Medical Orders for Life Sustaining Treatment (MOLST) Webinar
December 6, 2011
12:00 pm – 1:00 pm

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Faculty Introduction

Presenter

Susan D. Block, MD
Dana-Farber Cancer Institute
Brigham and Women's Hospital
Harvard Medical School Center for Palliative Care
Faculty and Planner Disclosures

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

Presenter:
Susan D. Block, MD - N/A

Planners:
Susan D. Block, MD - N/A
Caroline Carregal - N/A
Linda Masiello - N/A
Candace Savage - N/A

MMS Sponsored Program Committee:
Aram V. Chobanian, MD - N/A
Romolo J. Gaspari, MD – N/A
Roy A. Johnson, MD – N/A
Laura Michelles - N/A
Robin Schoenthaler, MD - N/A
Deeb N. Salem, MD - N/A
Henry Tuligan, MD - N/A
James Yeh, MD - N/A

Massachusetts Medical Orders for Life Sustaining Treatment (MOLST)

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

• 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

• 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

• 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

- 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

• 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

Evidence (2)

• 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

• 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

• 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)

- 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

- 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?

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

• 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

• 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

- 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

- 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
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

- 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

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

- 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
Dana-Farber Cancer Institute
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Submit your questions using the Questions pane.
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