MOLST 101

Medical Orders for Life Sustaining Treatment
2012
Legislation Update

• S 2361 B passed the Senate
• Transmitted to the Governor (some bills may pass but do not get transmitted to the Governor and die.)
• Now, we wait. MOLST will become law, either signed or unsigned by the Governor, unless the Governor vetoes it on 6/17/12
• By statute it would go into law by July 1.
• Signed into law by Governor Chafee on June 13, 2013. We are now a MOLST state!
Federal Law

• Self-determination act of 1990
  – Requires health care to provide information on advance directives
Rights of the Terminally Ill Act (Chap. 23-4.11)

The legislature finds that adult persons have the fundamental right to control decisions relating to their rendering of their own medical care, including the decision to have life sustaining procedures withheld or withdrawn in instances of a terminal condition.

The laws of the state shall recognize the right of an adult to make a written declaration instructing his or her physician to withhold or withdraw life sustaining procedures…

Could not have hospice without the Right’s of the Terminally Ill Act
Rights of Terminally Ill (Chap. 23-4.11)

Upon the request of a physician, acting on behalf of a qualified patient who does not wish to be resuscitated, the department of health shall issue a nontransferable, non-removable bracelet to a specific qualified patient, which will be marked “DNR”.

- to be used for patients in the community
- will be registered with the local fire department
• Improving End of Life Care Coalition
  – Drafted an amendment to the Rights of the Terminally Ill Act
  – Strengthens the law
  – Fills in the gap of having decisions honored when going from facility to facility
  – Submitted legislation January 2012
MOLST

- Medical
- Orders for Life
- Sustaining Treatment
What is MOLST?

- Medical Order That provides:
  - Information about life decisions
  - Information about choices for medical treatment
- Form
- Program
Who can Order MOLST

• A “MOLST qualified health care provider”
  • Physicians
  • Registered Nurse Practitioners
  • Physician Assistants
Why the title MOLST

• MOLST is the Rhode Island version of:
  – POLST
  – MOST
  – COLST

• RI selected MOLST because it accurately reflects that MOLST is a MEDICAL ORDER
WHY MOLST?

• Studies have shown that patient wishes about care are often not known.
  – Even when a patient has an Advance Directive, it may not be accessible when needed.
  – Also, Advance Directives are not always clearly defined.

• The MOLST form is clear about wishes and easy to access and read. Plus, it is an actionable medical order that healthcare providers can follow.

• The MOLST form allows healthcare providers to know patient wishes for end-of-life care and to honor them.
What Does MOLST Cover?

• A request by a terminally ill person that directs a health care provider regarding resuscitative and life sustaining measures
Who Is MOLST For?

• “Qualified patient" determined by the attending physician to be in a terminal condition
• To ensure that seriously ill person's wishes regarding life-sustaining treatments are known, communicated, and honored across all health care settings.
Purpose of MOLST

- Discussion of key end-of-life care issues
- Communication with patient and family or surrogate decision maker
- To improve implementation of advance care planning
Advance Directives vs. MOLST

- Advance Directives are legal tools that allow a patient to plan for future health care needs
  - Durable Power of Attorney for Health Care
  - Living Will
- For anyone 18 and older
- General instructions for future treatment
- Appoints decisionmaker

- MOLST is a medical order directing health care providers for the treatment for a terminally ill patient
- Specific orders for current treatment
- Can be signed by decisionmaker
Need for Advance Directives

- MOLST summarizes advance directive choices
- Preferably accompanies an advance directive
- MOLST can be used in a facility before advance directive is obtained
Other uses of MOLST Form

- Facilitates decisions in transitions of care
- Form travels with the person through transitions
- Form available to emergency personnel
Where Does MOLST Fit In?

**Advance Care Planning Continuum**

- Age 18
- Complete an Advance Directive
- Update Advance Directive Periodically
- Diagnosed with Terminal Illness *(at any age)*
- Complete a MOLST Form
- End-of-Life Wishes Honored
Need for Rules and Regulations

• What is on the form
• Where to place the form
• The importance of the form
• Facility medical directors to honor the form
Program Coordination

• How will the program be sustained
• Which department in the state will coordinate
• Where will the forms be available
How Will MOLST Work?

• Qualified patient (terminally ill) talks with a qualified health care provider about his/her wishes for end of life care
  – What is the medical condition(s)?
  – What is the treatment options?
  – What is the prognosis?
  – What are the patient's wishes for end of life care?

• MOLST qualified health care provider may exam the patient
How Will MOLST Work?

- MOLST qualified health care provider explains the difference between an advance directive and MOLST medical order
- Qualified patient decides what they wish for his/her end of life care
How Will MOLST Work?

• The MOSLT qualified health care provider and qualified patient execute the MOLST Form setting forth the terminally ill patient’s wishes for medical treatment

• A qualified patient may change his/her mind about end of life care treatment
  – Revoke the MOLST at any time and anyway
    • Verbal
    • Written
What If The Patient is Cognitively Impaired?

• Health care decision makers authorized by law may communicate the patient’s wishes for end of life care medical treatment.
  – Health care agent

• Must be consistent with qualified patient’s wishes
MOLST vs. Pre-Hospital DNR (Do Not Resuscitate)

<table>
<thead>
<tr>
<th>MOLST</th>
<th>Pre-Hospital DNR</th>
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</thead>
<tbody>
<tr>
<td>• Allows for choosing resuscitation</td>
<td>• Can only use if choosing DNR</td>
</tr>
<tr>
<td>• Allows for other medical treatments</td>
<td>• Only applies to resuscitation</td>
</tr>
<tr>
<td>• Honored across all healthcare settings</td>
<td>• Only honored outside the hospital</td>
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</tbody>
</table>
How Will MOLST Work?

- MOLST Form
  - Issued by DOH
  - Uniform
  - Brightly colored paper
  - Consistent with regulations that DOH promulgates

- MOLST Form is affixed to the front of the patient’s medical record
  - Easily found

- Someday, MOLST will be part of a medical record
Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

A  Cardiopulmonary Resuscitation (CPR):  If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.
  - Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
  - Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B  Medical Interventions:  If person has pulse and/or is breathing.
  - Comfort Measures Only  Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location.
  - Limited Additional Interventions  In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital only if comfort needs cannot be met in current location.
  - Full Treatment  In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

C  Artificially Administered Nutrition:  Offer food by mouth if feasible and desired.
  - No artificial means of nutrition, including feeding tubes.
  - Trial period of artificial nutrition, including feeding tubes.
  - Long-term artificial nutrition, including feeding tubes.

D  Information and Signatures:
  - Discuss with:  Patient (Patient Has Capacity)  Legally Recognized Decisionmaker
  - Advance Directive dated ________ available and reviewed → Health Care Agent if named in Advance Directive:
  - Advance Directive not available
  - No Advance Directive
  - Signature of Physician
    - My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.
  - Print Physician Name:  Physician Phone Number:  Physician License Number:
    - Physician Signature: (required)  Date:
  - Signature of Patient or Legally Recognized Decisionmaker
    - By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.
    - Print Name:  Relationship: (write self if patient)
    - Signature: (required)  Date:
    - Address:  Daytime Phone Number:  Evening Phone Number:
Purpose of the Form

- Summarizes individual advance directive decisions and information
- Information turned into MEDICAL ORDER
- Signed by Medical provider and Individual
- Some states have advocate sign
When Should MOLST be Reviewed?

- Transfer from one care setting to another.
- Change in patient’s health condition.
- Patient’s treatment preferences change.
- Patient Care Conference.
THINGS MOLST DOES NOT DO?

• Does not solve all the issues related to end of life care
• Does not mandate an electronic medical record
• Does not conflict with existing DNR processes
• Does not replace Comfort One
Encourages the conversation about end of life care between patients and health care providers.

Establishes a vehicle, a medical order, setting forth end of life care wishes that is portable, just like any other medical order.
MOLST

• Prevents unwanted or medically ineffective treatment
• Reduces patient and family suffering
• Helps ensure that patient wishes are honored.
Established group of key stakeholders

Improving End of Life Coalition

- Department of Health
- Hospital, LTC, EMS oversight, surveyors
- Spiritual leaders
- Hospital Association
- Long-term Care Associations
- Colleges and Universities
- Hospice and Home Health
- Office for Aging, Society on Aging, Ombudsmen
- Medical Society
- Nursing Association
- Bar Association
Where does Rhode Island Stand?

Improving End of Life Coalition

• Drafted legislation to improve end of life care
• Provided educational programs for nursing home
  • Pain Assessment and Management
  • Durable Power of Attorney for Health Care
  • Intractable Pain
  • End of Life Care Conversation
  • Honoring Patient’s Wishes
WHERE TO FROM HERE?

• Phase One
  – Enact MOLST
    • July 1, 2012 pending

• Phase Two
  – Draft Rules and Regulations for DOH
  – DOH promulgates Rules and Regulations that include the MOSLT form

• Phase Three
  – Training and educational programs concerning MOLST
<table>
<thead>
<tr>
<th>Web Site Resources</th>
<th>Details</th>
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<tbody>
<tr>
<td><a href="http://www.polst.org">www.polst.org</a></td>
<td>Center for Ethics in Health Care Oregon Health &amp; Science University</td>
</tr>
<tr>
<td><a href="http://www.wvendoflife.org">www.wvendoflife.org</a></td>
<td>West Virginia Center for End-of-Life Care: POLST</td>
</tr>
<tr>
<td><a href="http://www.compassionandsupport.org">www.compassionandsupport.org</a></td>
<td>New York State Community-Wide End-of-life/Palliative Care Initiative: MOLST</td>
</tr>
<tr>
<td><a href="http://www.eperc.mcw.edu">www.eperc.mcw.edu</a></td>
<td>End of life and palliative care education resource center</td>
</tr>
<tr>
<td><a href="http://www.hardchoices.com">www.hardchoices.com</a></td>
<td>“Hard Choices for Loving People”: A resource for professionals, patients and their families regarding end-of-life treatment decisions</td>
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</tbody>
</table>
9 Elements of MOLST

1. Form constitutes medical orders
2. Form is standardized in format, color, and wording
3. Form is primarily used with patients with advanced, progressive chronic illness
4. Form may be used to limit treatment or to express the desire for full treatment
5. Form provides clear direction about the desired response if the patient is pulseless and apneic

6. Form allows for clear directions about other life-sustaining treatment
   - Hydration
   - Artificial nutrition
   - Antibiotics
9 Elements of MOLST

7. Form transfers with the patient
8. Health professionals use the forms for discussion on end of life issues
9. Success of the program and implementation is measured and monitored
Case Study: What We Didn’t Know

My Health Care Wishes
The California Medical Association’s
Advance Health Care Directive Kit

© California Medical Association 2000-2009
Case Study: What Happened

- AD not transferred with patient.
- DNR wishes not documented.
- Over-treatment against patient wishes.
- Unnecessary pain and suffering.
MOLST slides

• I acknowledge the Compassionate Care of California for help, information, and the generous use of some of its slides.
• I also want to thank the POLST Paradigm for their assistance.
• I acknowledge the assistance of Maureen Glynn for generous use of the slides.