IPRO

Moderator: Sara Butterfield
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3:00 PM ET

Operator: Good day, ladies and gentlemen. And welcome to the Care Transitions Initiative Demonstration eMOLST conference call. At this time, all participants are in a listen-only mode. Later, we will conduct a question and answer session, and instructions will follow at that time. If you require any assistance during the call today, please press star, then 0 on your touch tone telephone. As a reminder, this call is being recorded. I would now like to turn the conference over to your host for today's conference, Ms. Sarah Butterfield. Ma'am, you may begin.

Sara Butterfield: Thank you and good afternoon, everyone. On behalf of the IPRO Care Transitions project team we welcome you to the Care Transitions learning session this afternoon. We've been working with several of the community coalitions on the MOLST in advance care planning and we're very pleased today to be highlighting and seeing a demonstration of the eMOLST tool. And we're continuing to work with everyone on a community-wide approach to advanced care planning and adoption of MOLST on a community-wide effort. So we're very pleased today that Dr. Bomba's able to join us and be able to give us an overview of the eMOLST.

As a reminder, today's webinar is being recorded and it's going to be posted to the Care Transitions webpage. Takes about five to seven days to make that available. As soon as it is available, we'll send that notice out so folks can access it that may not have been able to attend today. And it also might be a nice learning tool for some of the other disciplines within your organizations.

As mentioned, all of the lines are currently muted, but we're going to open those lines up, once Dr. Bomba has finished her demonstration, for your questions and comments and for further discussion.

And we're very fortunate to have once again as our expert speaker Dr. Patricia Bomba. And Dr. Bomba is the Vice President and Medical Director of Geriatrics at Excellus Blue Cross and Blue Shield and MedAmerica Insurance Company. She's also the Chair of the MOLST statewide implementation team and eMOLST program director and Chair of the National Healthcare Decisions Day New York State Coalition. And Dr. Bomba's collaborative work with the New York State Department of Health on health policy and legislative advocacy established the MOLST as a statewide program. And currently she chairs the MOLST statewide implementation team and the National Healthcare Decisions

Day New York State Coalition. And she's New York State's representative on the National Board.

Joining Dr. Bomba is going to be Katie Orem. And Katie, you've had -- we're fortunate to have her back. You've heard her present also. She's the Geriatrics and Palliative Care Program Manager at Excellus Blue Cross and Blue Shield and the eMOLST administrator for New York. And she supports the evaluation and expansion of geriatric palliative care and end of life care initiatives internally and across New York State and nationally through collection of data and now assistive outcomes. And in her role as the eMOLST administrator, Katie has been presenting eMOLST information to organizations in upstate New York, throughout the state, particularly in the Rochester area. And she's got previous experience presenting posters and abstracts at several conferences. So we're very, very excited to have both Dr. Bomba and Katie back with us today.

And with that, Dr. Bomba, I'm going to turn the call over to you.

Patricia Bomba: Thanks, Sara. And I want to say thank you for having us back. And I'm delighted to have so many organizations on the line to be able to share the information. Because there's always a wide variation of folks who are either on the line and/or who listen in to the webinar, we're going to do some slides quickly before we actually do t he demo so that we can illustrate how eMOLST is designed to improve quality and patient safety, reduce patient harm and aims for -- to achieve the triple aim.

I want to just point out that the work we're doing on advanced care planning with Sara from a community perspective, as well as across the state, aligns with the seven preferred practices that are part of the national quality forum. These preferred practices focus on advanced care planning, ensuring that whenever we touch a patient at whatever setting, if they have not or have, we ought to identify who they wish to speak for them if they lose the ability to make decisions the next time we see them, what's important to them, what are their values, beliefs, their goals for care. And then begin to identify the cohort of individuals who's appropriate for a MOLST program.

That group who is facing the end of life, they're in a nursing home, they have advanced stage and have specific things that they want or don't want, and/or anyone at any age where it wouldn't surprise you that they might die in the next year, we are working and eMOLST is really aligning with making these documents available across care settings. And so eMOLST is the digital transformation of the MOLST process, which is a shared decision making process on life sustaining treatment that crosses care transitions.

We work to ensure that people are aware of it, we work with collaboratives through the state. We have a program called Community Conversations on Compassionate Care that aims to get people to think early about advanced care as a process, to talk about what's important to them, to pick their healthcare agent and do a healthcare proxy.

The National Quality Forum aligns and recommends the establishment of ethics review committees and this aligns with our Family Healthcare Decisions Act, it's all integrated into the eMOLST application. And for children, as you know, for the first time with Family Healthcare Decisions Act, we have a guideline and a framework, an ethical framework and legal requirements for making these types of decisions with children. And from a national level, it aligns with making sure that children who have the ability to make decisions are part of that decision making process.

Advance care planning as a process is ongoing; there are two different types of documents, two different cohorts of patients. The eMOLST is really a registry that looks at medical orders, not the traditional advance directives. And you'll see that in the demo.

As we look at advance directives, we focus on the healthcare proxy. We know the living wills that people have it, but because they don't work and they're not actionable in an emergency, we came up with looking at MOLST and developing MOLST as a model for our state based on the national model POLST.

So in our state it's medical orders for life sustaining treatment. The national model is called POLST or Physician Orders for Life-Sustaining Treatment. And different states can have different names, but they all have to have certain particular requirements to be endorsed. And you can see that our state is an endorsed POLST program.

It's important because sometimes people get confused as to what is MOLST, what is POLST. Again, MOLST is the name for New York State's program, POLST is a national model and different states can have different names.

It's an end of life care transition program in the paper world. It's clearly in the digital world as well because our aim is to make sure there's access to these documents in an emergency at all care settings. And that they're also accessible to EMS.

This is a long history of the MOLST and eMOLST program. I put it here predominantly to let you know that as we were building eMOLST we had to stop and start as we had significant changes in legislation. It has also added a level of complexity to making these decisions with or without a MOLST form. There are ethical -- an ethical framework, there are legal requirements. What eMOLST is pulls it all together and that's what you'll see in the demo.

We also integrated at a high level as a key teller of palliative care, integrating with the new -- relatively new laws now on the Palliative Care Access Act and the Palliative Care Information Act.

So I want to talk briefly about what is eMOLST versus what is the eMOLST registry. So what you're going to see a demo of is a secure web based application. The enrolled users, depending on their clinical role, can work on completing the eMOLST form, as well as documenting that goals for care discussion, as well as the right MOLST chart documentation form that aligns with the checklists that were developed by the Department of Health as well as the Office for Persons with Developmental Disabilities.

All of the requirements for making these decisions, as I said with or without a MOLST, are codified and integrated into eMOLST. And it allows the end user to -- it drives the user frankly along the right pathway and it also helps teach them that as they're doing this process because there are seven different pathways that can be chosen currently under the law.

Once the process is completed, both a MOLST form, as well as a copy of the goals for care discussions as copied into the MOLST chart documentation form, are created. They can be printed as PDFs, they also automatically become part of the registry so they are available across care transitions. And for the clinicians on the line, just think about having the access to capacity determination from one setting to the other and how helpful that is, particularly for those where MOLST was created in the hospital, moving then to

the nursing home, where the manpower issues to be able to do the process correctly -- manpower may not be there.

The registry is basically an electronic database. And this is accessible 24/7 in an emergency, both at clinical care sites and across care transitions.

This is just a little schematic to show you that anywhere that you can have access to the Internet, you can have access to the eMOLST application. So that if you're in an electronic health record in your clinical care site, you can have a link to the eMOLST application. If you have a paper based record, if you have access to the Internet, you can create these documents, print them and add them to your paper record. We also have worked with systems that are hybrid, they have some in EHR, they have some paper, they're in the midst of digital transformation.

The vision then is to have access and think of this as a state level service, so that if I'm in Rochester and have my MOLST form and I'm coming out to Albany and end up needing to have care at Albany Med or St. Peters Healthcare, that my eMOLST form would be accessible across counties, across healthcare systems, across the state.

The protocol, and I'm not going through this, but this is a protocol that really shows that MOLST is a process, it's not just the form. That's integrated into the process. So the standardized clinical process for doing that is integrated and allows for teams then to work together to be able to use this process.

These are the seven checklists and they vary depending on whether the person has capacity and can make their own decisions, whether there's a healthcare agent, which is checklist two. Family Healthcare Decision Act with a selected surrogate is checklist three. When there is no surrogate, the new pathway where two physicians can see if the patient needs clinical standards and can use that pathway they don't need clinical standards. Those cases still go to court, but prior to Family Healthcare Decisions Act, all of those cases went to court.

Checklist five is a hybrid, where people are in the community, and those of you on the phone who know the law, Family Healthcare Decisions Act applies to hospitals, nursing homes and hospices. This allows people in the community for a MOLST to be completed when there is no capacity and no healthcare agent because the work we've done in MOLST allows for surrogates to make DNR and DNI decisions and then for clear and convincing evidence to allow for the completion of the rest of the MOLST form.

That's fairly complicated and it's all actually embedded into the checklist and into the eMOLST. Then there's the checklist for minors and then the OPWDD checklist for persons with developmental disabilities, with intellectual disabilities who lack capacity. There are some folks in that group who have capacity, they would go to checklist one or those who have a healthcare agent would go to checklist two.

So think of it this way. The paper that gets created by the process includes the MOLST form and a documentation of the conversation. This is all embedded into the eMOLST and both of these documents are created and stored in the registry so you can go back and again look at things like capacity across care transitions.

I'm going to show you a few screenshots and then we're going to go right to the demo so we have enough time for questions. This will be the shot of the initial screen when you get to eMOLST. Everyone gets a user name and there's a password. And there's access

based on the clinical use. So there are clinical users and there's administrative use. From a clinical perspective, there are some individuals like physicians who have access to not only looking at the form, helping to create the form and currently the only subset of clinicians who can actually sign a MOLST form and that's in accordance with public health law.

The second group would be those clinicians who are trained and qualified to do the discussion. Advanced clinical practice nurses, nurse practitioners, PAs, social workers can have access to helping to create as part of a team the MOLST form, but they don't have the ability to sign the MOLST form.

Then there are those clinicians who basically need access to seeing the form. As an example, the nurses who are in the nursing home and on the floor, the floor supervisors, the evening supervisors in a nursing home, EMS in the community, they need access in an emergency to a read only version of the MOLST. They are not part of creating the form or signing the form. And then there are folks who have no clinical access, but they really have administrative access and we can get to that later in the demo.

This is the screenshot you can get to all of the different active links that are on a webpage that's dedicated to eMOLST on compassionandsupport.org.

When you log in, you will see your list of patients. You will see in the top screen that once you're enrolled there's some basic demographic information that is put in once and you don't have to continue to put it in. Think about the MOLST form and putting in your license or your DE number multiple times -- or excuse me, or your NPI number multiple times. You do it once with enrollment and it gets auto populated.

A list of your patients with designated eMOLST numbers that are auto generated, their last name, first name, are in the system. You will be seeing the training site, which is not an active -- it is not the active registry. Once you get involved and you're enrolled as a user, you have access to the registry.

You can search either by first name, last name, gender, date of birth. If someone has an eMOLST number you can also search by eMOLST number. If you have someone who's had a MOLST form created through the system, it will be populated in the top of the MOLST form.

You also have a set of notifications in terms of the activity in eMOLST. You also can come to a patient summary sheet, where you can basically view the registry with old forms that are voided. You will only see the current MOLST form. So for those of you who know the MOLST process and the system, you'll know that sometimes you may have two forms. You have to say which is the accurate one, it's the most recent one, but in eMOLST you only see the latest MOLST form.

We have the ability to add or remove from custodianship, which allows multiple users to be part of the clinical work on this individual person, which clearly happens in one setting where a nurse practitioner perhaps and the doc are working in collaborative practice in the nursing home. That patient still goes to the hospital, the ER doc needs to be a custodian of the patient until there is a decision as to whether they're admitted. The hospital then can take care of it. The primary physician and nurse practitioner retain the name on their list of patients. It doesn't go away.

We also have the capacity to mark as deceased from a quality improvement, quality assurance process so that then you can look on the backend and it says here's the list of patients that have died that have had MOLST forms. Let's see how we're doing as a system in terms of meeting those needs.

You have the ability to review and review the MOLST form without having to create yet a new form or make a single change that will show you without having to void a complete paper MOLST and create a new one. You just can make a singular change.

There are seven sections in eMOLST. The discussion basically looks at the clinical process. You'll see in section 2 and 3 when we demonstrate it's basically section A of page 1, which gives the same view, just like the paper MOLST form. You get into consent and then the additional requirements for documentation of the discussion and the chart documentation form, all of that can have access to those clinical users that are enrolled with the capacity to do the dialog and do the discussion. They've been trained in MOLST, they're comfortable talking about end of life discussions.

Again, only physicians can sign it. That's not MOLST, that's true for any of these decisions in New York State, with or without the MOLST. And then you can print it.

You'll see that the consent for resuscitation is here. If the same person is making the same consent for page 1 and page 2, there's a button that says same as above. If the discussions or the consents are different, person consented to a DNR order, they lost capacity in the surrogate or a healthcare agent is making it, the system allows for that.

You'll also be able to see that with every section there's a summary here that you can go through before you move on to sign it. This is electronic signature. The physicians who are enrolled have a unique eMOLST password with questions as well as images that are protected because only one -- they are the only people that can sign the MOLST form.

You'll see that what's created is an image of a MOLST form that's just like the DOH MOLST form, except it's in white to be printed on pink paper. And the same workflow given to the patient as they go home or move across care transitions or from the nursing home going out for an outing and they'll be coming back to the nursing home.

You'll see a summary of orders for an emergency. You can also then come into the section, we'll show you how to void or begin new orders during the review process. This is the data page, this is the webpage for eMOLST. Lots of active links with a lot of tools to get started at your organization.

Our emails are here as well on this webpage. They're on the PowerPoint that we will be sending after this webinar, as well as the fact that what's new for this year we created over the summer and tested into the fall, a training site so that trainers in facilities can have access to do demos and share that so we can provide access to folks that will be sharing this with others in their facility and doing a demonstration of eMOLST to help us to move this project forward.

So now I'm going to turn this over and we're going to go right to the active site and Katie will be working with me as ICOC and she is going to begin to do the demonstration and you'll see some of these screenshots that I've shown you but also you can see some additional screenshots as we actively create an eMOLST form as part of the demo.

So Katie has logged in with her unique user ID number. And so she demonstrated that if you don't have the correct password, that you won't be able to get in. What you're seeing now is a screen that you will see a single Fake Hospital, but for each individual user, because this is the training site. So I know Dr. Burke is on the line and he has multiple facilities that he participates in. You'd be able to put on all of the different sites where the clinical practice and where MOLST may be created. So it may be the hospital, the nursing home, a home based palliative care practice in the patient's home or an office setting.

This helps us to build up the analytics on the backend so that from a system perspective you can see where eMOLST is getting done and where we need to be able to focus limited resources in terms of education and training.

So Katie has shown a patient summary sheet. This is Rosalie and you can see the list of patients. And so this is where you would see your list of patients to be able to say this is my patients. You can also see the status. Some of these are in draft and that's an example of where you're working in joint practice, perhaps with the nurse practitioner who has started the form or the social worker who's working with you in the nursing home. And you'd be able to go in and do the review, affirm the orders with the family or the person, depending on the capacity and make those decisions. It also shows you when the forms are due for a review and renew or where it's been started but no form has yet been created.

So we're going to search for a patient and Katie's going to search there and if that person's not in the registry we'll create a new person and a new form. And so it says the patient was not found and we'll create a profile. It's making sure that we don't have duplicates in the system and obviously you know that with any other system you need to key in and you need to put it in correctly so that you can find it later. So we will create the profile and it will take in all of the information that is needed to auto populate the MOLST form as well as the demographic information on all of the pages and all of the future pages where you do a review and renew.

You can see we're collecting some demographic information for the future so that we'll be able to as systems look at this how are we making decisions and are there implications for how we do training down the road. So all the information is in there. You will see a lot of these boxes come up in the eMOLST system as reminders as partly why it's very helpful with training. It reminds you to make sure you have spelled everything correctly, again for access later.

So we will work to create a new eMOLST form and you see those two active systems, if you are removing from custodianship, as I mentioned earlier, or if the person is deceased. We'll create the form and you see actively right before that create eMOLST form. Again, that's the location for the registry, where it says look for the old eMOLST voided forms. So there's always access to the older documents if there's a need to do that.

So we're waiting for the eMOLST editor to reload, and as you see that it seems a little slow today, but one of the things as we're populating this, it's auto saved to the server. And that allows for the real clinical world where you may be starting to do this work, get called to see a patient, get called for a phone call, so you don't lose your work, because there's auto conversion.

In the first part of the eMOLST application you'll see a section called paper conversion because we have worked through a process with the Department of Health to allow taking

paper forms and having them put into the system. Particularly that's important in areas where there's been good penetration. We'd have to wait forever for people to start using eMOLST.

It also allows so that if the -- it can be done in a way without having an additional conversation with consent. It's purely an administrative function and so eMOLST will auto generate the date when the form was created. When you put in the information here in eMOLST it will populate another instruction so that there's an acknowledgement that consent was obtained on such and such date and it's primarily paper conversion. All of that gets auto populated.

You'll see the patient status, and we're not going to get into the nuances because you can get access to the training site and see a little bit more. But it helps to drive the system so there are questions about whether the person is a minor patient, whether they're from a correctional facility. If it's no, no, no, it then disables buttons down the road so that the provider doesn't have to worry about notifications that are not necessary but are required under the law if the person is from such and such facility.

We have changed most recently health status to integrate the clinical frailty scale because our original work with palliative performance scale did not meet the needs of early users. It was hard to categorize patients. We've put in the images to make it easier for people to associate the image and the description. We have a specific health status scale for children that we established through research with our pediatric palliative care docs throughout the state.

Prognosis is listed in terms of ranges in the way we teach MOLST. We also then ask about advance directives. We don't store them, but we drive the process, recognizing that if someone hasn't done a healthcare proxy they still may have the ability to choose a healthcare agent and it's a different ethical framework and it becomes an easier workflow for places, particularly in the nursing home.

So we're going to do a setting in the nursing home and we're going to say that the person doesn't have capacity to make decisions because that will drive us to having the public health law surrogate make the decision because they didn't have a healthcare agent or a healthcare proxy.

You'll see that we have some values and beliefs that are chosen here. It's not that everybody has to be bucketed there because we have a text box for very person centric goals for care. As I teach MOLST, I always say my goal for care is to be a grandmother. And if I'm not a grandmother and it's time for me to have my MOLST form, that's going to drive my choice of interventions, particularly if my daughter is finally pregnant. So that individual personal can be integrated into the text box.

We've taken from the geriatric literature goals of care and have bucketed into three large buckets, one focused on longevity, so I might be there if I'm waiting for that grandbaby to be born or I might be the older adult or the person with frailty who's younger who says I just want to be functionally well. I want to be independent, I want to be able to die in my home. And people then may get to the point where they say it's time to focus on comfort only. And so people tend to move through those stages. We've included other so that we can accommodate other personal goals for care.

We ask where the eMOLST is being completed, where the patient is in the setting because that helps to drive the requirements under public health law. And you'll see as we

scroll down that the system will auto populate and choose the right checklist, which is very helpful as opposed to the paper world where people may not know what the requirements are or if they do, pick up a set of requirements that are differently seen and some of the facilities have created their own tools and they're not always accurate. This assures that folks are following the right process.

And as you move through that, Katie will scroll up and you can see that the discussion then can be affirmed before you move onto the form. Making sure that you have a conversation to validate that this is exactly what we've heard. It's also useful when you're working in a team, so if the NP has started it, the physician can look and see what the discussion has been and affirm that as well. And we know that sometimes people change their minds from day to day, even before the form is completed.

As I said earlier, section 2 is section A of the MOLST form, exactly how it's written on the MOLST form. And so we will demonstrate incompatible orders because this person has chosen resuscitation and you will see that you can't choose comfort measures because if someone says they want to be resuscitated and if they survive, they will be on a ventilator, transferred to the hospital for post recovery from a cardiac arrest care. And so in the real paper world we know they're incompatible orders and when they happen in an emergency, I'm the one who gets the call. So we want to avoid those and the system doesn't allow for it.

So we'll go back and choose DNR because this is a person who's chosen comfort measures based on what the surrogate said would be appropriate and what the person would have wanted. And that was consistent with the patient values. You can see the choices that are here, just like the MOLST form.

And if we scroll up you can see skip and return later. That was put in specifically for the nursing homes where the regs require a conversation on day 1 of admission to see if the person has any preferences. Not that they have to walk through all of the choices in the whole MOLST form, but they have to ask have you made a decision about it? So that can be completed on day 1 and it goes right to the end of consent for page 1.

But for the download we're going to walk through rest of the form, making the choices without really getting into the specific nuances of the choices, but adding other instructions. And as you know, in other instructions you can put in for dialysis, for phlebotomy, for other choices. You can also put in things like the person would prefer hospice care. Or what to do if in the case of antibiotics and what specific preferences would be.

We save and continue, and again this is a time where you can validate by scrolling to the top of the eMOLST, say I just want to confirm before we finish this form, this is what we've talked about, these are the choices and then you get down to the level of consent. Provide for the consent and this is all being done in one session. We'll be able to just use same as above. And as you can see with the demo, we want people to focus more time in the discussion and less in terms of the documentation and do the documentation and process correctly.

You see all these buttons everywhere. Where there's a highlighted active link, it takes people out to get information. List of surrogates, links to feeding tube guidelines, which as you all know, is one of the top -- it is the number one treatment that should be avoided in people with advanced dementia in the list of -- the choose wisely list by both AHPM and AGS that we need to be able to have honest conversations about that.

So once we do this we walk through the chart documentation form and this part is demonstrating all of the other requirements under Family Healthcare Decisions Act and it really helps people to know that this is an addition. This is kind of the replacement for those of you who knew the supplemental forms. Supplemental forms are obsolete. There was one for adults, one for minor patients. It only applied to DNR. These checklists apply to all life sustaining treatments and the requirements -- the ethical framework to make the decisions, including capacity determination, concurrent determination, notification of the patient, identification of the appropriate public health law surrogate.

Also in this is all of the language from the law that affirms that decisions need to be made in concert with the person's values and beliefs and not the surrogate's values and beliefs. And so recognizing that who the person is, you'll see, as Katie's moving along, that you'll see some pink lines if she misses something. But this is all of the informed consent process for the surrogate, which also aligns and it also validates for the provider to say no, it's not about you, but it's really about what the person wanted. And we need to understand that.

There are also specific clinical standards that have to be determined by two physicians and if there's a surrogate making decisions. If the person is in coma or has life expectancy less than six months, you can proceed with the MOLST form. If they don't meet that standard as identified by two physicians, then anything on page 2 of the MOLST form needs to go to ethics review committee and there's a spot in a nursing home. In the hospital that requirement isn't there and that goes back to the idea of this being a community wide process and it's everyone's job to do the MOLST and to have these conversations. In the hospital setting, it's only if there's disagreement with the attending in terms of decisions about artificial hydration and nutrition.

So as you can see, when you have these special requirements it's all wrapped into the application. There's no need to attach any other documentation, it's all confined in one space. And for those that are from nursing homes, it's done correctly so when you do it you can focus and know and the health department knows that you're doing it correctly and it helps in terms of preventing survey deficiencies and allows you to do your quality work to say let's look at the cohort of individuals and let's just make sure that their care plan supports their MOLST orders and let's look at the cohort of individuals who say do not hospitalize. Can we manage their care in this care setting? And if not, what else do we have to do to buff up their -- or beef up their care plan?

Similarly we have integrated into the application the attestation by a close friend and an electronic signature, but with a box for attestation. Again, no need for additional paperwork.

And then we have put into the application the signatures. All of eMOLST is done with verbal consent, which is allowed under our law, it's been vetted with the health department with lots of attorneys. And so with verbal consent with two witnesses, you can have completion of the eMOLST form. One of those witnesses can be the physician.

We've also integrated in the ability to track the time spent. That's an optional field. For some of our providers who have been trained and are qualified for enhanced reimbursement, they use this as a tool to be able to track both their face to face and non face to face time, follow-up with family members, et cetera. And that's a different conversation.

We have the ability to do NPI searches, so that the affirmation of capacity determination, also the clinical determination of the standard can be put in without having the second physician attest to it and go into the application. And most people don't know their NPI number, so we have an NPI search function on the application. It's a link out to it.

So as you see, before you sign the MOLST form, again we go to the top, and this is just to be able to see if you're doing the MOLST process as a team in joint practice, as I did when I was in the nursing home, with a nurse practitioner, you're able to see the work and affirm the work. Make edits in any of this before you sign the MOLST form, particularly if there is a change in what people want between when the first conversation was done and the last one before the MOLST is signed.

But once it's done, again up till section 6, anyone who's trained and qualified for the conversation can have access to this level. And it's only physicians who can sign the form. Again, this would be true not only for MOLST, but for any orders related to life sustaining treatment and DNR in New York State in all clinical settings. To go otherwise, we would have to -- I mean to be able to have NPs, PAs or others, we'd have to change the law and if that law gets changed, we can change the application very easy in terms of allowing other users to have access.

So we're going to sign the form. Signature failed because -- and Katie demonstrated that because there was something that she didn't put in correctly.

Katie Orem: I've had to change my questions a lot for testing.

Patricia Bomba: You're going to be locked out, Katie.

Katie Orem: We'll see. Yes, I can't -- I have changed it like 30 times in the last two weeks.

Patricia Bomba: So what Katie had demonstrated is that when you change your passwords and you get to a certain level then I think what she's going to need to do is reset herself. So we will -- she will reset herself. Normally what happens is that there are eMOLST administrators. While she does that, she'll reset herself, but eMOLST administrators can change the password. We also have a system where Katie has made changes for those folks and we have a new enhancement so that people can auto change their passwords once they're enrolled.

Katie Orem: Yes, people can change it themselves.

Patricia Bomba: They can change it themselves without having to call us. But that's a new enhancement that we're rolling out.

So what we're showing you here is the kinds of things that you'll be able to do yourself once this new enhancement is put into place. And we'll have that enhancement ready hopefully by early February.

Katie Orem: I'm hoping this will work.

Patricia Bomba: So we know when Katie graduated from high school. But once she critically changes that we'll be able to go back to the demo with the training site and hopefully complete the demo. What we can demonstrate we know is what interruptions happen and how we can retain the eMOLST forms.

Katie Orem: Sorry, guys. I was testing that passive reset functionality and I had to reset my questions like 30 times probably in the last two weeks. So I just can't remember what they are right now.

Patricia Bomba: Okay. So what I'm going to do is we're going to log out of Katie's and I'm going to log in and see if we can sign this. And this will demonstrate how one can do it in joint practice. Katie has done the conversation. I'm going in to Fake Hospital to confirm. And once I go in, I'm going to search for the form that we just created so that I can sign it. Okay. So -- and go to the list of my patients. I was trying to for the sake of the demo go too fast. But it went forward really pretty fast. So what we're going to do is search by the eMOLST number that we created. And you'll see Minnie Mouse is up here retained as a draft. So she hasn't been signed yet.

What we'll also do is demonstrate what happens -- I have not yet been in the system to take care of Minnie, so there's an attestation that says I am taking of her and I'm requesting access to eMOLST. So that's from a privacy HIPPA perspective and that's what would happen across care transitions in terms of attestation.

So what we want to be able to do is edit the form. And it's getting loaded and if all works well you will see how all of the work that Katie did is retained. So here we are as we go down and everything's been retained. So even though we had an interruption we can save and continue. And you'll see everything's been saved. And I can look through this as the provider, working in joint practice with Katie, modify anything I want to do if there's something different from my conversation with the surrogate. Save and continue. And now I'm going to sign the form. Again as a summary, the same form that we just did.

So that's ready to go and so that's a signed MOLST form. We can view and print it later or we can view and print and give it to the patient. But we're going to view and print it later for the demo. And it says this is because we have a security. It's always continue to this website. That's because we've built it off our system internally, but there's nothing that you have to worry about. This is a good website. You can always -- you'll see that, but you can always continue to the website.

Katie Orem: It has to do with where the security certificate is held. Like in this case, Internet Explorer doesn't recognize Excellus as the holder of the security certificate. For the live website with real patients, we paid for an externally -- a third party security certificate, but they're quite expensive, so we haven't needed to purchase one for training with all the fake patients.

Patricia Bomba: So this is again the training. So you can see we created Minnie Mouse and it aligns with what we did in eMOLST. You'll see the auto generated eMOLST number here. All of the orders are signed, it's verbal consent, date and time with the witnesses, made by the public health law surrogate, signed by me. Again, dated today. Living will, but no healthcare proxy. All of the decisions that were made, again witnessed. Public health law surrogate, dated and timed. Verbal consent. EMS is trained to look for verbal consent with two witnesses.

We don't have a review and renew yet, so that's blank, but that would get populated when it's time to review and renew Minnie. And we have the chart documentation form. Again, the person's been enrolled once and it auto populates all of these forms with all of the demographic information so that there's less time spent and it's all legible and it's done correctly and the orders are not incompatible.

Everything that Katie wrote in, there's Nancy Green agreed, Minnie has dementia, won't regain capacity, is listed here including all the requirements under public health law. Including the ethics review committee and including the time spent that one can use for billing purposes.

So that's really the essence of creating the MOLST form. And what we're going to do is get back here and I think -- I'm not sure if we're ending at 3:00 or 3:30, Sara.

Sarah Butterfield: We have the WebX till 4:30 actually, but we have time for questions.

Patricia Bomba: Okay. I think what I'd like to do is stop at this point because this is the clinical and then if there are questions from an administrative end, we can go back and do more of the demo. But I think it's a good break here as we've created the form and talked about enrolling users from a clinical endpoint that we stop and open up the line for questions. And then we can go back to address other parts of the demo.

Sara Butterfield: Okay, great. And Diamond, can you explain to folks how they can ask questions please?

Operator: Of course. Thank you. Ladies and gentlemen, if you have a question at this time, please press star then the number one key on your touchtone telephone. If your question has been answered or you wish to remove yourself from the queue, please press the pound key. One moment while we wait for questions. Okay, and we have a question coming from Patricia Hale.

Patricia Hale: Hear me?

Operator: Ma'am, you may begin.

Patricia Hale: Hello, can you hear me?

Patricia Bomba: I can hear you.

Patricia Hale: Great.

Patricia Bomba: How are you? Long time no talk to.

Patricia Hale: Yes. (Inaudible) presentation, I found it very, very interesting. I'm in the informatics world and very, very interested in being able to incorporate these kinds of information into our electronic health records. And so one of the things we've talked about doing is making a link in our order sets and our EMR where a physician could easily go out to the web and access your eMOLST area. We have high security through our EMR, but I -- from what I'm understanding from your presentation, we would also need to have all of our physicians registered in your system in order to see. Or are there different levels where we could have people access and see if there was a form available, even though they would not be able to actually enter one.

Patricia Bomba: So there's a lot of questions that are integrated there, so I would say the first level of integration into an EHR, if you think of it in the same way you think of a link to ISTOP database, that you would go out to the ISTOP.

Patricia Hale: Yes, and we are including links for that.

Patricia Bomba: So think in terms of the same way for eMOLST and that's the first level of integration is a link that can be created in the EHR for eMOLST. What we need to be able to do and we have some spreadsheets on that webpage, which was a screenshot, the eMOLST webpage. We have an Excel spreadsheet where folks can basically tell us who should be enrolled and the list of the physicians who are creating MOLST forms and signing them. Who else within the system would be part of it? And oftentimes what we see is the usual suspects that are doing this work. It's the palliative care teams, the (inaudible), the hospitalists, the emergency room docs.

And so that's the enrollment template. So separating the physicians and then their other staff who participate in the discussions, but they have to be separated out. And all of that is in a spreadsheet that helps us then to enroll users in any one system.

We can also have an eMOLST administrator at your facility that we would work with and you can enroll them yourself or we can batch enroll them and we can work with you on that. And so oftentimes then it gets down to the level of the clinicians who need access but they're not participating in the discussion. They need to see it. That's a different level of access. Does that make sense, Pat?

Patricia Hale: Yes, yes, it does. What about resident physicians?

Patricia Bomba: That's a great question. So with resident physicians they -- if there's resident physicians that are first level, they are not New York State licensed physicians for the most part year one. And as residents move into fellowship, many of them have New York State licenses. So for the internal, and this is what I've learned as I've gone across the state, for some of the policies and procedures, none of the residents have access to signing these types of orders with or without MOLST. If there is a place that allows a -- and some of it relates to training, that they're not geared for it, many of the residents can be part -- if it's that, they can be part of creating the MOLST form. They can sign it, if it aligns with policies and procedures at your system, if they're doing it internally. But if it's going across the care transition it has to be a board certified physician.

So there can be in the cohort of residents and fellows some particular senior residents and fellows who have their New York State license, they're moonlighting, they're doing whatever, they would be able to not only -- and they're trained in MOLST, they could create an eMOLST, but their forms wouldn't be able to be honored across care transitions.

Those that can sign a MOLST form are New York State licensed physicians, are border state physicians because along the border we have some New York State residents who are cared for by, for instance, Vermont physicians, Pennsylvania physicians, New Jersey down in downstate, as well as our physicians who are in the VA. And in the VA system, they may retain a license that is non-border state, New Mexico I know of one of the physicians in the Albany area has New Mexico license, but it's valid in the VA system. He usually cares for vets who would then come to the outside and into the community and potentially might come to Albany Med. That would be a legal and valid license.

So that's a little bit more depth, but that helps to, I hope, explain where we work with resident physicians. And again, that's the law and that's true for any medical orders across care transitions.

Patricia Hale: Thank you. That's very helpful.

Patricia Bomba: Okay.

Sara Butterfield: Diamond, do we have other questions?

Operator: At this time I'm not showing any further questions. Again, ladies and gentlemen, if you would like to ask a question, please press the number one key. Star and the number one key. I'm showing no further questions at this time.

Patricia Bomba: So I would say that one of the big questions that always comes is like how do we get started? And what if we've never used MOLST, should we start in this paper world? And I would say from our experience, if there's never been any use of the MOLST program in process, beginning with eMOLST makes the most sense. And I think you've probably picked that up in the -- my preface remarks and through the demo because if you're in the paper world, you then have to convert just like you do as you're moving from paper records into EHR at whatever site you're at. And so getting it right into eMOLST makes the most sense.

It doesn't mean that you can go straight to eMOLST and everyone's perfect. There's a basic understanding of what this shared decision making process is about and why we have created MOLST. And that's the work that I think Sara and the group and those of you on the call have been working on. How do we work together to get the work done because it's everyone's job.

So we've tried to facilitate with Sara education, we have other vehicles on the website and we're looking to build more sustainable scalable education. So people need to understand what this program's about, what the process is about and if you're looking at a system there's a role for everyone. For instance, the unit secretaries will need to know what MOLST is about if there's never been implementation. There will also need to be looked at workflow and what is the workflow for integrating this into the other documents for care transitions? So what is happening currently? And so we know from our work with systems we have this sort of interim world or transitional world where we have some folks that are still in paper, some that are in EHR, some that are in this hybrid world. And so it's working through workflows as well to integrate MOLST in that one area.

So it's education, workflow changes that we -- and we'd be happy to work with you on and some of those tend to be unique. But as we begin to work on those within systems and systems are getting more creative in this world, that integrate hospitals, nursing homes, hospices, homecare, all of that is what MOLST is about.

So I thought I would kind of give you that as a two level. The other beauty of it, as you've seen this, and we only demonstrated one of the checklists, but we do go in and show you all of those and it helps to drive the process. And it helps to educate in and of itself.

We have some videos to help augment some of the training that we've done. We have one that's on the YouTube channel that shows why the value of eMOLST. We also have one that has Dr. Joyce Joicus. This one is on the eMOLST overview, but we have the process so that we can help educate folks on the communication process. This one's demonstrating a hospital setting. We're in the last stage of editing one where Dr. Girk and folks from St Peters are demonstrating the nursing home and we've tried to put into that video how eMOLST can help when physicians are offsite and the requirements under public health law is to have the physician's signature. Or the persons come from the hospital so ill that the DNR order wants to be signed that night and patients admitted who

had a non-hospital DNR form, it's all signed, they've lost capacity, but that's clear and convincing evidence that that's what they want.

And so that will be up shortly and we'll be looking for those of you that are in other settings to build this as 1, 2 and then more in the series so that we would demonstrate the clinical office setting, the home based palliative care team in the patient's home. How do we do this with children? How do we do this with persons with developmental disabilities/intellectual disabilities?

So giving you a sense of some of the tools that are out there to help your population to implement both MOLST and eMOLST, we have a lot of videos online, we have this training site. After the webinar we will be working with Sara to send out the slides that I used. There are also slides that I can show you, as well as more of the demonstration in the time that's remaining. But I wanted to show some of these tools as we waited for questions.

Are there more questions?

Operator: Not at this time.

Sara Butterfield: Dr. Bomba, this is Sara. One of the things, just a logistical question. We find in many of the communities that it's really the skilled nursing facilities that are ready to move ahead with eMOLST. Many of them have policies and procedures in place and their thought communicated back to us is they're thinking of waiting until the hospitals come onboard and the hospitals really are having a harder time moving this through the system.

What would be your advice for those skilled nursing facilities? Would it be to continue on and move forward with implementation of eMOLST? What are your thoughts?

Patricia Bomba: I think clearly from our work with other facilities, moving forward with eMOLST makes sense because it will, even if they're in the paper world, because what we've seen with other facilities is once the process is done correctly, it helps in terms of preventing survey deficiencies, the clinical outcomes are improved.

And what we've been told from the facilities is the improved workflow so that, for instance, you know when MOLST forms are due for review and renewal, there's not a need to pull all the charts to have the physician look at it. It's much more efficient. They still have done the same workflow to print out a form, for instance, for their paper record because they haven't moved -- perhaps they don't have an EMR, they're still in the paper world. But they've seen workflow efficiencies by doing it that way.

And we are working with some facilities that are then moving in the transition into a full blown EMR and it's been a staged approach. So I think the facilities that are thinking of it but don't have an EHR, it shouldn't be a barrier because people have access to the Internet. And as we talked about with Pat, have to have access to the ISTOP link. And so those clinicians who are looking at ISTOP, many of those same patients need the MOLST form.

It also becomes an easier way to begin to look at getting it into the system. And for those systems who have never done MOLST, I would say start with eMOLST because there is work involved in terms of moving from paper to eMOLST. And there is -- we have not seen any one best practice in the state, which means we have not seen any facility doing this right. And again, I affirm, it's not just about MOLST, it's making these kind of

clinical decisions, which are big decisions about life sustaining treatments. This is the guidepost to help people to do it right.

And so when we've done the paper to eMOLST conversion, we've had to kind of help people and hold their hands to say it's okay if you didn't do it right. Now we have a system to be able to say what are the gaps because it's really a quality improvement project anywhere in terms of either starting it or moving form paper to eMOLST.

As an example, people haven't even realized that if a surrogate is making decisions that certain clinical standards need to be met by two physicians. And if the clinical standard is not, as I said earlier, coma or life expectancy less than six months, page 2 before it's signed, has got to go to the ethics review committee. So where it's been signed and their ethics review committee hasn't been there, I said okay, let's look at those five cases where you didn't meet the standard. Let's convene the ethics review committee, review the cases and then document as part of your quality improvement project, we are in the midst of conversion, we found these gaps in quality and what we're doing now is meeting those gaps. You're the ethics review committee, there's been a consensus agreement with the MOLST orders and so those are documented on those dates and then the eMOLST is completed.

The one thing that eMOLST will do is it won't let you drive through the system if it's not done correctly. And that's the other piece for those systems that are thinking about it, but they have to get their team together, begin to use the chart documentation forms because if you use the chart documentation forms and they're on the compassion support website, then you're ready -- it's a much easier conversion process.

Many of the folks have had difficulty finding the documentation. So if you go to the MOLST and you go to checklist for adult patients, you'll see the checklist above and then you'll see these chart documentation forms. That's what's been integrated into the eMOLST application. That's what's created and is stored in the registry. There are the five for adults, there's one for children and then the OPWD checklist there. We found that to be most helpful in preparing the facilities. And we'd be happy to help them to move that forward and make sure that they have the tools. And again, as part of the follow-up to this webinar, we'll send those active links and the PowerPoint.

And for those on the line who want to register as a user and be enrolled in the training site so that you can hopefully get more buy-in in your facility so that people can see the value, it's there. The other piece on the eMOLST side is a one-page that we'll send to you, a one-page description of eMOLST, but on the back side it's why should you do it. And it's really because of improving clinical outcomes, legal outcomes, a system based solution.

Does that make sense, Sara?

Sara Butterfield: Yes, thank you very much.

Patricia Bomba: Are there others that have questions?

Sara Butterfield: Diamond, do we have anyone in the queue?

Operator: I'm showing no further questions at this time. Ladies and gentlemen, if you would like to ask a question, please press the star then the number one key at this time.

Patricia Bomba: So one of the two things we can do, because we have a little bit more time if there are no questions, is we can do some more backend. If there's interest in the administrative end I think that would be helpful for folks.

Katie Orem: Usually we have some good questions about how enrollment goes I think. So I can show you the information we need for enrollment in the template that Dr. Bomba was describing earlier.

Patricia Bomba: And we have two templates. One is for enrollment and we also have a template built for folks to think of the paper conversion as a quality improvement project and how to get started there. So Katie has demonstrated the enrollment sheet.

Katie Orem: Yes, so here is our user enrollment template for eMOLST. It's just an Excel sheet, it's pretty easy to use. The instructions are on the first tab. Here you put in each user. Each user takes a row, first name, last name, professional suffix and title, phone number and email. And then the physical address where they're located. For anybody with an NPI we take -- we record their NPI number and for anybody with a state license number we record that. Obviously not everybody has each of these, but physicians, NPs, PAs, they should have both.

And then you assign clinical roles, which Dr. Bomba was describing earlier, from no patient access all the way up to form signer. Form access non-signer is like the person involved with the discussion who can't sign a MOLST form. That also could be like the resident who's not licensed in New York. And then form readers can just read the form, they have read-only access. That's like floor nurses, unit secretaries. Depending on the setting, some social workers are just readers.

And then the administrative roles. QA, QI is what most people have. It gives basic access to analytics when those are built. Then we also have HIPPA entity administrators, which is a role that lets you create users on the spot. For example, in a nursing home setting if you have a new nurse starting and you want to give her access right now, you don't want to wait for me to do it, you can make her -- make one of your staff a HIPPA entity administrator, they'd be able to enroll her on the spot.

And then HIPPA entity auditors just gives you access to the audit logs, it doesn't let you do the other administrative enrollment features in eMOLST. And over here you just list the facilities that folks need access to. Some docs cover multiple nursing homes and so you just write the names of the nursing homes and hospital systems they need access to in here. And that's what would appear on the login screen. When you saw Fake Hospital, right, everybody's list is unique based on where they need to login.

Patricia Bomba: So in addition to this template, as you're getting started, I would also encourage you to read the eMOLST trainer's manual and that really is a high level manual that talks about what needs to be done to get started. Again it's on the front page of the eMOLST application, but also on the eMOLST webpage on compassion and support.

So this program manual was put together to answer questions that you may not think of since there's not a lot of questions today, about how to get started, some of the system requirements. We've tried to put a high level and then the names of the -- the description of the different roles that Katie's already outlined. But this is really the checklist for getting started. And again, if people have no clue about MOLST, they need to understand what MOLST is and there are additional tools on getting them to understand MOLST on

Compassion and Support, the videos that we showed you on the Compassion and Support YouTube channel. And there's quick access to that in the top toolbar on every webpage on Compassion and Support.

So if you look through this there's also an eMOLST agreement that is on the website that you can take to hospital legal so that they can look at it or the legal at the nursing home just to be able to understand what eMOLST is about from a systems perspective.

So all of these tools are out there. We also, as I said, you have our email addresses so that we can -- and we look forward to working in communities and that's who's on this call. It's communities in the areas where IPRO has really given great support to this end of life care transition program.

Sara Butterfield: And Dr. Bomba, could you just explain for those folks that may be ready to do this what are their first steps to be able to do -- to move forward with eMOLST?

Patricia Bomba: So we want -- what we would like is to get administrators from the HIPPA covered entity. So for the HIPPA covered entity it could be a small nursing home in one of your regions. Or it could be like a system like Albany Med or St Peters Partners that have multiple users that we would work with to understand where do we get started. I think that's where sometimes systems stop because they're saying oh my goodness, how do we get that started? And we've seen each system is a little unique. So getting who is going to be the HIPPA covered entity administrator that would be able to then work with Katie and if you have a small system, it may be one. If you have a large system, it's obviously more than one. If you're a hospital with three nursing homes developing into a system, you need to have someone at each one to help ease in those users and fill in the templates or to work with HR.

Then Katie can enroll those HIPPA covered entity administrators and then coordinate a training. And then it really varies depending on whether the facility has paper MOLST forms and has been trained or not. If they have MOLST forms then we really need to -- and they've been trained in MOLST and people know how to do the discussion, it's a very focused training on the conversion and helping to design it based on the level of how good the documentation is, to be able to look at it as a two-eyed project and then really to work through and say okay, if there are gaps in quality, how do you manage those.

The eMOLST participating agreement that I mentioned earlier that needs to be reviewed, so that needs to go through the normal contract review process. You need to identify the users. We've shown you the template. We really want to have those key team -- I think it's usually helpful to have a team depending on the size of the facility that's going to work on implementation. And that team also has to look at workflow. How does that workflow impact? And I think what we've seen is most of the facilities who have gone through digital transformation have somewhat of a team of people who have been designated to integrate anything that's new. Like we used the ISTOP as the example earlier. Again, eMOLST is very similar to ISTOP, so it would be looking at though how does this impact workflow?

And so it's really sort of organization specific depending on how small or large it is. And that's where we've met with the team of sort of people at a system level to say how do we move this forward and where are we going to start? So in some places it's let's start with the nursing home components and that was the question you asked before, and let's get all of our forms into the system and do that paper to eMOLST conversion. And then if we have a system that's joined with the hospital, then we need to have the key folks in the

hospital have access, like the emergency room. Like the hospitalists. And many of the systems -- docs from the community are not going into the hospital, so the hospital is the palliative care team, the geriatricians who are still there, the emergency room docs and their teams tend to be the first level because they're the ones who are creating the forms, frankly.

But you have to look at the other workflows. Once they're created, how is it going to impact that discharge from the nursing home to the hospital or vice versa?

And then basically from that group of initial ones, who are going to be the trainers in the system to help with implementation? So that's at a very high level and that's kind of outlined in the system. Again, if there's paper MOLST that's there, it's identifying who's going to be accountable. It can't be the physicians. And so it tends to be an opportunity for training. So the people who are doing paper conversion oftentimes are selected from those that are really doing the MOLST because it helps them to veer into the system and really recognize the system. In some systems it's been other specific nurses who have been assigned to that task. It's very, very simple. So it really is system dependent as to whether you find the nurse to do it or you find that you want to use it as a training opportunity. And that's where we kind of help guide the systems who are interested.

Katie Orem: And there's always one additional question we receive is cost for implementations -- access.

Patricia Bomba: It's a great question and I'm surprised no one's asked it. At this point we have not charged for access to the application. We view this as a state level service. We're building a registry for the state. So we have to develop a sustainability plan from the finances because there are things that we want to be able to do. And so far the initial dollars for development, they've long run out and it's through the gracious support -- honestly of Excellus Blue Cross Blue Shield with -- who pay my salary, Katie's and we work with our external vendor. But our IT team helps to support because the servers are housed here separately just dedicated to eMOLST, no connections with anything else. And that was predominantly done because it was cheaper than trying to put out into external servers. And we would not have been able to manage it.

So no cost at this end. We will be looking for a sustainability plan and we are imagining it maybe -- hopefully something that the state will support because it is a state level service. We see the potential for analytics once we get some ground support to build it. And again, from analytics we want people to use basic analytics, but we imagine that as we build more sophisticated analytics it has real power and potential for research and that would be something that we could build a financial model around. So that's been one of our ideas.

But right now we have not put any financial barriers. If that's really what systems need, if they want to pay for it, if that really will help them to know that there's value in it, we're happy to put a cost out there and we've tried not to create barriers. And I'm saying this tongue in cheek because it's free right now and we're trying to figure out what can we do to understand better what are the barriers from getting this off the ground in any one place?

Katie Orem: Sure. Thank you.

Patricia Bomba: You're welcome. Maybe there are other questions as we've been chatting.

Operator: I'm showing no further questions at this time.

Patricia Bomba: Okay. I'm just going to go back very quickly in the last few minutes just to make sure we've covered everything that we talked about. We explained a little bit about security and privacy confidentiality, it's why we have another level of access in the first level of integration to be able to get out to this website because we don't want any Tom, Dick or Harry. It's only enrolled users because you can see it's the user identity.

In the one page analytics you will see that we've aligned the quality outcomes with the key elements for crossing quality chasms and eMOLST meets all of those needs. You'll have that document to share with your internal team. It improves legal outcomes because it improves compliance with public health laws. Again, I can't underscore the accurate documentation and the avoidance of incompatible orders, which is another improved clinical outcome. It reduces the potential liability that comes when these documents are not done correctly or if a system is not MOLST and the system is just using their own system, there's lots of room for errors, particularly potential liability and clearly reduces and avoids potential DOH deficiencies.

I would also say from a CMS perspective that a year and a half ago with the new regs that have come out with FTGS, they've included the POLST paradigm, which is again the national model. So there are now 16 states that have it and they've included that in terms of the quality and what the expectation is.

Surveyors will say if there's room for improvement, that systems ought to consider MOLST. We have had hospital systems who have gotten less than stellar feedback on their -- from JACO and form the joint commission and have sought using eMOLST as a solution to improving both quality and legal outcomes.

We've been able to show you through the demo it's pretty easy to learn once -- if people know MOLST it's easy to convert. For those that don't know, it's a standardized clinical process that even if they come to a training that's been hosted by IPRO, this is a real world process that it takes what we've taught and it's standardized across the setting. It tracks with it's review and renew. There's lots of opportunities to link with the eMOLST training we've created. And it's a system based solution that goes beyond a single setting out to the community approach to advance care planning for seriously ill persons. And we are the only program across the country that has developed this kind of product. We have states developing registries. Frankly if the form's not done correctly, then it's not helpful as a registry.

There are some -- Oregon is now looking to do ePulse. This is just the form that they're looking at. We have encapsulated the entire process. And so we've also been able to use it without integration or with integration into EHR. We've recommended having MOLST as a separate tab on a toolbar and as we've talked to vendors, we've talked about that because that's really what the national model is moving towards. And clearly defining and separating MOLST from advance directives because MOLST are medical orders needed in an emergency and that's where our link to the eMOLST application comes. And we've developed this improved financial model for providers who have been trained in our service area.

We talked about next steps. We want to make sure you look at the eMOLST manual, look at the getting started checklist. Here are our email addresses. Sara's going to share that with you. We have lots of opportunities for advanced learning for folks as they move

forward with this. So I'll leave that on and see if there's any last minute questions before we close. Or comments from you, Sara.

Sara Butterfield: I think you've addressed, Dr. Bomba, I think we were very excited to have folks actually see the demonstration and how the tool flows. And the -- how it really addresses all the different requirements. And I think some of that has been overwhelming for the paper version, and I think to my thought this is a much easier way to go through the process.

We would encourage folks, and that's why I asked that question before, that it's not really waiting for the rest of the community, albeit our goal is to get a community-wide approach to this, but there are folks that are ready to go and we would like to see them actually take the next step and implement within their organization. And we're happy to support that along with Dr. Bomba and Katie because they're truly ready. They've got their internal systems and processes set and are ready to implement. And we just really encourage them to contact us and let us know they're ready to move forward.

Patricia Bomba: And that would be great. And if you have regions and we can set up sort of trainings in that region so that if there were two nursing homes, for instance, in one of your care transition coalitions, we could go out and do a training in the morning in one and in the afternoon. Or figure out the most efficient way to do that and really get them going. So it's not dependent on the whole community because we all wait for who's going to go first. And I think that as you do that, someone has to start.

And as I said, for the nursing homes on the call, the nursing homes who have gone from the paper world into just eMOLST where they still have paper records, they saw efficiencies in their processes and their workflow just by doing eMOLST. And they really, frankly from my perspective, as we convert everyone over, I'll sleep at night because I'll know the forms are done correctly.

And lastly, the same requirements that you see in this application have got to be met if you're not using MOLST. If you're using any other process. So we really encourage you to use it because it helps then across the care transitions. Obviously the value is if someone gets started and then the nurse -- and then the hospital gets started, then you really have that care transition value that's a value add.

Sara Butterfield: Absolutely. And Diamond, can we do one more check for questions?

Operator: Of course. Again, ladies and gentlemen, if you would like to ask a question, please the star then the number one key on your touchtone telephone. If your question has been answered and you'd like remove yourself, please press the pound key. I'm not showing any further questions at this time.

Patricia Bomba: So we will, at the end of this, we will make sure that Sara -- we'll work collaboratively to get information to all the attendees. And also let you know that if you have interest in getting access to the training site and just using it yourself. And I would tell you that in doing that, as a leader, I've had physicians connect with me and ask specific public health law questions where they're sitting at the chief medical officer that they didn't know. And they recognize the value of just walking through there to the point that Sara made earlier.

It helps to guide the person because if you're not doing it day in and day out, it's hard to remember. The more you use it, the more that you understand the value. And I can sputter the law because I've been enmeshed in it, but if I was out in clinical practice, this

is a tool that can help all of our providers. So I encourage its use and encourage you to connect with us and Sara. And we'll work together to figure out next steps.

Sara Butterfield: Thank you so much, Dr. Bomba. Thank you much, Katie for joining us again this afternoon. And again, if you have any questions you know how to contact us and we will forward the information Dr. Bomba shared out to everyone. And thanks so much. And with that, Diamond, if you want to close the call please.

Operator: No problem. Ladies and gentlemen, this concludes today's conference. Thank you for your participation and have a wonderful day.

Sara Butterfield: Thank you.

Patricia Bomba: Thank you.

Katie Orem: Thank you.