



The MOLST Program

(Medical Orders for Life-Sustaining Treatment)

A POLST Paradigm Program • A Community-Wide End-of-Life/Palliative Care Initiative Project

Definition

MOLST is designed to improve the quality of care people receive at the end of life. MOLST is based on:

- Effective communication of patient wishes
- Documentation of medical orders on a bright pink form
- A promise by health care professionals to honor these wishes

- Traditional advance directives like the living will are insufficient
 - Require further interpretation
 - Do not result in medical orders
 - Are too often ignored
- Regional variations in cost of care
- Disparity between patient preferences and actual site of death
- Functional health illiteracy

Needs Assessment

Performance Goals

Short-term Goals (Accomplished!)

- Successful MOLST Community Pilot and adoption of MOLST as a statewide program in July 2008
- Revised, standardized NYSDOH-5003 MOLST form is easy to understand and aligns with Family Health Care Decisions Act. Both became effective June 1, 2010.
- Volunteers prepared to engage in community conversations regarding end-of-life issues, options, and the value of advance directives, including the MOLST form

Long-term Goals

- Informed and prudent use of life-sustaining technologies and intensive care services
- Greater efficiencies in health care delivery
- Improved patient and family satisfaction
- Reduction in costs associated with medical liability and defensive medicine by providing physicians an efficient framework for discussing end-of-life options

Role of the Health Plan

- Leadership
 - MOLST Statewide Implementation Team
 - National Healthcare Decisions Day New York State Coalition
- Operations
 - Distribution and fulfillment
 - Training
 - Quality Improvement
 - Monitor Performance
 - Share best practices and lessons learned
- Funding
- Sustainability
- eMOLST Registry
- MOLST DVD and Educational Resources
- Community website: CompassionAndSupport.org

Lessons Learned

- A health care and community collaborative model can effectively improve end-of-life care
- Health Plans can provide effective leadership for this model
- Model can be replicated using six steps:
 1. Define vision, mission, and values
 2. Employ results-oriented approach
 3. Design effective, inclusive coalition membership
 4. Create effective leadership
 5. Demonstrate strong commitment to purpose
 6. Monitor performance

Next Steps

- Expansion of statewide professional training, system implementation and community education
- Further legislative work with the Office of Mental Health (OMH) and the Office for People With Developmental Disabilities (OPWDD)
- eMOLST Registry and community workflow with Rochester RHIO eMOLST Pilot
- Establish partnerships with other Blue Plans
- Extend MOLST further in Care Management Functions, including integration with the Care Transitions Intervention, and Quality and Efficiency Measures for Accountable Care Organizations

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