<th>Vital Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>BP, HR, HRUC, Resp, SpO2, Temp, WBC, LACT, PaO2, PaCO2, pH, K, Na, Cl, Calcium, Glucose, ALT, AST, ALKP, Albumin, Creatinine</td>
</tr>
</tbody>
</table>
John Doe
114 Year Old Male, Born On January 01, 1900

OR POLST 2014
100%

MEDICAL INTERVENTIONS

- ARTIFICIALLY ADMINISTERED NUTRITION
- DOCUMENTATION OF DISCUSSION
- CONTACT INFORMATION
- HEALTH CARE PROFESSIONAL INFORMATION
- SIGNATURE OF PHYSICIAN / NP / PA

CONFIRM AND SUBMIT POLST
John Doe
114 Year Old Male, Born On January 01, 1900

OR POLST 2019

Sign Document

Doctor
Middle
Who

(888) 777-3333

ABC123

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Doe John

CONFIRM AND SUBMIT POLST
HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT (POLST)

Physician Orders for Life-Sustaining Treatment (POLST)

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient Last Name: John
Patient First Name: Doe
Patient Middle Name: 
Address: 17360 Holy Names Drive, Lake Oswego, OR 97034
Date of Birth: 1900-01-01
Gender: M

A. CARDIOPULMONARY RESUSCITATION (CPR):
   Unresponsive, pulseless, & not breathing.
   • Attempt Resuscitation/CPR
   • Do Not Attempt Resuscitation/DNR
   If patient is not in cardiopulmonary arrest, follow orders in B and C.

B. MEDICAL INTERVENTIONS: If patient has pulse and is breathing.
   • Comfort Measures Only. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs can be met in current location.
   Treatment Plan: Provide treatments for comfort through symptom management.
   • Limited Treatment. In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit.
   Treatment Plan: Provide basic medical treatments.
   • Full Treatment. In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated.
   Treatment Plan: All treatments including breathing machine.
   Additional Orders:

C. ARTIFICIALLY ADMINISTERED NUTRITION:
   Offer food by mouth if feasible.
   • Long-term artificial nutrition by tube.
   • Defined trial period of artificial nutrition by tube.
   • No artificial nutrition by tube.

D. DOCUMENTATION OF DISCUSSION: (REQUIRED) See reverse side for add’l info.
   • Patient (if patient lacks capacity, must check a box below)
   • Health Care Representative (legally appointed by advance directive or court)
   • Surrogate defined by facility policy or Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion—see reverse side)
   • Representative/Surrogate Name: John Doe
   Relationship: Self

E. PATIENT OR SURROGATE SIGNATURE AND OREGON POLST REGISTRY OPT OUT
   Signature: 
   Relationship: Self

F. ATTESTATION OF MD / DO / NP / PA (REQUIRED)
   By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient’s current medical condition and preferences.
   Print Signing MD / DO / NP / PA Name: 
   Signer Phone Number: 
   Signer License Number: 
   This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check out box: 

Vynca Confidential
OREGON AT A GLANCE

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (2013)</td>
<td>3.93 million</td>
</tr>
<tr>
<td>Number of deaths (2013)</td>
<td>33,931</td>
</tr>
<tr>
<td>Number of hospitals</td>
<td>58</td>
</tr>
<tr>
<td>Number of nursing homes</td>
<td>136*</td>
</tr>
<tr>
<td>Emergency Medical Services (EMS)</td>
<td>Single statewide trauma system</td>
</tr>
</tbody>
</table>


ESTABLISHING THE REGISTRY

Legislation

The Oregon Legislative Assembly House Bill 2009 created the Registry within the Oregon Health Authority. The legislation requires signing health care professionals or their designee to submit a patient’s POLST form to the Registry, unless the patient decides not to have their form in the Registry. (There is no requirement for any patient to fill out a POLST form — POLST participation is always voluntary.)

Pilot testing

The Registry was pilot tested in Clackamas County for six months. The pilot served to develop the infrastructure for POLST form receipt and entry in the Registry and to establish the hotline for urgent form requests.

The pilot project was funded by several private philanthropies, the largest of which was The Greenwall Foundation. The Oregon POLST Task Force oversaw the pilot. In addition, extensive educational outreach was provided pro bono by the Center for Ethics in Health Care and nearly 1,000 health care professionals statewide.

Evolution of the Oregon POLST Program

- **1990**
  - EMS and ethics leaders are concerned that individuals’ treatment preferences are not being honored because of lack of documentation of actionable medical orders.
  - A task force forms that eventually becomes the Oregon POLST Task Force.

- **1995**
  - POLST form is released statewide, accompanied by education and communications efforts.

- **1999**
  - Oregon Medical Board redefines the EMT/first responder scope of practice to provide protective immunity.

- **2000**
  - The Registry is pilot tested in one county.

- **2001**
  - POLST form is modified to serve minors by adding “parent of minor” to indicate the surrogate for most children.
  - Nurse practitioners are added as a signer.
  - (Previously, only physicians could sign the forms.)

- **2005**
  - Oregon’s POLST Registry launches in December and becomes the first statewide POLST Registry in the country.

- **2007**
  - Oregon Medical Board changes rules to clarify that POLST orders must be followed in all Oregon health care facilities, even if the POLST orders are signed by someone not on that facility’s medical staff, until or unless health care professionals receive new information to the contrary.
  - Physician assistants are added as signers.
REGISTRY FORMS

POLST only, or other forms  POLST forms only

Pros/cons of this model  Emergency responders need written physician orders as they operate under protocol; advance directives cannot be followed in the field because they are not medical orders.

FINANCING

Cost to run the Registry  Pilot program and start-up costs (excludes education costs): $250,000
Annual operating budget: $370,000 (year 1) to $380,000 (year 6)
Research costs vary by project.

Source of funding  State general fund (except research and education/outreach costs)

ADMINISTRATION

Administrative agencies  The Oregon Health Authority contracts with the Oregon Health & Science University (OHSU), Department of Emergency Medicine for Registry operations. The department subcontracts with the 24/7 Trauma Transfer Center, also located at OHSU, to serve as the Registry’s emergency communications center for urgent hotline calls.

Other groups involved in oversight or other roles  The POLST Registry Advisory Committee is convened by the Oregon Health Authority. The Registry is a public/private partnership. The content of the POLST form is controlled by the Oregon POLST Task Force which provides ongoing education and outreach regarding POLST and the Registry. Administrative support of the Oregon POLST program and the expenses of education and research are borne by the Center for Ethics in Health Care at OHSU through private philanthropy and volunteer efforts of health care professionals statewide.

Voluntary elements  Completion of the POLST form is voluntary. An individual may also complete the form and check the opt-out box to choose not to have it submitted to the Registry.

Mandatory elements  The signing health care professional, or designee, is mandated to submit the form to the Registry unless the patient chooses not to have it submitted. For a form to be entered into the Registry, it must have at least one order recorded, as well as the patient’s first and last name, date of birth, and an MD, DO, NP, or PA signature and date of signature.

Registry staff  
- 1.0 FTE project coordinator who manages day-to-day operations, including staff supervision and daily work planning for the Registry team.
- 3.5 FTE Registry specialists who process all forms received, including validation, data entry, activation, and resolution of “not Registry ready” forms. The team also responds to nonurgent requests for POLST forms and processes registrant mailings.
- 0.5 FTE project liaison who works with state government partners, the POLST Registry Advisory Committee, the Oregon POLST Task Force, and the call center, and provides Registry outreach and education for EMS.
- 0.25 FTE senior management for budget development and oversight, strategic planning, and reporting.
OPERATIONAL

Deaths with POLST forms
During 2010 and 2011, nearly 18,000 people who died in Oregon had POLST forms in the Registry: 31% of deaths.

Wishes honored
Using the data described above, researchers found a strong association between scope of treatment orders on Oregon POLST forms and patient location of death.

<table>
<thead>
<tr>
<th>Scope of Treatment</th>
<th>PERCENTAGE DYING IN HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Treatment</td>
<td>44%</td>
</tr>
<tr>
<td>No POLST in Registry</td>
<td>34%</td>
</tr>
<tr>
<td>Limited Treatment</td>
<td>22%</td>
</tr>
<tr>
<td>Comfort Measures Only</td>
<td>6%</td>
</tr>
</tbody>
</table>


Revisions and form reconciliation
Approximately 15% of forms received each month are updated POLST forms for existing registrants. A Registry search function is required to provide information to EMS in the field. An algorithm was developed to weight information available from emergency health care professionals (e.g., name, date of birth, address, Registry ID). When an updated form is received, the registrant’s earlier form is archived and replaced with the newer form.

Missing information
All forms must have an MD, DO, NP, or PA signature to be entered into the Registry. Registry staff members confirm that the signer’s license is active. Forms without signatures, orders, the patient’s first or last name, the patient’s date of birth, or date of signature are considered “not Registry ready,” and are marked for follow up. Approximately 15% of forms received are not Registry ready, and of those, the Registry team is able to resolve approximately 60% with the form sender, resulting in a form that can be entered. With implementation of ePOLST, the Registry anticipates fewer forms that are not Registry ready.

Registration confirmation
After entering their first POLST form into the Registry, registrants are mailed a confirmation packet, which includes a magnet (see right) and three stickers, all with their Registry ID number and name. When the Registry receives an updated form, it sends the registrant a letter, which summarizes the registrant’s updated POLST information. The registrant ID number stays the same. The Registry mails, on average, over 32,000 letters each year.

<table>
<thead>
<tr>
<th>Registry Form Status through November 30, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active 59%</td>
</tr>
<tr>
<td>Archived* 41%</td>
</tr>
<tr>
<td>Missing 15%</td>
</tr>
</tbody>
</table>

*Match to death certificate data.
Source: Communication with staff members of the Oregon POLST Registry, [www.orpolstregistry.org](http://www.orpolstregistry.org).
**POLST Registry Hotline Functionality for Urgent Calls**, May 15, 2009 to November 30, 2014

**HOTLINE CALLERS, n=4,559**

- **Emergency Department**: 48%
- **Hospital Acute Care**: 21%
- **EMS**: 27%
- **Other/Not Classified†**: 3%

**HOTLINE CALLERS**

- **Emergency Department**: 48%
- **Hospital Acute Care**: 21%
- **EMS**: 27%
- **Other/Not Classified†**: 3%

**Hotline staff search the Registry**

- **POLST form faxed to hospital**
- **Verbal order relayed to EMS**

**Patient Match‡**: 37%

**Requests for Information, Urgent vs. Nonurgent through November 30, 2014**

- **4,559 hotline calls**: 37% resulted in a match
- **3,106 business line calls**: 64% resulted in a match

*Nonurgent calls are responded to by the business office during regular working hours. The Registry provides hospitals, clinics, long-term care facilities, hospices, and other health care professionals who submit forms to the Registry with registered POLST forms for their patients or residents. Bar chart on the right compares the nonurgent business line calls with these urgent calls.

†While all calls are now classified, this was not standardized at outset.

‡Calls with no match mean the patient in question did not have a POLST form, or did not have a form in the Registry, or that there was too little information to yield a match.

Note: Segments don’t add to 100% due to rounding.


---

**TECHNOLOGY**

**Source code**

The Registry is a SQL-server database with a .NET web-based front-end.

**Customization**

The program search function for the Oregon POLST Registry was custom built to serve EMS in the field. A subcontract with the developer is maintained for ongoing updates and upgrades.

**Pros/Cons**

The search and match functionality allows health care professionals to quickly locate POLST orders for people in emergency situations when limited patient information is available (for example, the patient’s medical record number is not available).

Authors
Dana Zive, director, Oregon POLST Registry; senior scholar, Center for Ethics in Health Care; research senior instructor, Center for Policy and Research in Emergency Medicine, Oregon Health & Science University

Susan Tolle, MD, director, Center for Ethics in Health Care at the Oregon Health & Science University; chair, Oregon POLST Task Force

Form Without Errors
1. Scanned
2. Data entered
3. “Pending” additional review and not eligible for searches
4. Reviewed and confirmed
5. “Activated” and eligible for searches
6. Confirmation packet mailed to the patient

Form With Errors
1. Follow-up with sender to retrieve appropriate information
2. Recorded in database of forms with completion errors (protected health and other personal information is removed)
3. New form follows cycle from the top

Source: Communication with Oregon POLST Registry staff.
### Q4 General Survey Questions: Does your state have a POLST Registry? If yes, why did you start one and what stage is it in?

Answered: 28  Skipped: 6

<table>
<thead>
<tr>
<th>#</th>
<th>Responses</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>yes</td>
<td>12/21/2014 2:02 PM</td>
</tr>
<tr>
<td>2</td>
<td>no</td>
<td>12/19/2014 12:57 PM</td>
</tr>
<tr>
<td>3</td>
<td>No</td>
<td>12/19/2014 8:05 AM</td>
</tr>
<tr>
<td>4</td>
<td>Yes, Oregon has a statewide POLST Registry and I will be co-leading this session with Woody. We developed the registry because 25% of POLST forms could not be found at the scene</td>
<td>12/17/2014 11:04 AM</td>
</tr>
<tr>
<td>5</td>
<td>Yes, it was started to track improvement in POST and advance directive submissions Status is active, paper submission only, PDF via computer and fax retrieval only</td>
<td>12/17/2014 8:37 AM</td>
</tr>
<tr>
<td>6</td>
<td>No</td>
<td>12/16/2014 6:54 PM</td>
</tr>
<tr>
<td>7</td>
<td>NO</td>
<td>12/16/2014 1:45 PM</td>
</tr>
<tr>
<td>8</td>
<td>Not yet, but I would like to see us do so.</td>
<td>12/16/2014 5:38 AM</td>
</tr>
<tr>
<td>9</td>
<td>No</td>
<td>12/15/2014 1:47 PM</td>
</tr>
<tr>
<td>10</td>
<td>no.</td>
<td>12/15/2014 7:40 AM</td>
</tr>
<tr>
<td>11</td>
<td>NO</td>
<td>12/15/2014 7:20 AM</td>
</tr>
<tr>
<td>12</td>
<td>no</td>
<td>12/15/2014 7:31 AM</td>
</tr>
<tr>
<td>13</td>
<td>No in Nebraska</td>
<td>12/15/2014 6:09 AM</td>
</tr>
<tr>
<td>14</td>
<td>No</td>
<td>12/15/2014 5:51 AM</td>
</tr>
<tr>
<td>15</td>
<td>no under development</td>
<td>12/15/2014 4:24 AM</td>
</tr>
<tr>
<td>16</td>
<td>No</td>
<td>12/14/2014 8:12 PM</td>
</tr>
<tr>
<td>17</td>
<td>no</td>
<td>12/14/2014 6:13 PM</td>
</tr>
<tr>
<td>18</td>
<td>No</td>
<td>12/14/2014 6:37 AM</td>
</tr>
<tr>
<td>19</td>
<td>yes, established.</td>
<td>12/13/2014 1:21 PM</td>
</tr>
<tr>
<td>20</td>
<td>Established by legislation but not implemented</td>
<td>12/13/2014 12:52 PM</td>
</tr>
<tr>
<td>21</td>
<td>no</td>
<td>12/13/2014 7:11 AM</td>
</tr>
<tr>
<td>22</td>
<td>No</td>
<td>12/12/2014 10:26 PM</td>
</tr>
<tr>
<td>23</td>
<td>No</td>
<td>12/12/2014 8:41 PM</td>
</tr>
<tr>
<td>24</td>
<td>Yes, at the encouragement of OR</td>
<td>12/12/2014 5:09 PM</td>
</tr>
<tr>
<td>25</td>
<td>In status awaiting funding</td>
<td>12/12/2014 3:00 PM</td>
</tr>
<tr>
<td>26</td>
<td>No</td>
<td>12/12/2014 2:43 PM</td>
</tr>
<tr>
<td>27</td>
<td>Yes. We wanted data transfer and alignment. Early stages.</td>
<td>12/12/2014 2:38 PM</td>
</tr>
<tr>
<td>28</td>
<td>no</td>
<td>12/12/2014 2:35 PM</td>
</tr>
</tbody>
</table>
Q5 If no, where is your state:

Answered: 24  Skipped: 10

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actively working to implement a POLST Registry</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>In discussions/starting to make plans to actively work on implementing a POLST Registry</td>
<td>45.83% 11</td>
</tr>
<tr>
<td>Not considering a Registry at this time</td>
<td>54.17% 13</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
</tr>
</tbody>
</table>
Q6 What do you/your coalition consider the biggest barrier to implementing a POLST Registry?

Answered: 32   Skipped: 2

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policymaker/legislator buy-in/interest</td>
<td>9.38%</td>
</tr>
<tr>
<td>Funding</td>
<td>43.75%</td>
</tr>
<tr>
<td>Technological implementation</td>
<td>12.50%</td>
</tr>
<tr>
<td>Legal barriers</td>
<td>6.25%</td>
</tr>
<tr>
<td>Lack of interest</td>
<td>3.13%</td>
</tr>
<tr>
<td>Reaching appropriate level of POLST use within state</td>
<td>25.00%</td>
</tr>
</tbody>
</table>

Total                                           | 32        |
# What would you be most interested in learning from a session on state registries?

Answered: 24  Skipped: 10

<table>
<thead>
<tr>
<th>#</th>
<th>Responses</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How to work with existing EMR, how to make available with EMS, how to make it affordable. Has anyone incorporated into health information exchanges? lessons learned from others</td>
<td>12/19/2014 12:57 PM</td>
</tr>
<tr>
<td>2</td>
<td>Challenges encountered by states who were developing their registry. Lessons learned, if you will.</td>
<td>12/19/2014 8:05 AM</td>
</tr>
<tr>
<td>3</td>
<td>Who maintains the registry and how is it paid for?</td>
<td>12/17/2014 1:06 PM</td>
</tr>
<tr>
<td>4</td>
<td>Continuing dialogue about technology strategies</td>
<td>12/17/2014 8:37 AM</td>
</tr>
<tr>
<td>5</td>
<td>how to assess when a state is &quot;ready&quot; for a registry; what's the best way to pitch key stakeholders on its importance</td>
<td>12/16/2014 1:45 PM</td>
</tr>
<tr>
<td>6</td>
<td>Cost; technology requirements; components of successful registries, and factors that may have caused some registries to be less successful;</td>
<td>12/16/2014 5:38 AM</td>
</tr>
<tr>
<td>7</td>
<td>How do you identify &quot;readiness&quot; to implement a POLST registry</td>
<td>12/15/2014 1:47 PM</td>
</tr>
<tr>
<td>8</td>
<td>How to get all the &quot;parties&quot; together to work toward a common goal.</td>
<td>12/15/2014 8:18 AM</td>
</tr>
<tr>
<td>9</td>
<td>How to get everyone connected</td>
<td>12/15/2014 6:09 AM</td>
</tr>
<tr>
<td>10</td>
<td>Legislative approaches.</td>
<td>12/15/2014 5:51 AM</td>
</tr>
<tr>
<td>11</td>
<td>all topics</td>
<td>12/14/2014 8:12 PM</td>
</tr>
<tr>
<td>12</td>
<td>funding</td>
<td>12/14/2014 6:13 PM</td>
</tr>
<tr>
<td>13</td>
<td>about emerging technology that is being developed and proposals about how to pay for it</td>
<td>12/14/2014 2:30 PM</td>
</tr>
<tr>
<td>14</td>
<td>how to implement</td>
<td>12/14/2014 6:24 AM</td>
</tr>
<tr>
<td>15</td>
<td>reciprocity</td>
<td>12/13/2014 1:21 PM</td>
</tr>
<tr>
<td>16</td>
<td>Advocacy challenges</td>
<td>12/13/2014 12:52 PM</td>
</tr>
<tr>
<td>17</td>
<td>Implementation</td>
<td>12/13/2014 8:12 AM</td>
</tr>
<tr>
<td>18</td>
<td>how they are structured and maintained cost</td>
<td>12/13/2014 7:11 AM</td>
</tr>
<tr>
<td>19</td>
<td>Pros and barriers</td>
<td>12/12/2014 10:26 PM</td>
</tr>
<tr>
<td>20</td>
<td>Funding, policy/legislative buy-in, EHR integration</td>
<td>12/12/2014 8:41 PM</td>
</tr>
<tr>
<td>21</td>
<td>Integration of registries with EMR Interstate coordination</td>
<td>12/12/2014 3:00 PM</td>
</tr>
<tr>
<td>22</td>
<td>Benefits. How a POLST registry works. Funding ideas.</td>
<td>12/12/2014 2:43 PM</td>
</tr>
<tr>
<td>23</td>
<td>Alignment of advance directive and POLST programs. When is POLST most appropriate?</td>
<td>12/12/2014 2:38 PM</td>
</tr>
<tr>
<td>24</td>
<td>examples of well functioning registries, lessons learned, recs for identifying key stakeholders, thoughts on funding</td>
<td>12/12/2014 2:35 PM</td>
</tr>
</tbody>
</table>