



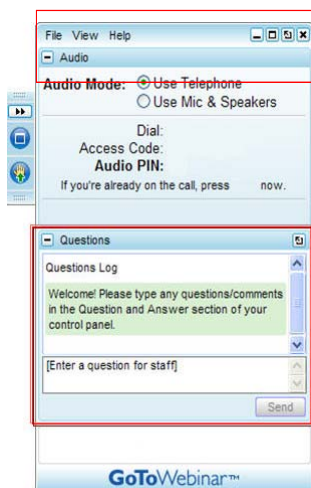
## Medical Orders for Life Sustaining Treatment (MOLST) Webinar

December 6, 2011  
12:00 pm – 1:00 pm

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- You can join the audio for today's conference by selecting "Use Mic & Speakers"
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## General Information

- 1.0 AMA PRA Category 1 Credits™ (Risk Management)
- Online evaluation and CME certificate
- PowerPoint slides available for download
- You will also receive this information in a reminder email, following the webinar
- Questions during the webinar may be typed into the “questions” box on the right side of your screen
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## Faculty Introduction

### Presenter



**Susan D. Block, MD**  
Dana-Farber Cancer Institute  
Brigham and Women's Hospital  
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## Faculty and Planner Disclosures

The faculty and planners of today's webinar have no relevant interests and/or relationships to disclose.

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## Massachusetts Medical Orders for Life Sustaining Treatment (MOLST)

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Susan Block, MD

Chair, Department of Psychosocial Oncology and Palliative  
Care

Dana-Farber Cancer Institute and Brigham and Women's  
Hospital

Harvard Medical School Center for Palliative Care

## Polling Question

1. Do you currently use a MOLST form with your patients?
  - a. Yes
  - b. No

## Goals of MOLST

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- A communication process:
  - Encourage discussions between patients with advanced illness and clinicians about goals and preferences for end-of-life care
  - Provide patients and clinicians a mechanism to translate wishes and preferences into medical treatment orders that will be honored across settings of care

## MOLST Background

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- Rationale:
  - Patients regularly transfer across care settings and information about preferences is not available
    - And some patients may not want to transfer to another setting
  - EMTs need guidance in the field
  - Emergency departments need easily identifiable information about preferences
- Ethical basis:
  - Patient right to self-determination
  - Patient right to refuse and accept treatments according to personal preferences

## MOLST Background

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- Based on Physician Orders for Life-Sustaining Treatment (POLST)
- Similar program in 20 states
- When completed, MOLST is an actionable medical order that applies across settings
- Replaces and supplements current Comfort Care/DNR form
  - Applies to EMTs and ALL clinicians
  - MOLST allows patients to request or refuse intervention
  - Addresses broader variety of medical treatments

## MOLST is an Important Part of Advance Care Planning

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- Completion of a Health Care Proxy or Durable Power of Attorney for Health Care to identify a decision-maker if the patient is unable to speak for him or herself
- Communication with family members and clinicians about values, preferences and wishes that should guide treatment if the patient is unable to speak for him/herself
- Advance directive/living will
- Ongoing conversations with clinicians and family members/health care agent as medical situation evolves
- Documentation of discussion/HCP information in medical record
- Completion of MOLST form

## Polling Question

2. How comfortable are you about discussing end-of-life issues with your patients?
  - a. Very comfortable
  - b. Somewhat comfortable
  - c. Uncomfortable
  - d. Very uncomfortable

## Benefits of Advance Care Planning: The Evidence

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- Patients welcome ACP and expect physicians to initiate these discussions
- 80-90% of patients want information about prognosis
- Even when the information is upsetting, caregivers want to know prognosis
  - Helps with decision-making, planning
  - Prognostic information does not compromise hope or cause depression, even in setting of poor prognosis
  - With sicker patients, caregivers tend to prefer more information
- Prognostic information changes patients' choices
  - Patients who expect prognosis of <6 months are more likely to prefer less aggressive care (Weeks et al JAMA 1998)
- Clinicians are distressed by poor end-of-life decision-making

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## Evidence (2)

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- Early discussion of end-of-life care issues among cancer patients is associated with improved outcomes:
  - Patients are more likely to have wishes followed
  - Increases quality of life
  - Reduces rate of hospitalization and ICU admission
  - Increases use of hospice
  - Reduces stress, anxiety, depression, PTSD and bereavement morbidity in survivors
  - Improves family satisfaction
  - Strengthens clinician-patient relationship
  - Reduces costs

## ACP prepares patients and family members for end-of-life decisions

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- Helps patient feel confident that EOL wishes will be honored
- Prepares family emotionally
- Provides information about decision-making process (health care agent) and goals and values
- Relieves burden on family
- Supports clinical staff in doing the right thing

## Problems with EOL conversations

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- Happen late, without patient preparation, and often in emergency situations when patient is too sick to participate optimally
- Happen without context – prognosis not discussed explicitly and do not provide patient with information about the “big picture” that is needed to make informed decisions
- Focus on procedures inappropriate. Patients are experts on personal values not on procedures.
- “Chinese menu” approach overwhelming; lack of guidance about what makes medical sense
- 30% of patients over 60 require surrogate decision-making, yet families are often not prepared, leading to stress and traumatization related to decision-making (Silveira et al NEJM, 2010; Wendler Annals Intern Med 2011)
- No mechanism to translate patient preferences into orders to assure patients received desired care.



## EOL Communication: General Principles

- Discussions about end-of-life issues are about:
  - Managing anxiety
  - Decision-making
- Decisions require re-negotiation over time
- Patients need time to cope with anxiety– EOL planning/decision-making is a PROCESS
- EOL discussions are procedures, like an appendectomy
  - Skills in performing this procedure can be learned
  - Roadmaps and checklists can be resources
- Focus on what is important to the patient (quality of life, suffering, survival) rather than on what is relevant to the MD (procedures)

## Focus on the *patient's* goals of care



## General Principles (2)

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- Support hope, and help patients focus on realistic possibilities
- Key elements of effective, compassionate discussions:
  - Empathy
  - Understanding
  - Commitment to providing support, non-abandonment
  - Attention to symptom control
  - Emphasis on what can be done
  - Focus on non-biomedical hopes (Clayton J et al. Psychooncology 2008)

## MOLST is only one part of the process of end-of-life decision-making

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- MOLST form cannot be appropriately completed without a “pre-MOLST” conversation about values and goals of care
- Exploring and clarifying patient goals is a process and may take multiple conversations
- Values and goals (and MOLST form) should be documented in medical record so that this information is easily retrievable
- ALL patients should have a health care agent to make decisions if they are incapable of speaking for themselves

## Polling Question

3. Physicians, nurse practitioners, and physician assistants can all sign the MOLST form.
- a. True
  - b. False
  - c. Not sure

## Who should discuss MOLST with patients?

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- Discussions of advance care planning can be undertaken by any clinician
- Physicians, nurse practitioners and physician assistants can all sign MOLST

## Target Patient Population

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- Patients with serious or advancing illness ONLY
  - Examples:
    - Life-threatening disease
    - Chronic progressive disease, including dementia
    - Life-threatening injury
    - Medical frailty
  - Usually in last months to year of life
    - *“Would you be surprised if this patient died in the next year?”*
  - Appropriate for any age
  - This is not a document for everyone.

## Preparation for completing MOLST

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- Reassure patient that no decision is necessary today, and that discussion may unfold over time
- Reassure patient that ongoing treatment will be provided as desired by the patient
- Reassure patient about current health care status (if needed)
- Obtain relevant information about patient, family, medical condition, and prognosis
- Encourage patient to include family
- Assess capacity
  - If patient lacks capacity, plan discussion with health care agent
- Identify and document name of health care agent
  - Include contact information
- Ask patient if s/he has advance directive/living will or existing ACP document

## Discuss values and goals about end-of-life care

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- Patient understanding of prognosis
- Patient information preferences
- Goals for the future
- Fears and worries
- Acceptable quality of life and suffering
- Undesirable states
- Desired family involvement in decisions
- Review key information about patient medical situation
- Review benefits and burdens of potential treatments
- Make a recommendation about treatments based on patient values and medical options
- Explore patient/family reactions
- Reassure patient that all patients will be made as comfortable as possible at the end of life

## MOLST Form


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- Intended for use in all settings of care (hospital, nursing home, LTAC, home)
- MOLST form provides information to guide health care professional responses *in an emergency* about patient wishes/preferences:
  - For CPR (Y/N)
  - For Intubation (Y/N)
  - For transfer to hospital (Y/N)
- Patient can both request and refuse treatments
- Must be signed by patient (or agent) and clinician
- Should be regularly reviewed and updated with patient

## Additional Options

- Also contains (page two) information about patient preferences for other treatments that might be offered in less acute setting:
  - Respiratory support
  - Dialysis
  - Artificial nutrition
  - Artificial hydration
  - Other preferences

## SAMPLE MOLST FORM – Page 1

Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST)		Patient's Name	
www.molst-ma.org		Address	
		Date of Birth	
		Gender	
		Print name and phone # of Patient's Primary Care Provider (if available)	
<p>► Sections D and E must be fully completed for a valid form photocopy, fax or electronic copies of signed MOLST forms are valid.</p> <p>► If a section is not completed, there is no limitation on the treatment indicated in that section.</p> <p>► This form is effective immediately upon completion. Send this form with the patient at transfer or admission.</p>			
<b>Every Patient Should Receive Full Attention To Comfort</b>			
<b>A</b>	<b>Cardiopulmonary Resuscitation:</b> for a patient in cardiac or respiratory arrest		
Never use this	<input type="checkbox"/> Do Not Resuscitate	<input type="checkbox"/> Allow Resuscitation	
<b>B</b>	<b>Intubation and Ventilation:</b> for a patient in respiratory distress		
Never use this	<input type="checkbox"/> Do Not Intubate and/or Ventilate	<input type="checkbox"/> Intubate and/or Ventilate	
<b>C</b>	<b>Transfer to Hospital</b>		
Never use this	<input type="checkbox"/> Do Not Transfer to Hospital unless patient requests	<input type="checkbox"/> Transfer to Hospital	
<b>D</b>	<b>Signed in section D by:</b> (Check one box if applicable, to be signed by the patient, or <input type="checkbox"/> parent/guardian of a minor)		
Signature of the patient or health care agent, parent/guardian of a minor patient	<p>► If signed by patient, confirms that he/she signed this form and that this form reflects his/her treatment preferences as expressed in Section D.</p> <p>► If signed by the health care agent, parent/guardian of a minor patient, confirms that the form reflects the signer's assessment of the patient's wishes, or, if the patient is unconscious, the signer's assessment of the patient's best interests.</p>	<p>Signature of patient, health care agent, guardian or parent/guardian of a minor</p> <p>Print name and contact number(s) for person signing Section D</p>	
Signature of Physician, NP or PA	<p><b>E</b> Signature of Physician, Nurse Practitioner (NP) or Physician Assistant (PA)</p> <p>Signature confirms this form accurately reflects discussion(s) with Section D signer</p> <p>Print name and contact number(s) for person signing Section E</p>	<p>Date of Signature</p>	
<b>Record of Periodic Review:</b> (Spot review if no change to this form is needed, the Physician, NP or PA should sign and print name and contact number(s) below)		<b>Date reviewed with Section D signer</b>	
1.			
2.			
3.			
4.			

SAMPLE MOLST FORM – Page 2

[illegible]

## Completing MOLST

- Ask patient to sign, if s/he is ready
- Clinician signs and completes
- Provide patient with a copy for home, health care agent, and encourage him/her to keep one at all times
- Copy MOLST for patient record

## When to review MOLST form

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- When patient transfers to different setting of care
- When patient's medical situation changes
- When patient's values, goals, or treatment preferences change

## Changing MOLST

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- Destroy or write "VOID" on both sides of form and all copies
- Sign a new MOLST form



## Implementation

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- Rolling out across MA incrementally
- CC/DNR form will be honored throughout transition
- Education of HCPs (MDs, RNs, NPs, EMTs, etc.) ongoing
- Community education also ongoing

## Questions?

**Presenter**



**Susan D. Block, MD**  
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Brigham and Women's Hospital  
Harvard Medical School Center for Palliative Care

Submit your questions using the Questions pane.

## Evaluation, CME Credit & Resource Information

To complete your evaluation, please visit:

<http://www.massmed.org/MOLSTeval>

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- Enter the CME Activity Code: MOLST12611
- Enter your FIRST and LAST name.

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