MOLST Demonstration Update

Massachusetts Care Transitions Forum

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MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT (MOLST)
www.molst-ma.org

DPH Seal

Patient's Name _____
Date of Birth _____
Medical Record Number if applicable: _____

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

→ This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the patient's clinician.
→ Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections H and G are complete.
→ If a section is not completed, there is no limitation on the treatment indicated in that section.
→ The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A Select one circle →
CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest
○ Do Not Resuscitate ○ Attempt Resuscitation

B Select one circle →
VENTILATION: for a patient in respiratory distress *(for CPAP/BiPAP preferences, see Section F on page 2)*
○ Do Not Intubate and Ventilate ○ Intubate and Ventilate

C Select one circle →
TRANSFER TO HOSPITAL
○ Do Not Transfer to Hospital (unless needed for comfort) ○ Transfer to Hospital

PATIENT or patient's representative signature
D
Required - Select circle and fill in every line for valid orders

Select one circle below to indicate who is signing Section D:
○ Patient ○ Health Care Agent ○ Guardian* ○ Parent/Guardian* of minor

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. ***A guardian can sign to the extent of MA law. Consult legal counsel with questions about guardian's authority.**

Signature of Patient (or Person Representing the Patient) _____ Date of Signature _____
Legible Printed Name of Signer _____ Telephone Number of Signer _____

CLINICIAN signature
E
Required – Fill in every line for valid orders

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.

Signature of Physician, Nurse Practitioner, or Physician Assistant _____ Date of Signature _____
Legible Printed Name of Signer _____ Telephone number of signer _____

Optional Expiration date and other patient care contacts

This form does not expire unless expressly stated. *Expiration date (if any) of this form:* _____
Health Care Agent Printed Name _____ Telephone number _____
Primary Care Physician Printed Name _____ Telephone number _____

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.
HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

What is ***MOLST*** in Massachusetts**?**

- A way to help the sickest patients communicate their end of life treatment preferences across care settings
- A process of shared medical decision-making about life-sustaining medical treatments
- A standardized form for writing medical orders
- An appropriate way to meet the standard of care for honoring patient preferences about end-of-life care

MOLST Demonstration Project

- Focused on a region of the Commonwealth (Greater Worcester)
- Included nine settings across the continuum of care, where patients enter and transition through the health care system
- Settings included:
  - Acute Care
  - Primary Managed Care
  - Emergency Medical Services
  - Nursing Homes, Home Health, Hospice Care
- MOLST form implemented April 1, 2010

Demonstration Results

- Training and Outreach:
  - Within demonstration sites: face-to-face training, orientation or presentations to over 1200 administrators, clinicians, and health and social service professionals; and 700 EMTs
  - Outside of demonstration sites: face-to-face informational sessions for clinicians, health and social service professionals, first responders, policymakers, consumers, patient advocates and stakeholders
  - Thousands of additional consumers, health professionals and other stakeholders received information about MOLST via print materials, video and/or the MOLST website at www.molst-ma.org.

Demonstration Results

MOLST Form Utilization:

- Nursing homes (April – August) and home visiting program (April – November: minimum of 171 patients engaged in discussions about MOLST with their clinicians, resulting in 150 signed MOLST forms
- Additional numbers of MOLST forms signed with patients at discharge from acute care hospital site but not tracked, or used with patients beyond the demonstration sites by special requests of their clinicians
- A large majority, though not all, of the MOLST forms were signed to express patients' preferences to limit or forego life-sustaining treatments.

Demonstration Results

Select overall findings:

- Strong interest in and support for MOLST in Massachusetts
- Potential for MOLST impact on many health care reform issues
- Community-level engagement and collaboration is important
- Identifying a clinician champion is very important
- Effective site implementation of MOLST includes several critical components
- Staff at all levels need to understand basic information about advance directives and MOLST
- NPs play an important role in assisting patients through the MOLST process

Identified Challenges

There is a need for:

- Coaching/support to institutional champions/implementation teams
- Coordination of efforts between institutions, payers, patient groups, and providers
- Periodic update and modifications of the MOLST form
- A mechanism for reaching final decisions in order to maintain standardization of form and process
- A way to provide consistency and integrity to the program

*The **MOLST** Form*

Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST)
www.molst-ma.org

Patient's Name

Address

Date of Birth Gender

Print name and phone # of Patient's Primary Care Provider, if available:

- Sections D and E must be fully completed for a valid form; photocopy, fax or electronic copies of signed MOLST forms are valid.
- If a section is not completed, there is no limitation on the treatment indicated in that section.
- Decisions should be based on the patient's current medical condition and preferences.
- This form is effective immediately upon completion; send form with patient whenever transferred or discharged.

Every Patient Should Receive Full Attention To Comfort

A Select one box	**Cardiopulmonary Resuscitation:** for a patient in cardiac arrest (no pulse/not breathing) ☐ Do Not Resuscitate ☐ Attempt Resuscitation
B Select one box	**Intubation and Artificial Ventilation:** for a patient in respiratory distress or respiratory arrest ☐ Do Not Intubate and/or Artificially Ventilate ☐ Intubate and/or Artificially Ventilate
C Select one box	**Transfer To Hospital** ☐ Do Not Transfer to Hospital ☐ Transfer to Hospital
D Signature of the patient, parent/guardian of a minor, patient's authorized guardian or health care agent (Check box to show who is signing and complete requested information)	**Signed in section D by:** ☐ the patient, or ☐ patient's authorized guardian, or ☐ parent/guardian of a minor, or ☐ health care agent ► If signed by the patient, confirms that the patient signed of own free will and that the form reflects his/her treatment preferences as expressed to the signer in Section E. ► If signed by the authorized guardian or health care agent, confirms that the form reflects the signer's assessment of the patient's wishes, or, if those wishes are unknown, the signer's assessment of the patient's best interests. **Signature of patient, parent/guardian of minor, authorized guardian or health care agent** — **Date of Signature** **Print name and contact number(s) for person signing Section D**
E Signature of MD, NP or PA	**Signature of Physician, Nurse Practitioner (NP) or Physician Assistant (PA)** – Signature confirms that this form accurately reflects discussion(s) with the person signing Section D — **Date of Signature** **Print name and contact number(s) for person signing Section D**

Record of Periodic Review: This form should be reviewed and updated periodically. If a periodic review confirms that ***no change*** is indicated, the Physician, NP or PA should sign and print his/her name and contact number(s) below:	**Date reviewed with the person signing Section D**
1.	
2.	
3.	
4.	

Recommended MOLST Form Changes

- Revised/clearer instructions
- Clarified language regarding intubation and ventilation and used terms CPAP/BiPAP instead of non-invasive ventilation
- Deleted lines for “periodic review” but included an optional expiration date
- Added clinician signature to Section F - Patient Preferences for other Medically-Indicated Treatment

Recommendations

- Organizational “home” and coordinator for MOLST
- Thoughtful roll-out process beyond demonstration area
- Statewide MOLST health professional training resources
- Public awareness campaign about end of life decision-making
- Ongoing tracking, evaluation and quality improvement activities
- Issuance of a new circular bulletin by DPH
- Mandatory MOLST training for EMS personnel

Funding

- Current funding ends June 30, 2010
- Now seeking funding for additional 3 years (and beyond) for program expansion, evaluation and improvement
- Approaching foundations for grant funds:
  - Robert Wood Johnson Foundation
  - Blue Cross/Blue Shield of MA Foundation
  - Community Benefits Programs
  - United Health Care
  - Others