

Life-Sustaining Treatment Decisions for Unbefriended Nursing Home Residents: Application of a Clinical Ethics Algorithm in Conjunction With the MOLST Form

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Abstract

Background: In 2016 New York City's public hospitals and nursing homes (NHs) developed an *Algorithm for the Unbefriended* as a quality improvement (QI) aid to provide a framework for clinical ethics consultations in accordance with applicable laws and regulations. The purpose of the algorithm is to assist clinicians in making life-sustaining treatment (LST) decisions when patients lack the capacity to do so and also lack the availability of surrogate decision-makers. From June 2016 through December 2017, the Algorithm was applied by the clinical ethics consultant (CEC) at Coler Rehabilitation and Nursing Care Center (a NYC Health + Hospitals NH) to 25 NH residents in order to help make end-of-life (EOL) care decisions which involved LST. Details of the application of the "Algorithm for the Unbefriended" were reported in the fall 2018 issue of the NYS Bar Association *Health Law Journal*. The key outcome recorded was that unnecessary treatments were largely avoided in 68% of these NH residents at the EOL. Based upon this finding, along with other positive results and a positive staff satisfaction survey, the authors concluded that the Algorithm met its goal of better addressing the EOL care needs of the unbefriended. In the spring of 2018, another QI initiative was introduced in all of New York City's public NHs, spearheaded by its social workers, in which Medical Orders for Life-Sustaining Treatment (MOLST) forms were to be completed for all suitable NH residents. The main purpose of the application of the Algorithm in conjunction with the MOLST form was to further improve EOL care for this unbefriended population.

Methods: Beginning in June 2018, NYS MOLST forms were completed during all interdisciplinary ethics panel (IEP) discussions led by the CEC at Coler in which the Algorithm was also applied. Over an eight-month period, the Algorithm was applied in conjunction with the MOLST form at IEP meetings involving 27 NH residents. LST decisions were endorsed by an IEP assembled for each case discussion and a MOLST form was completed. From these initial 27 NH residents, aggregate outcome data were gathered and analyzed by the Coler CEC.

Results: The referral rate for the initial 27 NH residents was 3.38 cases per month, more than 2.5 times higher than in our previous study. Of the 27 NH residents, 10 (37%) were appropriately referred before reaching the advanced stage of their illnesses in sharp contrast to the earlier study. Fifteen (88%) out of the remaining 17 residents who were in the more advanced stage of their illnesses had appropriate palliative measures endorsed that either limited or prevent-

ed short-term acute care hospital (STACH) transfers, which was significantly more effective than in the earlier study. After follow-up ethics meetings in 6 of the 17 cases, the palliative plan of care was consistently advanced, so that 6 out of 6 of these NH residents had a do not hospitalize order (DNH) in place. Eight (30%) out of 27 NH residents later died at Coler with 6 (75%) out of these 8 on a fully palliative care plan with comfort measures only (CMO) checked off on the MOLST forms, significantly improved from the earlier study.

Conclusions: In contrast to the previous study, referral rates were much improved and appropriate cases were also referred earlier in the course of their illnesses. This was in keeping with a key goal of the MOLST QI initiative which is the timely identification of NH residents for consideration of palliative measures. For those NH residents in the more advanced stage of their illnesses, the simultaneous utilization of these QI measures contributed to even more effective advance care planning than when the Algorithm was applied alone. Based upon a user satisfaction survey, there was a widespread agreement that the MOLST QI Initiative for the Unbefriended was highly effective as care team members experienced less apprehension and moral distress while feeling empowered to better address the EOL advanced care planning needs for this highly vulnerable population. Thus, the MOLST QI Initiative for the Unbefriended was beneficial in improving EOL care for the unbefriended. Furthermore, by helping to alleviate apprehension and moral distress among health care profes-

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sionals, it also provided a major added benefit in helping to “heal the healer.”

Introduction

In 2016 New York City’s public hospitals and NHs developed an *Algorithm for the Unbefriended* (see **Table 1**) to aid clinicians in making life-sustaining treatment (LST) decisions on behalf of patients who lack the capacity to do so and who also lack available surrogate decision-makers. The Algorithm was a quality improvement (QI) aid and also provided a framework for clinical ethics consultations that was clearly supported by relevant laws and regulations, including the New York’s Family Health Care Decisions Act (FHCDA).¹

Over the initial 19-month period, from June 2016 through December 2017, the Algorithm was applied by the clinical ethics consultant (CEC) at Coler Rehabilitation and Nursing Care Center (a NYC Health + Hospitals NH), addressing the care of 25 NH residents in order to help make end-of-life (EOL) care decisions that involved LST. Details of the application of the “Algorithm for the Unbefriended” and its outcomes were reported in the fall 2018 issue of the New York State Bar Association *Health Law Journal*.²

Among the key outcome results reported in the study was that unnecessary treatments were largely avoided for 68% of these NH residents at the EOL as the interdisciplinary ethics panel (IEP) endorsed a reduction in discharges to acute care, thereby sparing these frail, debilitated and elderly NH residents, most of whom were in the advanced stage of dementia, from medically inappropriate and burdensome treatments that would provide little or no benefit. Based upon this, along with numerous other positive outcome results and a staff satisfaction survey, the authors found that the Algorithm met its intended goal of better addressing the EOL care needs of the unbefriended in an ethical and compassionate manner with an interdisciplinary process that greatly minimized the likelihood that arbitrary decisions would be made.²

Medical Orders for Life-Sustaining Treatment (MOLST) QI Initiative

In the spring of 2018, another QI initiative was introduced in all of New York City’s public NHs spearheaded by its social workers, in which MOLST forms were to be completed for all suitable NH residents. The timely identification of appropriate NH residents for consideration of palliative measures was a key goal of the MOLST QI Initiative. The main purpose of the application of the Algorithm in conjunction with the MOLST was to further improve the EOL care of this vulnerable population.

Overview of MOLST

According to the New York State Department of Health, MOLST is intended for those patients with serious health conditions: (1) who want to avoid or receive any or all

life-sustaining treatment; (2) who reside in a long-term care facility or requiring long-term care services; and (3) who might die within the next year.³ In keeping with its intended purpose, MOLST is ideal for NH residents with life-limiting illnesses who are elderly, frail, debilitated and with major cognitive impairment.

In accordance with New York State (NYS) law, MOLST orders remain valid when the patient transitions from one health care setting to another, such as from a NH to a short-term acute care hospital (STACH) and vice versa. Accordingly, MOLST orders must be reviewed regularly as per facility policy every time a patient transitions between care settings, when a major change in health status occurs, or whenever patients or their health care decision-makers change their minds about treatment.³ As such, MOLST orders remain in effect and valid across the continuum of care, accompanying the patient to each new setting and are constantly updated to reflect changes in the patient’s health status and prognosis.

In NYS, decision-making standards, procedures to be followed and statutory witness requirements vary for decisions to withhold or withdraw LST, including Do Not Resuscitate (DNR), depending on who makes the decision and the setting in which the decision is made. Thus, the NYS MOLST provides several different checklists, reflective of the different types of health care decision-makers and the settings in which these decisions are made.³ MOLST (Checklist #4)⁴ is intended for adult hospital, hospice or NH patients who lack the capacity to make informed medical decisions and also lack a health care agent⁵ or available surrogate from the list of FHCDA potential surrogates.⁶ Thus, a legal framework and set of procedures exist for completing the NYS MOLST form for unbefriended NH residents without decisional capacity which enabled this QI initiative to include this vulnerable NH population.

Methodology

Beginning in June 2018, NYS MOLST forms were completed during all IEP discussions led by the CEC at Coler in which the Algorithm was applied. The IEP utilized the same process and evidence-based rationale used in the earlier study with regard to its care plan recommendations. The key difference, however, was that the discussions during these IEP meetings were geared to include the check listed items in the MOLST, beginning with cardiopulmonary resuscitation (CPR). In those cases where the IEP determined that just DNR was appropriate, it was documented in the ethics report why the withholding of other measures was not yet warranted.

As part of the MOLST QI process, during quarterly Minimum Data Set (MDS)⁷ meetings, the interdisciplinary care team is required to reassess the MOLST. If in the case of an unbefriended NH resident without decisional capacity, the care team determines that the resident’s medical condition has deteriorated further such that additional

MOLST measures should be considered, then an ethics referral is made so that a follow-up IEP discussion can take place. Accordingly, a MOLST reassessment can occur at any time during the course of an unbefriended NH resident's stay, such as when a sudden major medical deterioration occurs, which would trigger an ethics referral for a follow-up IEP discussion.

Over an initial eight-month period, from June 7, 2018, to February 7, 2019, the Algorithm was applied in conjunction with the MOLST form at 35 ethics case meetings involving 27 NH residents. LST decisions were endorsed by an IEP assembled for each of these case discussions, and a MOLST form was completed. From these initial 27 NH residents, aggregate outcome data were compiled and analyzed by the Coler CEC (see Tables 2 to 6).

Evidence-Based Rationale Applied

The evidence-based rationale applied during these IEP discussions for limiting treatment interventions on the MOLST form was the same as in the earlier article describing the use of the Algorithm.² For the withholding of CPR, intubation with mechanical ventilator support and tube feeding, the evidence-based rationales are summarized below.

Evidence-Based Rationale for Do Not Resuscitate (DNR)

In general, NH residents undergoing CPR have survival rates to discharge from an acute care hospital ranging from 0 to 5%.⁸ For those with dementia, CPR survival rates are significantly lower than for cognitively intact patients.^{9,10} In one study, involving elderly NH residents who suffered unwitnessed cardiac arrests, the CPR survival rate was 0%.¹¹ With such dismal survival rates reported in the literature, it is readily apparent why the attending physician, along with a concurring physician, agreed that the requirement set forth in step 9 of the Algorithm was met.

Evidence-Based Rationale for Do Not Intubate (DNI)

Although a study of mechanical ventilation in NH residents with advanced dementia and severe functional impairment found that the usage of this aggressive modality increased significantly, there was no substantive evidence of improved survival.¹² Thus, based on the lack of improved survival for residents with advanced dementia placed on mechanical ventilators, the same rationale, which was applied to justify DNR orders, was used for DNI as well.

Evidence-Based Rationale for No Tube Feedings in Advanced Dementia

Contrary to a lingering misconception among some caregivers, in the advanced stage of dementia tube feeding does not constitute LST, for no evidence of any benefits exists with regard to improved survival, prevention of aspiration pneumonia, prevention or improvement of pressure sores, improved overall functioning or even palliation.^{13,14}

As a result, the present standard of medical care for those with advanced-stage dementia is to offer oral assisted feeding and to avoid tube feeding.^{15,16} Since tube feeding does not constitute LST in advanced stage dementia, step 9 of the Algorithm did not need to be applied in order to withhold it.

Outcome Results

Table 2 shows the referral rate of the 27 NH residents at Coler Rehabilitation and Nursing Care Center when the Algorithm was applied in conjunction with the MOLST forms. The referral rate for these residents was 3.38 cases per month. This value was more than 2.5 times higher than the 1.32 per month reported in our previous study when the Algorithm alone was applied to NH residents at the same institution.

Table 3 shows the advanced care planning measures endorsed at the initial IEP meeting and at follow-up meetings over the eight-month period. Of the 27 NH residents, 10 (37%) were not yet in the advanced or terminal stage of their illnesses as evidenced by the fact that during the initial ethics meeting an order for DNR was endorsed but not for DNI. This earlier referral of appropriate NH residents was in sharp contrast with the earlier study where both DNR and DNI orders were endorsed for all 25 NH residents, all of whom were already in the advanced stage of their illnesses.

Table 4 shows that when the Algorithm was applied in conjunction with the MOLST forms to the 17 (63%) of 27 NH residents who were in the more advanced stage of their illnesses, advanced care planning palliative measures that either limited or prevented STACH transfers were put in place at the initial IEP meeting in 13 (77%) out of the 17 NH residents. This compared favorably with the 16 (64%) out of the 25 NH residents who had such measures put in place at the initial IEP meeting in the previous study where only the Algorithm was used. After the eight-month period of follow-up ethics meetings, 15 (88%) out of the 17 NH residents had advanced care planning palliative measures that either limited or prevented STACH transfers, which was a significant improvement from the earlier study when, upon completion of follow-up meetings, 17 (68%) out of 25 had such measures put in place (see Table 3). In seven (41%) out of the 17 NH residents, CMO, which equates to a fully palliative care plan and includes a DNH order, were endorsed at these follow-up IEP meetings in which the Algorithm was applied in conjunction with the MOLST. This was better than the 6 (24%) out of 25 NH residents who had CMO put in place in the previous study where the Algorithm was applied alone.

Table 5 provides a close look at the 6 NH residents who required follow-up meetings when the Algorithm was applied in conjunction with the MOLST forms. Of these 6 NH residents, 5 (83%) had appropriate palliative interventions added while one NH resident remained on a fully palliative

care plan with CMO. Most notably, in 4 (67%) out of the 6 NH residents, the plan of care was advanced to fully palliative with CMO checked off on the MOLST form. After all of the follow-up IEP meetings were completed, 6 out of the 6 of these NH residents had a DNH order in place as 5 (83%) out of the 6 were on CMO, which included a DNH order. These results demonstrate that when the Algorithm was applied in conjunction with the MOLST, in follow-up meetings, the palliative care plan was consistently advanced.

Table 6 shows that as of February 7, 2019, 8 (30%) out of 27 NH residents in which the Algorithm was applied in conjunction with the MOLST forms had died at Coler. Of these 8 NH residents, 6 (75%) were on a fully palliative care plan with CMO checked off on the MOLST forms. One NH resident was on a mainly palliative care plan with a DNH order, and the remaining one was on limited medical interventions which included DNR and DNI orders, along with an order to limit STACH discharges. This contrasted with our previous study where only 5 (42%) out of 12 NH residents were on what would have been equivalent to CMO at the time of death, 4 (33%) out of 12 were on DNR/DNI with an order to limit STACH discharges, and 3 (25%) out of 12 were on DNR/DNI only, without an order to limit STACH discharges. Thus, when the Algorithm was applied in conjunction with the MOLST, those NH residents who later died had significantly more advanced care planning measures in place than in the earlier study.

Table 7 shows the results of a satisfaction survey intended to gauge feedback from interdisciplinary care team members who participated in these IEP discussions as to the effectiveness of utilizing the Algorithm in conjunction with the MOLST forms. A total of 24 respondents from the departments of NH Medicine, Social Work, Nursing, and Food and Nutrition participated in the survey. The survey reflected that there was widespread agreement that the process was highly effective.

Discussion

Improved Advanced Care Planning for the NH Residents in the More Advanced Stage of Their illnesses

Advanced care planning is regarded as the single most consistent and modifiable factor linked to the avoidance of unnecessary and unwanted treatments at the end-of-life.^{17, 18, 19, 20} Our previous study² highlighted that the use of the Algorithm in NH residents acted as a valuable QI tool helping to improve advanced care planning for this most vulnerable population. The Algorithm more effectively addressed the EOL care needs of the unbefriended in an ethical and compassionate manner, supported by built-in safeguards that greatly minimized the likelihood of arbitrary decisions. The authors underscored that unnecessary, burdensome and unwanted treatments were largely avoided for those NH residents in the advanced stage of their illnesses by supporting either no acute care hospital discharges or limited acute care hospital discharges for

short-term treatments that could not be provided in the NH. Based upon the QI data obtained in the present study for the 17 NH residents in the more advanced stage of their illnesses and their related mortality data, it appears that the simultaneous utilization of these QI measures contributed to even more effective advance care planning than when the Algorithm was applied alone. The net overall effect was to further improve the EOL care of these vulnerable unbefriended NH residents, which was the main purpose of applying the Algorithm in conjunction with the MOLST.

Earlier Referral of Appropriate NH Residents

As for those 10 NH residents for which the only palliative intervention endorsed by the IEP was an order for DNR, they all exhibited major cognitive impairment which was deemed to be moderately severe, along with other significant medical co-morbidities and debilitation. Thus, in all of these cases, the attending physician along with a concurring physician agreed that the requirement set forth in step 9 of the Algorithm was met, based upon the dismal survival rates reported in the literature.^{8,9,10,11} In these particular cases, however, the same clinical determination could not be made for other forms of LST such as intubation and mechanical ventilator support. As the timely identification of appropriate NH residents for consideration of palliative measures was a key goal of the MOLST QI Initiative, implementing a DNR order was considered a good starting point for the development of a palliative plan of care for this subset of NH residents who predictably will become sicker and more debilitated over the course of time.

Satisfaction Survey

There was a widespread agreement that the use of the Algorithm in conjunction with the MOLST forms was highly effective as care team members experienced less apprehension and moral distress while feeling empowered to better address the EOL advanced care planning needs for this highly vulnerable population. It was also felt that the use of the Algorithm in conjunction with the MOLST made it easier for the attending physician with input from other care team members to complete the MOLST forms with less uncertainty, apprehension and with greater confidence that the appropriate decisions were made.

Helping to “Heal the Healer”

In addition to being valuable QI aids, the combination of the Algorithm and the MOLST appears to have served a dual function in helping to “heal the healer” as 96% of the care team members favorably responded to the satisfaction survey question of whether using the Algorithm in conjunction with the MOLST at these IEP meetings helped allay or relieve any apprehensions or moral distress that they may have felt in regard to the type of decisions to be made. This is important because a major issue among today’s healthcare professionals (HCP’s) is their high prevalence of burnout which can adversely impact quality, safety, and

health care system performance.²¹ Indeed, moral distress which can result from various factors such as perceived powerlessness, rendering of unnecessary/futile care, and offering false hope²² has been shown to be a significant predictor of burnout among nurses.²³ In particular, registered nurses who work in NHs, more so than those who work in other settings, appear to be at higher risk for burnout and lower job satisfaction.²⁴ Similarly, physician burnout has been found to be independently associated with job dissatisfaction.²⁵ Thus, the authors feel that the MOLST PI initiative for the Unbefriended not only was beneficial in improving EOL care for this vulnerable population, but by helping to alleviate apprehension and moral distress among HCPs, it provided a major added benefit which they wish to underscore.

The Merits of the Interdisciplinary Ethics Panel (IEP) Approach

Based upon first-hand experience, the authors believe that the IEP approach in which the CEC facilitates an ethical discussion among assembled interdisciplinary care team members of EOL care options was the key factor leading to the success of the MOLST QI Initiative for the unbefriended at Coler when the Algorithm was applied in conjunction with the MOLST. They surmise from the responses received that the IEP approach enables the care team members to act as involved stakeholders for these unbefriended, elderly NH residents. They feel that this is appropriate and befitting since no one else knows these residents better than these caregivers who are often the only ones to offer them comfort and emotional support over the long-term. These actions on the part of the staff reflect the deep bond that has been created between them and these residents. As a result, they contend that the net overall effect greatly increases the likelihood that the decisions which are made by the IEP are done so in the perceived best interests of these NH residents. It is the staff's impression that this transparent, interdisciplinary process, which allows the care team members the opportunity to act as involved stakeholders, significantly helps to relieve their apprehension and moral distress as well as leads to a greater sense of confidence that the appropriate decisions are made in the completion of the MOLST. The authors note that care team members were instructed not to apply their own personal values or cultural beliefs unless such were consistent with those of the NH resident. When the resident's values or prior wishes were unknown, they were instructed to apply the ethical principle of the best interest standard which requires an objective assessment of the relative burdens versus the benefits of available treatment options. When this standard is evoked, it should be determined to the extent possible from the perspective of the resident, not that of the decision-maker.

Limitations to the Study and Applicability Elsewhere

The sample in this present study was intentionally limited to approximately match up with the sample size in the

earlier study so that the outcome data could best be cross compared. In comparison to most other NHs in NYS, our sample size of 27 residents would be considered relatively large, as it is estimated that 3 to 4% of NH residents in this country are unbefriended,²⁶ which would amount to six to eight unbefriended residents for a typical 200-bed NH. Nevertheless, the authors caution that Coler is a very large NH with many unbefriended residents, and therefore, these results may not necessarily translate to other NHs.

Whether or not the combined use of these two quality improvement aids can be beneficial if applied elsewhere would require further study. However, based upon the highly favorable response to question 6 in the satisfaction survey in which care team members felt that the process in place made it easier to complete the MOLST form with greater confidence that the appropriate decisions were made, the authors are optimistic that such a process would succeed elsewhere. They would also like to note that implementation of the initiative proceeded smoothly and that no unintended consequences were encountered.

Conclusions

In the present study, in which the Algorithm was applied in conjunction with the MOLST over an initial eight-month period as part of the MOLST QI Initiative at Coler Rehabilitation and Nursing Care Center, the referral rate for the 27 unbefriended NH residents without decisional capacity was more than 2.5 times higher than in the previous study when the Algorithm was applied alone. In contrast to the previous study, appropriate cases were also referred earlier in the course of their illnesses in keeping with one of the key goals of the MOLST QI initiative, i.e. the timely identification of NH residents for consideration of palliative measures. In addition, for those NH residents in the more advanced stage of their illnesses, it appears that the simultaneous utilization of these QI measures contributed to even more effective advance care planning than when the Algorithm was applied alone.

The MOLST QI Initiative for the Unbefriended not only was beneficial in improving EOL for this vulnerable subpopulation but by alleviating apprehension and moral distress among HCPs also provided a major added benefit in helping to "heal the healer." The success of this initiative also helped pave the way for a later Palliative Care Improvement Initiative at Coler by identifying many appropriate candidates for its palliative care program, which is geared toward avoiding unnecessary and burdensome end-of-life medical interventions in favor of palliative measures aimed at promoting comfort and easing pain and suffering. Finally, the authors feel that the IEP approach, by allowing the care team members to act as involved stakeholders, was largely responsible for contributing to a greater sense of confidence that the appropriate decisions were made in the completion of the MOLST forms.

Table 1. New York City Health + Hospitals Clinical Ethics Consultation Guidelines: Algorithm for the Unbefriended

AN ALGORITHM FOR DECISIONS REGARDING WITHHOLDING OR WITHDRAWING LIFE SUSTAINING TREATMENT FOR ADULT PATIENTS WITHOUT DECISIONAL CAPACITY AND WITH NO SURROGATE

Attending physicians may use the process described below to develop a plan of care when making a decision whether to withhold or withdraw life-sustaining treatment from unbefriended patients without decisional capacity. If an attending physician seeks an ethics consultation for such a plan of care for an unbefriended patient, the clinical ethics consultation process should include the following elements:

1. Convene a multidisciplinary group, including primary care providers, major consultants, nursing and social work staff and the Palliative Care team to explore the medical/ethical issues related to options for care;¹
2. Explore and decide if the patient had any advance directives; advance words, ideas, documents; or communicated values before considering the “best interest” standard;
3. Identify potential therapeutic interventions. Then identify those interventions that are unlikely to provide benefit, highlighting those that might increase suffering for no medical or health gain;
4. Consider national guidelines, NIH consensus statements and end-of-life standards developed by medical and specialty societies;
5. Specify the comfort and palliative interventions that are appropriate given the patient’s condition. Consider all options for comfort and palliative care; itemize those elements of the condition of the patient that would qualify the patient for palliative care;
6. Articulate the recommendation of the multidisciplinary group;
7. Prepare a Clinical Ethics Consultation Report documenting the meeting, including the issues discussed, and the recommendation that the multidisciplinary group reached in a form that reflects: 1. Ethically Relevant Medical Facts, 2. Ethically Relevant Social Facts, 3. Ethical Analysis of Treatment Options and 4. Ethics Recommendation;
8. Circulate the Clinical Ethics Consultation Report to the multidisciplinary; and
9. In the event that the multidisciplinary group recommends withholding or withdrawing life-sustaining treatment, the attending physician with the independent concurrence of a second physician,² must determine whether the criteria below are satisfied to a reasonable degree of medical certainty before entering an order implementing the recommendation:
 - (i) life-sustaining treatment offers the patient no medical benefit because the patient will die imminently,³ even if the treatment is provided; and
 - (ii) the provision of life-sustaining treatment would violate accepted medical standards.

This paragraph shall not apply to any treatment necessary to alleviate pain or discomfort.

1 NYC Health + Hospitals/Legal Affairs and/or Risk Management of the subject facility are available for consultation if necessary.

2 In a residential health care facility, the medical director of the facility, or a physician designated by the medical director, must be the second physician that provides the independent concurrence.

3 The standard for the unbefriended patient is designed to be more rigorous than that for a patient with a surrogate. For a patient with a surrogate the patient will be projected to die within six months. Thus, “imminent” must be somewhat of a shorter time but need not be immediate, which is not the term used. April 14, 2016.

Table 2. Comparison of Referral Rates, Number of Interdisciplinary Ethics Panel (IEP) Meetings, Duration of Follow-Up Period and Number of Nursing Home (NH) Residents Requiring Follow-Up

Study Data Comparison	Total NH Residents	Referral Rates of NH Residents/Month	Duration of Follow-up Period (Months)	Number of IEP Meetings	Residents with IEP Follow-up Meetings
Algorithm Only 6/1/16 to 12/31/17	25	1.32	19	31	5
Algorithm plus MOLST 6/7/18 to 2/7/19	27	3.38	8	35	6

Abbreviation Key for Tables 3-6.

Do Not Hospitalize (DNH) as per NYS MOLST (unless pain or severe symptoms cannot otherwise be controlled); **Comfort Measures Only (CMO)** which equates to a fully palliative care plan, and it includes **Do Not Resuscitate (DNR)**, **Do Not Intubate (DNI)**, no tube feeding, DNH, no IV fluids and no antibiotics; **Limited Short-Term Acute Care Hospital (STACH)** transfer, usually for short-term medical treatments that cannot be provided in the nursing home, and it always includes DNR/DNI.

Measures put in effect to reduce or prevent STACH transfers include: (1) **Orders to limit STACH transfers**; (2) **DNH orders (without CMO)**; and (3) **Orders for CMO, which include a DNH order**.

Table 3. Comparison of Advanced Care Planning Measures Recommended at Initial IEP Meeting and after Follow-up IEP Meetings

Study Data Comparison	DNR	DNI	DNR Only	No Tube Feeding	Limited STACH transfer order	DNH without CMO	Order for CMO	Measures in Place to Reduce/Prevent STACH Transfers
Algorithm Only (n=25) 6/1/16 to 12/31/17 Initial IEP Meeting	25/25 (100%)	25/25 (100%)	0/25 (0%)	13/25 (52%)	9/25 (36%)	5/25 (20%)	2/25 (8%)	16/25 (64%)
Algorithm Only (n=25) 6/1/16 to 12/31/17 After 6-Follow-Up Meetings Involving 5 NH Residents	25/25 (100%)	25/25 (100%)	0/25 (0%)	14/25 (56%)	7/25 (28%)	4/25 (16%)	6/25 (24%)	17/25 (68%)
Algorithm plus MOLST (n=27) 6/7/18 to 2/7/19 Initial IEP Meeting	27/27 (100%)	17/27 (63%)	10/27 (37%)	12/27 (44%)	8/27 (30%)	2/27 (7%)	3/27 (11%)	13/27 (48%)
Algorithm plus MOLST (n=27) 6/7/18 to 2/7/19 After 8 Follow-Up Meetings Involving 6 of these NH Residents	27/27 (100%)	17/27 (63%)	10/27 (37%)	12/27 (44%)	5/27 (19%)	3/27 (11%)	7/27 (26%)	15/27 (56%)

Table 4. Comparison of Advanced Care Planning Measures Recommended in 17 NH Residents in the More Advanced Stage of their Illnesses at Initial IEP Meeting and After 8 Follow-up Meetings, Involving 6 of these NH Residents

Study Data Comparison	DNR/DNI	No Tube Feeding	Limited STACH with DNR/DNI	DNH without CMO	Order for CMO Only	Measures in Place to Reduce/Prevent STACH Transfers
Algorithm plus MOLST (n=17) 6/7/18 to 2/7/19 Initial IEP Meeting	17/17 (100%)	12/17 (71%)	8/17 (47%)	2/17 (12%)	3/17 (18%)	13/17 (77%)
Algorithm plus MOLST (n=17) 6/7/18 to 2/7/19 After 8 Follow-Up Meetings, Involving 6 of These NH Residents	17/17 (100%)	12/17 (71%)	5/17 (30%)	3/17 (18%)	7/17 (41%)	15/17 (88%)

Table 5. Advanced Care Planning Measures Recommended for 6 NF Residents in the More Advanced Stage of their Illnesses, Requiring 8 Follow up IEP Meetings in which the Algorithm was Applied in Conjunction with the MOLST

Study Data Comparison	DNR	DNI	DNR Only	No Tube Feeding	Limited STACH Transfer Order	DNH without CMO	Order for CMO only	Measures in Place to Reduce/Prevent STACH Transfers
Algorithm plus MOLST (n=6) 6/7/18 to 2/7/19 Initial IEP Meeting	6/6 (100%)	6/6 (100%)	0/6 (0%)	6/6 (100%)	4/6 (67%)	1/6 (17%)	1/6 (17%)	6/6 (100%)
Algorithm plus MOLST (n=6) 6/7/18 to 2/7/19 After 8 Follow-Up Meetings	6/6 (100%)	6/6 (100%)	0/6 (0%)	6/6 (100%)	0/6 (0%)	1/6 (17%)	5/6 (83%)	6/6 (100%)

Table 6. Comparison of Mortality Rates in NH Residents in Which the Algorithm Only Was Applied Versus Those NH Residents in Which the Algorithm Was Applied in Conjunction with MOLST

Study Data Comparison	Total Deaths	Deaths at Coler	Deaths on CMO/Full Palliative	Deaths on DNH without CMO	Deaths on either CMO or DNH without CMO	Deaths on limited STACH with DNR/DNI	Deaths on DNR/DNI without limited STACH
Algorithm Only (n=25) 6/1/16 to 12/31/17	12/25 (48%)	11/12 (92%)	5/12 (42%)	0/12 (0%)	5/12 (42%)	4/12 (33%)	3/12 (25%)
Algorithm plus MOLST (n=27) 6/7/18 to 2/7/19	8/27 (30%)	8/8 (100%)	6/8 (75%)	1/8 (13%)	7/8 (88%)	1/8 (13%)	0/8 (0%)

Table 7. The Algorithm for the Unbefriended/ MOLST Care Team Survey Results

(Overall 24 Respondents from the Departments of NH Medicine, Social Work, Nursing and Food & Nutrition)

	Extremely beneficial		Generally beneficial		Sometimes beneficial		Not sure		Not beneficial		Favorable Responses	
1. Was the <i>Algorithm for the Unbefriended</i> utilized in conjunction with the MOLST, beneficial in addressing the resident's end-of-life advanced care planning needs?	19	79%	5	21%	0	---	0	---	0	---	24/24	100%
	Strongly agree		Somewhat agree		Neither agree nor disagree		Somewhat disagree		Strongly disagree		Favorable Responses	
2. During these IEP meetings, in which the <i>Algorithm for the Unbefriended</i> was applied in conjunction with the MOLST, all major end-of-life care concerns were adequately addressed.	20	83%	3	13%	1	4%	0	---	0	---	23/24	96%
3. The Use of the <i>Algorithm for the Unbefriended</i> in conjunction with the MOLST at the IEP meetings helped allay or relieve any apprehensions or moral distress that you may have felt in regard to the type of decisions to be made.	17	71%	6	25%	0	---	1	4%	0	---	23/24	96%
4. I would recommend using the <i>Algorithm of the Unbefriended</i> in conjunction with the MOLST as an effective process to colleagues in other nursing facilities who care for similar types of residents.	20	83%	2	8%	2	8%	0	---	0	---	22/24	92%
5. The <i>Algorithm for the Unbefriended</i> , used in conjunction with the MOLST, helps to empower the attending physician and the other members of the care team to make these difficult types of decisions in a transparent manner, in which all viewpoint may be shared, including the wishes and values of the resident when known while demonstrating the utmost respect and compassion for these residents.	20	83%	2	8%	2	8%	0	---	0	---	22/24	92%
6. Using the <i>Algorithm for the Unbefriended</i> in conjunction with the MOLST at these interdisciplinary ethics case meetings made it easier for the attending physician and the other care team members to complete the MOLST form, with less apprehension, uncertainty, and with a feeling of greater confidence that the appropriate end-of-life care decisions were made.	21	88%	3	13%	0	---	0	---	0	---	24/24	100%

Endnotes

1. Chapter 8, Laws of 2010, adding N.Y. Public Health Law Article 29-CC ("The Family Health Care Decisions Act") and amending various other laws.
2. Howard J. Finger, James Zisfein, Khoi Luong, Cheryl A. Dury, Ravindra Amin, Steven Hahn, Albina Shkolnik, and Nancy Neveloff Dubler, *Life-Sustaining Treatment Decisions for Unbefriended Nursing Home Residents: Application of a Clinical Ethics Algorithm*, NYSBA Health Law Journal, Fall 2018, Vol. 23, No.2.
3. New York State Department of Health: Medical Orders for Life-Sustaining Treatment (MOLST), https://www.health.ny.gov/professionals/patients/patient_rights/molst/ Revised December 2018.
4. NYS MOLST Checklist #4 for Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available, https://www.health.ny.gov/professionals/patients/patient_rights/molst/docs/checklist_4.pdf.
5. Health Care Proxy: Appointing Your Health Care Agent in New York State, November 2017, <https://www.health.ny.gov/publications/1430.pdf>.
6. PHL § 2994-d. Health care decisions for adult patients by surrogates. 1. Identifying the surrogate.
7. The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff to identify health problems. Care Area Assessments (CAAs) are part of this process, and provide the foundation upon which a resident's individual care plan is formulated. MDS assessments are required for residents on admission to the nursing facility, periodically, and on discharge. Participants in the assessment process are licensed health care professionals. MDS information is transmitted electronically by nursing homes to the national MDS database at CMS, <https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/minimum-data-set-3-0-public-reports/index.html>.
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