

# **MOLST:**

## **Medical Orders for Life Sustaining Treatment**



## **MOLST Training Manual**

Bomba, Patricia *MOLST: Medical Orders for Life Sustaining Treatment, 2009 MOLST Training Manual.*

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*The Community-wide End-of-life Palliative Care Initiative and the MOLST Community Implementation Teams would like to extend their thanks to:*

- Highland Hospital, Jewish Home of Rochester, ROHM, St. Ann's Community, and ViaHealth and Jamaica Hospital for permission to use facility policies and procedures.
- St. Ann's Community for developing *The LTC Implementation Process.*
- ViaHealth for developing *The Hospital Implementation Process.*
- The Monroe and Onondaga EMS Community Implementation Team for developing *The EMS Implementation Process and EMS Web page.*
- Community Volunteers for providing education on the MOLST Program.
- Professionals throughout New York State for providing education on the MOLST Program.
- All Collaborators listed at [www.CompassionAndSupport.org](http://www.CompassionAndSupport.org)

*Dr. Patricia Bomba offers special thanks to David Klein, CEO of The Lifetime Healthcare Companies, and Senior Management of The Lifetime Health Companies for their generous support of this vital community collaboration.*



September 2009

Dear Colleagues,

With the input of more than 150 community volunteers, the Community-wide End-of-life/Palliative Care Initiative developed a successful two-step approach to advance care planning with two award-winning programs to help individuals “Know Your Choices and Share Your Wishes.”

Community Conversations on Compassionate Care (CCCC) Program is an award-winning program that combines storytelling with “Five Easy Steps” to promote conversations that help individuals 18 years of age and older complete a Health Care Proxy and Living Will. CCCC uses a collection of Advance Care Planning resources on-line, the Advance Care Planning booklet, and an array of Community Conversations on Compassionate Care videos that illustrates stories from real patients and families and explains the Advance Care Planning process using the Five Easy Steps.

Medical Orders for Life-Sustaining Treatment (MOLST) Program is designed to improve the quality of care seriously ill people receive at the end of life. It is based on effective communication of patient wishes, documentation of medical orders on a brightly colored pink form and a promise by health care professionals to honor these wishes.

Dealing with patient preferences regarding end of life issues is being recognized as compassionate and appropriate. The CCCC program attempts to do this with an educational program that starts long before patients are terminally ill. The MOLST Program ensures the wishes of seriously ill patients are honored.

The MOLST Program is based on the belief that individuals have the right to make their own health care decisions, including decisions about life-sustaining treatments, to describe these wishes to health care providers and to receive comfort care while wishes are being honored. MOLST translates patient/resident goals and preferences into medical orders. The MOLST program is based on communication between the patient/resident, Health Care Agent or other designated decision-maker and health care professionals that ensures sound and informed medical decision-making.

For more information on the CCCC and MOLST Program, please visit the community Web site, [CompassionAndSupport.org](http://CompassionAndSupport.org) and view the videos at the Compassion And Support Video Library. The Web site is dedicated to educating and empowering patients, families and professionals on educate the community on advance care planning, MOLST, palliative care, pain management and hospice care and related topics. A Spanish page and pediatric page are included.

The MOLST Training Center at [CompassionAndSupport.org](http://CompassionAndSupport.org) contains implementation and educational resources, including sample policies and procedures, quality improvement audit tool, educational work plans, MOLST videos and on-line a standardized educational training video for professionals, provides the core curriculum on MOLST and professional CME/CE credit.

Thank you for your time and support of the MOLST Program. Your ongoing commitment to MOLST training is needed for successful implementation of the MOLST Program across New York State.

Sincerely Yours,

*Patricia A. Bomba MD*

Patricia A. Bomba, M.D., F. A.C.P.

Chair, MOLST Statewide Implementation Team

Leader, Community-wide End-of-life/Palliative Care Initiative

Chair, National Health Care Decisions Day New York State Coalition

New York State Representative, National Physician Orders for Life-Sustaining Treatment (POLST) Task Force



Patricia Bomba, MD, FACP, Vice President and Medical Director, Geriatrics, Excellus BlueCross BlueShield leads the Community-wide End-of-Life/Palliative Care Initiative and implementation of [Community Conversations on Compassionate Care](#), [Medical Orders for Life-Sustaining Treatment program](#), a community website, [CompassionAndSupport.org](#), [Community Principles of Pain Management](#) and [Guidelines for Long Term Feeding Tube Placement](#). Her collaborative work with NYSDOH on health policy and legislative advocacy established MOLST as a statewide program. Currently, she chairs the MOLST Statewide Implementation Team and the [National Healthcare Decisions Day New York State Coalition](#), is New York State's representative on the National POLST Paradigm Task Force, and is a member of the Medical Society of the State of New York Ethics Committee. In addition to serving as a New York State Delegate to the White House Conference on Aging, she served as a member of the Review Committee of the National Quality Forum's *Framework and Preferred Practices for a Palliative and Hospice Care Quality* project. She has practiced Internal Medicine and Geriatrics in the Rochester community since 1979. Dr. Bomba is passionately focused on educating the medical community, and the public at large with a goal of improving the quality of life for seniors and their families. She has spoken extensively regionally, statewide and nationally to professionals, community groups and professional organizations on issues related to Advance Care Planning, MOLST, Palliative Care, Pain Management, and End-of-Life Care. Dr. Bomba is author of several articles on issues related to palliative care, and end-of-life concerns.



## **Behavioral Objectives for MOLST Conference**

**Sponsored by: Excellus BlueCross BlueShield, and The Community Hospice, Inc.**

**Supported by: Albany Medical Center, Northeast Health, Seton Health, and St. Peter's Health Care Services.**

### **The MOLST (Medical Orders for Life Sustaining Treatment) Program: A Community Approach to Improving Care at the End-of-life**

**September 30, 2009**

#### **Overall conference objectives**

At the end of the conference, the attendee will be able to:

1. Discuss the nuts and bolts of the MOLST Program as part of advance care planning.
2. Describe effective patient/family decision making.
3. Demonstrate the process for patient-centered, goals based communication.
4. Prepare for community implementation and quality improvement activities to improve care at the end-of-life.

#### **Plenary 1: A Two-Step Approach to Advance Care Planning**

At the end of the presentation, the attendee will be able to:

1. Define the advance care planning process and recognize the need for advance care planning along the health-illness continuum.
2. Contrast the differences between traditional advance directives and actionable medical orders, like DNR and MOLST.
3. Explain how the MOLST Program can be used to improve the quality of end-of-life care when compared to traditional advance directives.
4. Define the core elements, development and the appropriate cohort of patients for the MOLST
5. Discuss MOLST as an approved POLST Paradigm Program and state an overview of research that validates use of MOLST Program.
6. List the National Quality Forum's Preferred Practices for Advance Care Planning

#### **Video: "Writing Your Final Chapter: Know Your Choices...Share Your Wishes"**

At the end of the presentation, the attendee will be able to:

1. Define the MOLST Program as a key element of providing effective, high quality end-of-life care from the patient/family perspective.
2. Illustrate the key elements of the MOLST Program including effective communication, documentation of medical orders and system responsiveness.
3. Describe MOLST as an end-of-life transition-of-care program.

#### **Plenary 2: Effective Communication: Using the 8-Step MOLST Protocol to Explore Patient Goals and Guide MOLST Decisions**

At the end of the presentation, the attendee will be able to:

1. Explain why it is critical to explore patient/family goals and values in light of their medical condition and prognosis before approaching decision making about DNR and other life-sustaining treatment.
2. Use strategies for shared medical decision-making by initiating discussions about goals, values, and prognosis that begin by exploring the perspective of patients and their families and trying to reconcile them with the knowledge of the clinicians.
3. Review the unintended consequences of the language we use.
4. Describe strategies for approaching common pitfalls in these discussions ("He is a real fighter..." "We want everything done..." "Let's leave it in God's hands...").

### **Plenary 3: Decisional Capacity: Legal, Ethical, and Clinical Considerations**

At the end of the presentation, the attendee will be able to:

1. Define capacity and employ a strategy for assessing decisional capacity to make health care decisions.
2. Follow a practical strategy for making decisions about DNR and other potentially life-sustaining treatment when capacity is uncertain or absent under the confines of New York State law.
3. Illustrate how and when to activate a traditional advance directive; i.e., Health Care Proxy or Living Will
4. Describe how to make and document decisions about DNR and other potentially life-sustaining treatment when there are no traditional advance directives.

### **Plenary 4: Documentation of the Conversation and Completion of the MOLST**

At the end of the presentation, the attendee will be able to:

1. Summarize how to fill out the MOLST form.
2. Describe when to complete a Supplemental Documentation Form for Adults and Minors.
3. Discuss how to review and renew a MOLST form.
4. Review chart documentation of a conversation focused on advance care planning and the MOLST Program.

### **Plenary 5: The Critical Role of EMS**

At the end of the presentation, the attendee will be able to:

1. Discuss the information needed by EMS in the event of an emergency
2. Define "comfort care" as treatment for seriously ill patients
3. Review how the 2008 amendment to Public Health Law changes the scope of EMS practice
4. Review EMS experience regionally and in other parts of the country.

### **Plenary 6: The Confines of New York State Law**

At the end of the presentation, the attendee will be able to:

1. Identify traditional advance directives used in NYS, the legal roles and responsibilities of the Health Care Agent identified in the Health Care Proxy and the physician's responsibility.
2. Review New York State Public Health Law regarding Nonhospital DNR Law (PHL § 2977) before and after initiation of the MOLST Program.
3. Describe the legislation enacted to launch the Monroe and Onondaga Counties MOLST Community Pilot and results of the community pilot.
4. Explain the informed consent process and illustrate how the MOLST represents "clear and convincing evidence."

### **Plenary 7: Myths and Truths of CPR: Conversations Based on Evidence**

At the end of the presentation, the attendee will be able to:

1. Describe the history and purpose of cardiopulmonary resuscitation.
2. Recognize the lack of improvement in survival rates after in-hospital CPR despite steady increase in application of technology and techniques.
3. Identify the effect of age and other risk factors as outcome predictors for patients who experience cardiac arrest in various settings.

### **Plenary 8: A Practical Approach to Discussing Artificial Nutrition**

At the end of the presentation, the attendee will be able to:

1. Describe the expectations of patients, families, and their physicians regarding the use of PEGs.
2. Define the benefits, burdens and outcomes of PEG use, relative to those expectations.
3. Recognize and use strategies helpful in guiding a patient-centered, evidence-based MOLST discussion when a decision about the use of PEGs is discussed.

### **Plenary 9: Lessons Learned and Available Resources to Implement the MOLST**

At the end of the presentation, the attendee will be able to:

1. Apply the lessons learned from successful implementation of the MOLST Program in other regions in their practice setting.
2. Define appropriate use of Advance Care Planning and MOLST resources, including the MOLST videos, MOLST FAQs and [CompassionandSupport.org](http://CompassionandSupport.org).
3. Use the MOLST Training Center to prepare for implementation, including use of the videos, policies and procedures, quality improvement tools, educational plans.

### **Next Steps: Implementing MOLST as an End-of-life Care Transitions Program in Your Community**

At the end of the presentation, the attendee will be able to:

1. Recognize the MOLST as an End-of-life Care Transitions Program
2. Outline the barriers to implementation of the MOLST program and the methods used to overcome these obstacles.
3. Establish next steps needed to implement the MOLST Program in their practice setting.

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# MOLST Training Manual

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# ***MOLST:***

## *Medical Orders for Life-Sustaining Treatment*



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### *Plenary 1:*

## *A Two Step Approach to Advance Care Planning*

***Patricia Bomba, MD, FACP***  
*Vice President and  
Medical Director, Geriatrics*


***Penny S. Weller, LCSW-R***  
*Program Implementation Manager*

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*A Two-Step Approach to Advance Care Planning*

*The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life*



## A Two-Step Approach to Advance Care Planning

Patricia Bomba, M.D., F.A.C.P.  
 Vice President and Medical Director, Geriatrics  
 Chair, MOLST Statewide Implementation Team  
 Leader, Community-wide End-of-life/Palliative Care Initiative  
 Chair, National Healthcare Decisions Day New York State Coalition  
[Patricia.Bomba@lifesupport.com](mailto:Patricia.Bomba@lifesupport.com)  
[CompassionAndSupport.org](http://CompassionAndSupport.org)


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## Objectives

- Define the advance care planning process and recognize the need for advance care planning along the health-illness continuum
- Contrast the differences between traditional advance directives and actionable medical orders, like DNR and MOLST
- Explain how the MOLST Program can be used to improve the quality of end-of-life care when compared to traditional advance directives
- Define the core elements, development and the appropriate cohort of patients for the MOLST
- Discuss MOLST as an approved POLST Paradigm Program and state an overview of research that validates use of the Community Conversations on Compassionate Care and MOLST Programs
- List the National Quality Forum's Preferred Practices for Advance Care Planning




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*Created by Patricia Bomba M.D., F.A.C.P. for the community-wide implementation of the MOLST Program*

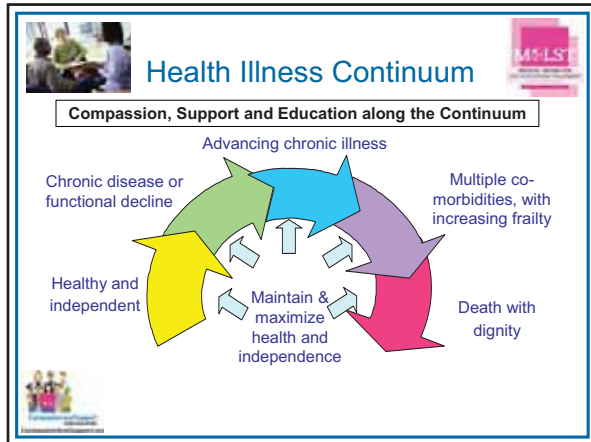
*CompassionAndSupport.org*

*September 2009*



*A Two-Step Approach to Advance Care Planning*

*The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
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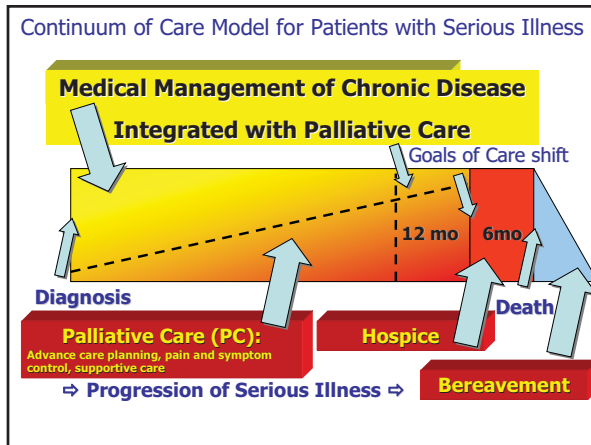
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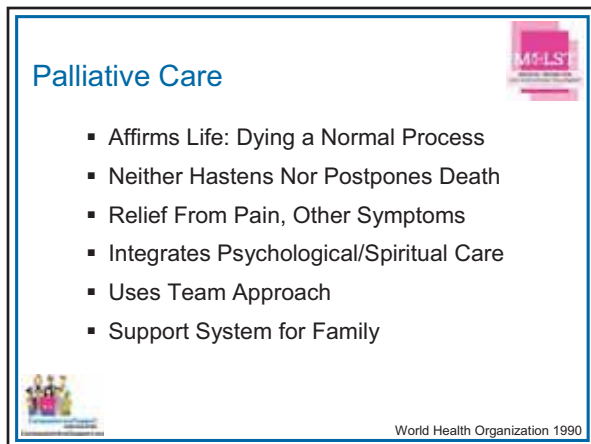
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*Created by Patricia Bomba M.D., F.A.C.P. for the community-wide implementation of the MOLST Program*

*CompassionAndSupport.org*

*September 2009*



**Palliative Care**

- Interdisciplinary care that aims to relieve suffering and improve quality of life for patients with advanced illness and their families.
- It is offered simultaneous with all other appropriate medical treatment.

www.capc.org

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**Palliative Care**  
Key Pillars

- Advance Care Planning
  - Step 1: Community Conversations on Compassionate Care (CCCC) Program
  - Step 2: Medical Orders for Life-Sustaining Treatment (MOLST) Program
- Pain and Symptom Management
- Support for the Patient and Family

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**Palliative Care**  
Provides What Patients Need

- Compassion
- Non-abandonment
- Acceptance
- Clear information that enables determination of the goals of care
- Identification of surrogate decision maker and preferences
- Treatment as a whole person

Bomba, 2001

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### Palliative Care

#### Provides What Patients Want at End-of-life



- Quality end-of-life care
  - receiving adequate pain & symptom management
  - avoiding inappropriate prolongation of dying
  - achieving a sense of control
  - relieving the burden on loved ones
  - strengthening the relationship with loved ones



Singer, et.al. JAMA 1999; 281:163-8

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### Palliative Care

#### Provides What Patients Want at End-of-life



- Quality end-of-life care
  - respect uniqueness of individual
  - provide appropriate environment
  - address spiritual issues
  - recognize cultural diversity
  - communication integral between dying person, family and professionals



McGraw, et.al. Conn Med 2002; 66 (11); 655-64

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### Advance Care Planning Needs Assessment

#### Honoring Patient Preferences for EOLC

- Life expectancy has increased
- Increased prevalence of chronic diseases
- Death in America often seen as "optional"
- Planning for the future is not just for the old, disabled or chronically ill
- Gaps in care and quality issues<sup>i</sup>
  - location of death, pain management, treatment preferences and hospice admissions
- Regional Variations in Site of Death
- Regional Variations in Cost of Care at EOL<sup>ii</sup>
- Healthcare Professional Communication Skills
- Functional Health Illiteracy



<sup>i</sup> IOM Report Approaching Death: Improving Care at the EOL, 1997  
<sup>ii</sup> Dartmouth Atlas

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### Regional Variations in Medicare Spending

- Large regional variations in the percentage of deaths occurring in hospitals
- High-spending regions
  - more inpatient-based and specialist-oriented care
  - however, no improvement in
    - health outcomes, including mortality rates
    - quality of care
    - access to care
    - patient/family satisfaction
- Good predictor of how hospitals treat patients under 65 with chronic disease

Dartmouth Atlas

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### Site of Death

How Americans Die



How Americans Wish to Die




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### Regional Variation Site of Death: National and State Data

	Deaths at home	Deaths in a Hospital	Deaths in a NH
Oregon (Nat'l Benchmark)	35.10%	32.50%	32.40%
National Mean (Average)	24.90%	50.00%	25.10%
New York	21.20%	61.80%	17.00%

Benchmarks, 2001, Launch of Community-Wide EOL/Palliative Care Initiative

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**End-of-life Care Cost Savings**

- Dollars are wasted on unwanted, unnecessary and futile treatments
- Reducing amount spent on ineffective treatments will help reduce the total cost of end-of-life care
- Cost savings estimate: 3.3 % of total costs <sup>iii</sup>
- 3.3% x \$1.4 trillion = \$59 billion

<sup>iii</sup> Terry Sanford Institute of Public Policy, Duke University.  
[www.pubpol.duke.edu/courses/pps255s/2004/w-team-a/benefits.htm](http://www.pubpol.duke.edu/courses/pps255s/2004/w-team-a/benefits.htm), 2004

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**Community Needs Assessment  
Honoring Patient Preferences for EOLC**

- IOM Report Approaching Death: Improving Care at the EOL, 1997 <sup>i</sup>
  - Gaps in care and quality issues
    - location of death, pain management, treatment preferences and hospice admissions
- Community End-of-Life Survey Report, 2001 <sup>ii</sup>
  - RIPA/EBCBSRR EOL/Palliative Care Professional Advisory Committee, Regional Variations in Site of Death
- Community-Wide End-of-life/Palliative Care Initiative, 2001 <sup>iii</sup>
  - Regional Variations in Cost of Care at EOL
  - Functional Health Illiteracy
  - Healthcare Professional Communication Skills

<sup>i</sup> [www.iom.edu/CMS/3809/12687.aspx](http://www.iom.edu/CMS/3809/12687.aspx)  
<sup>ii</sup> [www.CompassionAndSupport.org/index.php/about\\_us](http://www.CompassionAndSupport.org/index.php/about_us)

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**Community-wide End-of-life/  
Palliative Care Initiative**

- Advance Care Planning
  - Community Conversations on Compassionate Care
- Honoring Preferences
  - Medical Orders for Life-Sustaining Treatment (MOLST)
  - PEGS
- Pain Management and Palliative Care
  - Community Principles of Pain Management
  - CompassionNet
- Education and Communication
  - Education for Physicians on End-of-life Care (EPEC)
  - Community web site: [www.CompassionAndSupport.org](http://www.CompassionAndSupport.org)

Community-Wide EOL/Palliative Care Initiative, Launch May 2001




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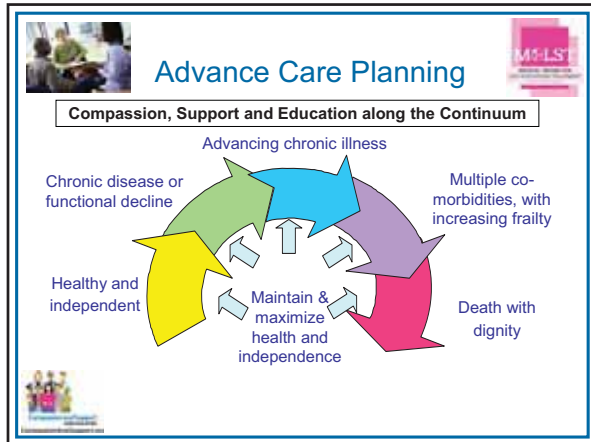
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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
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**Advance Directives**

<p><b>Traditional ADs</b></p> <p><u>For All Adults</u></p> <p><i>Community Conversations on Compassionate Care (CCCC)</i></p> <ul style="list-style-type: none"> <li>▪ New York           <ul style="list-style-type: none"> <li>▪ Health Care Proxy</li> <li>▪ Living Will</li> </ul> </li> <li>▪ Organ Donation</li> <li>▪ State-specific forms</li> </ul> <p><a href="http://CompassionAndSupport.org">CompassionAndSupport.org</a> <a href="http://CaringInfo.org">CaringInfo.org</a></p>	<p><b>Actionable Medical Orders</b></p> <p><u>For Those Who Are Seriously Ill or Near the End of Their Lives</u></p> <p><i>Medical Orders for Life-Sustaining Treatment (MOLST) Program</i></p> <ul style="list-style-type: none"> <li>▪ Do Not Resuscitate (DNR) Order</li> <li>▪ Medical Orders for Life Sustaining Treatment (MOLST)</li> <li>▪ Physician Orders for Life Sustaining Treatment (POLST) Paradigm</li> </ul> <p><a href="http://CompassionAndSupport.org">CompassionAndSupport.org</a> <a href="http://POLST.org">POLST.org</a></p>
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**Community Conversations on Compassionate Care**

Five Easy Steps

1. Learn about advance directives
  - NYS Health Care Proxy
  - NYS Living Will
  - Advance Directives from Other States
2. Remove barriers
3. Motivate yourself
  - View CCCC videos
4. Complete your Health Care Proxy and Living Will
  - Have a conversation with your family
  - Choose the right Health Care Agent
  - Discuss what is important to you
  - Understand life-sustaining treatment
  - Share copies of your directives
5. Review and Update

A Project of the Community-Wide End-of-life/Palliative Care Initiative

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Community Conversations on Compassionate Care  
How to Clarify Values and Beliefs

- Your values
- Your personal beliefs
- Your spiritual beliefs
- What makes life worth living
- What really matters to you
- Your hopes and wishes
- Your goals for care
  - quantity vs quality of life




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Community Conversations on Compassionate Care  
How to Choose a Health Care Agent

- Knows me well
- Understands what is important to me
- Will talk about sensitive wishes now
- Will listen to my wishes
- Willing to speak on my behalf
- Would act on my wishes
- Can separate his/her feelings from mine
- Will be available in the future
- Lives close by or willing to come
- Could handle responsibility
- Can manage conflict resolution
- Meets legal criteria




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Community Conversations on Compassionate Care  
Practical Issues: Review & Update, Accessibility

- Review & update
  - periodically
  - major life events
  - newly diagnosed chronic illness
  - advancing chronic illness
  - after complicated life-sustaining treatments
- Keep a copy and provide a copy
  - Health Care Agent and Alternate Agent
  - family members / loved ones
  - primary care physician and specialists
  - primary hospital/ care facility
  - spiritual adviser




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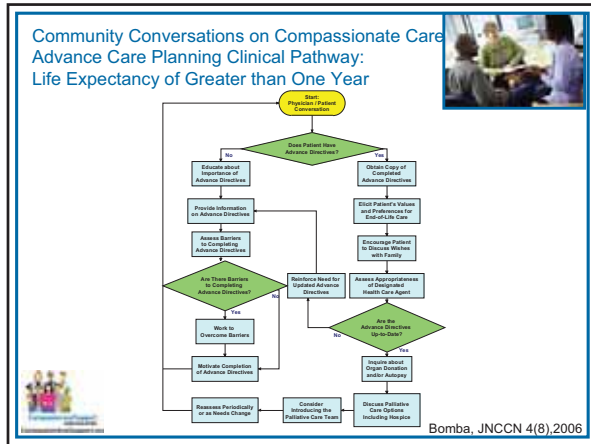
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A Two-Step Approach to Advance Care Planning

The MOLST (Medical Orders for Life-Sustaining Treatment) Program: A Community Approach to Improving Care at the End-of-life




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Medical Orders for Life-Sustaining Treatment (MOLST Program), A POLST Paradigm Program

- Improve the quality of care people receive at the end of life
  - effective communication of patient wishes
  - documentation of medical orders on a brightly colored pink form
  - promise by health care professionals to honor these wishes
- Complements the use of traditional advance directives

A Project of the Community-Wide End-of-Life/Palliative Care Initiative

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MOLST: Who Should Have One?

- Anyone choosing:
  - Do not resuscitate
  - Allow natural death
- Anyone choosing to limit medical interventions
- Anyone eligible/residing in LTC facility
- Anyone who might die within the next year

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Health Care Proxy / Living Will vs MOLST

- **Health Care Proxy / Living Will**
  - completed ahead of time
  - applies only when decision-making capacity is lost
- **MOLST**
  - applies right now
  - not conditional on losing decision-making capacity
  - set of actionable medical orders
  - approved by NYSDOH for use in **ALL** settings, including the community




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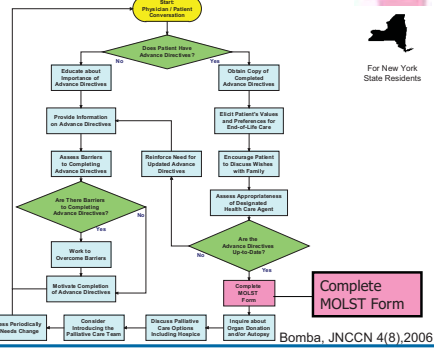
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### Medical Orders for Life-Sustaining Treatment (MOLST) Advance Care Planning Clinical Pathway: Life Expectancy of Less than One Year



For New York State Residents



Bomba, JNCCN 4(8),2006

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### Philosophy of MOLST

- Individuals have the right to make their own health care decisions
- These rights include:
  - making decisions about life-sustaining treatment
  - describing desires for life-sustaining treatment to health care providers
  - comfort care while having wishes honored




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Philosophy of EMS



- Designed in the 1960s and 1970s
- Emergency response to save lives
- Underlying assumption that people want everything done
- Assumes primary cardiac arrest (V Fib)




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### Reality for EMS



- Current survival to hospital discharge from out-of-hospital cardiac arrest is 5% or less.
- EMS does not want to attempt resuscitation when it is not wanted but they need documentation.
- EMS is often faced with decisions about how to proceed for patients with serious illness who are not in cardiac arrest.




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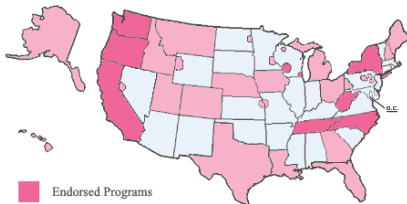
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### POLST Paradigm Program



Paradigm of communication, documentation, and system responsiveness

POLST Paradigm Program September 2009 POLST.org




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**POLST**

- A decade of research in Oregon has proven that the POLST Program more accurately conveys end-of-life preferences and yields higher adherence by medical professionals.

Lee, Brummel-Smith, et al. JAGS. 2000; 48(10): 1219-1225  
 Meyers, et al. J Gerontol Nurs. 2004; 30(9): 37-46  
 Schmidt, Hickman, Tolle, Brooks. JAGS. 2004; 52(9): 1430-1434

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**Research Conclusions from 7 Studies**

- 1996: Focus groups indicate POLST improved agreement with patient wishes 29-37%
- 1998: 0/180 NH residents with POLST orders of "DNR/comfort measures only" received CPR/ICU
- 2000: Frail elderly limit CPR (91%), antibiotics (86%), IV fluids (84%), and feeding tubes (94%).

[POLST.org](http://POLST.org)

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**Research Conclusions from 7 Studies**

- 2004: 96% of OR NH's report POLST is used to guide decisions and evolved to care standard
- 2004: 77% DNR residents prefer some additional interventions, 47% of CPR residents prefer some limitation
- 2004: OR EMT's indicate POLST changes treatment in 45% of patients
- 2004: POLST congruent with AD in all WA NH residents with high satisfaction N=21.

[POLST.org](http://POLST.org)

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Program Requirements**  
**Core Elements of MOLST**

- Contains actionable medical orders
- Recommended for use in persons who have advanced chronic progressive illness and anyone interested in further defining their end of life care wishes
- May be used either to limit medical interventions or to clarify a request for all medically indicated treatments
- Provides explicit direction about resuscitation status if the patient is pulseless and apneic
- Includes directions about other types of intervention that the patient may or may not want

[CompassionAndSupport.org](http://CompassionAndSupport.org)  
[POLST.org](http://POLST.org)

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**Program Requirements**  
**Core Elements of MOLST**

- Is a bright pink color easily identifiable in emergency
- Accompanies the patient and orders apply as he or she is transferred home or to a new care setting (e.g. long-term care facility or hospital).
- Should be reviewed and renewed:
  - Periodically & as required by NYS and federal law & regulations
  - If the individual's preferences change
  - If the individual's health status changes
  - If the patient is transferred to another care setting
- Includes education and training
- Features a plan for ongoing monitoring of the program

[CompassionAndSupport.org](http://CompassionAndSupport.org)  
[POLST.org](http://POLST.org)

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**Framework for the Conversation**  
**8-Step MOLST Protocol\***

1. Prepare for discussion
  - Understand the patient and family
  - Understand the patient's condition and prognosis
  - Retrieve completed Advance Care Directives
  - Determine "Agent" (Spokesperson) or responsible party
2. Determine what the patient and family know
  - re: condition, prognosis
3. Explore goals, hopes and expectations
4. Suggest realistic goals
5. Respond empathetically
6. Use MOLST to guide choices and have patient/family share wishes
  - Shared medical decision-making
  - Conflict resolution
7. Complete and sign MOLST
8. Review and revise periodically

\*Developed for NYS MOLST, Bomba, 2005




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### Medical Decision-Making Capacity

- Capacity is the ability to:
  - take in information,
  - understand its meaning and
  - make an informed decision using the information
- Capacity allows us to function independently
- Capacity is task-specific
- Capacity to choose health care agent vs ability to make medical decisions, based on the complexity of decisions
  - simple health care decisions
  - request for palliation (relief of pain and suffering)
  - complicated decisions regarding DNR and life-sustaining treatment




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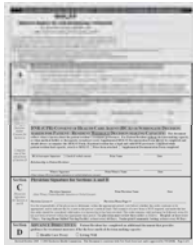
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### MOLST



- Page 1: **DNR**
  - Complete Section A, B, C for DNR
  - Section D: Advance Directives
- Page 2: **Life-Sustaining Treatment**
- Page 3 and 4: **Renew/Review**
- Supplemental Documentation  
Forms for DNR: Adult and Minor

[CompassionAndSupport.org](http://CompassionAndSupport.org)




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### History of MOLST Program



- Work initiated Fall 2001
- Created November 2003
- Adapted from Oregon's POLST
- Combines DNR, DNI, and other LST
- Incorporates NYS law
- Collaboration with NYSDOH – 3/04
- Revised 10/05
- Approved Inpatient DNR form
- Legislation passed 2005
- Community Pilot launched
- Chapter Amendment 2006
- Gov Paterson signed bill 7/8/08
- MOLST consistent with PHL§2977(3)
- Permanent change in EMS scope of practice, 7/08
- **MOLST permanent and statewide**




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Advance Care Planning**  
Community Goals: National Quality Forum

- Document the designated agent (surrogate decision maker) in a Health Care Proxy for every patient in primary, acute and long-term care and in palliative and hospice care.
- Document the patient/surrogate preferences for goals of care, treatment options, and setting of care at first assessment and at frequent intervals as condition changes.
- Convert the patient treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital, i.e., the Medical Orders for Life-Sustaining Treatment—MOLST, a POLST Paradigm Program.
- Make advance directives and surrogacy designations available across care settings; through collaboration with the RHIO
- Develop and promote healthcare and community collaborations to promote advance care planning and completion of advance directives for all individuals, e.g. Respecting Choices and Community Conversations on Compassionate Care

National Quality Forum, Framework and Preferred Practices for Quality Palliative Care & Hospice Care, 2006, Adapted for New York State

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**Advance Care Planning**  
Outcomes: Advance Directives and MOLST

- Traditional Advance Directives Outcomes**
  - Every adult (18 and older) will complete a Health Care Proxy
  - Every adult will have meaningful discussions about end-of-life
  - Every adult will have access to an easily recognizable document
  - Every adult will have access to educational sessions
- MOLST Short Term Outcomes**
  - Consistent uniform application of the Medical Orders for Life-Sustaining Treatment (MOLST) program.
  - Successful MOLST Community Pilot and adoption of a MOLST as a statewide program.
  - Expanded cadre of volunteers prepared to engage in one-to-one and community conversations regarding end-of-life issues, options and the value of advance directives, including the MOLST form.
- MOLST Long Term Outcomes**
  - Informed & prudent use of life-sustaining & 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.

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**Advance Care Planning Campaign**  
Rochester 2002

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A Two-Step Approach to Advance Care Planning

The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Advance Care Planning Booklets**

CompassionAndSupport.org

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**Behavioral Readiness to Complete a Health Care Proxy**

- See no need
- Recognize need, but have barriers
- Ready to complete
- Advance Care Directive reflects wishes
- Advance Care Directive needs update

Bomba, Doniger, Vermilyea 2002

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**Community Conversations on Compassionate Care (CCCC)**

- 1-2 hour facilitated workshop on advance care planning
- Goals
  - Increase comfort level in discussing death and dying
  - Increase conversations that lead to completion of an Advance Directive
- CCCC - *effective* in increasing advance directive completion rates

*A Community-wide End-of-life/Palliative Care Initiative project*

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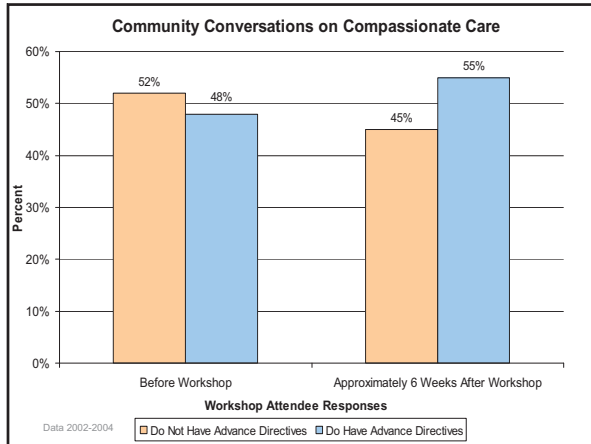
Created by Patricia Bomba M.D., F.A.C.P. for the community-wide implementation of the MOLST Program

CompassionAndSupport.org

September 2009



The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life




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**Community Conversations on Compassionate Care  
Advance Care Planning Community Resources**

- Advance Care Planning Booklet (English, Spanish)
- Advance Care Planning Brochure, Poster and Table Topper
- Advance Care Planning Facilitator Training
- Advance Care Planning Clinical Pathways
- Behavioral Readiness "tools"
- Community Conversations on Compassionate Care (CCCC) workshop
- Community Conversations on Compassionate Care (CCCC) DVD
- Advance Care Planning Public Service Announcements DVD
- CCCC video on-line with Five Easy Steps
- On-line resources at [CompassionandSupport.org](http://CompassionandSupport.org)
- Internal tracking and evaluation

[CompassionandSupport.org](http://CompassionandSupport.org)

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**Advance Directives  
National Metrics: Completion Rates**

- 1991 - Patient Self-Determination Act
  - 20% had a form of Advance Directive (AD)
  - 75% approved of a Living Will
- 2002 - Means to a Better End<sup>i</sup>
  - 15 -20% Americans have AD
- 2005 –Pew Research Center for the People and the Press<sup>ii</sup>
  - 29% - Americans have AD – living wills
- 2008-AARP survey<sup>iii</sup>
  - <40% -Americans 35 yo and older have AD

<sup>i</sup> Means to a Better End: A Report on Dying in America Today, November 2002  
<sup>ii</sup> The Pew Research Center for the People and the Press.  
 More Americans Discussing and Planning End-of-life Treatment, January 5, 2006  
<sup>iii</sup> [http://assets.aarp.org/ocenter/iii/getting\\_ready.pdf](http://assets.aarp.org/ocenter/iii/getting_ready.pdf)

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

End-of-life Care Community Survey Methodology



- United Marketing Research - conducted interviews
  - Random sample of residents living in a 39-county area of upstate New York
  - 2,000 adults, 18 and older, interviewed by phone
  - Between March 6, 2008 and April 6, 2008
  - Selection - random digit dialing (RDD) sample
  - Quota sampling approach
    - ensure meaningful number of individuals (about 400) surveyed within each of five regions
    - established for respondents 55 and older - minimize age bias



[End-of-Life Care Survey of Upstate New Yorkers: Advance Care Planning Values and Actions](#)  
[Excelsus BlueCross BlueShield, April 2008](#)

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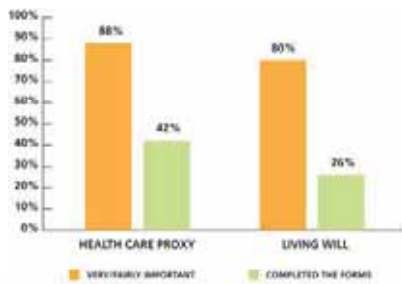
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Disparity between consumer attitudes & actions regarding advance directives



[End-of-Life Care Survey of Upstate New Yorkers: Advance Care Planning Values and Actions](#)  
[Excelsus BlueCross BlueShield, April 2008](#)

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Disparity between consumer attitudes and actions regarding health care proxies



[End-of-Life Care Survey of Upstate New Yorkers: Advance Care Planning Values and Actions](#)  
[Excelsus BlueCross BlueShield, April 2008](#)

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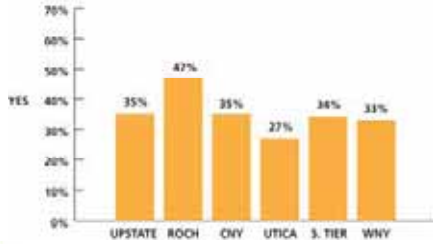
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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Has your doctor ever talked to you about Health Care Proxies and Living Wills?



End-of-Life Care Survey of Upstate New Yorkers:  
Advance Care Planning Values and Actions  
Excelsus BlueCross BlueShield, April 2008

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Employee Healthcare Decisions Survey  
Methodology

- Survey to all Health Plan employees
  - Launched via email on February 8, 2008
  - Two reminder emails were sent one week apart
  - 53% response rate (2,315 of 4,343 surveys)
  - 63% in 35-54 age range
  - The margin of error was ±2%
- Results compared
  - 2006 Healthcare Decisions Employee Survey (same 23 question survey)
  - 2002 Healthcare Decisions Employee Survey (shorter 6 question survey)

Employee Health Care Decision Survey  
Excelsus BlueCross BlueShield, April 2008

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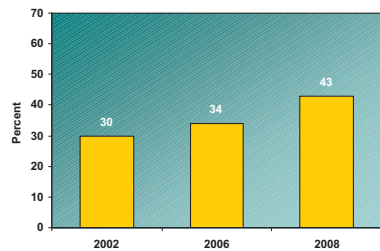
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Completion Rate for Health Care Proxies



Employee Health Care Decision Survey  
Excelsus BlueCross BlueShield, April 2008

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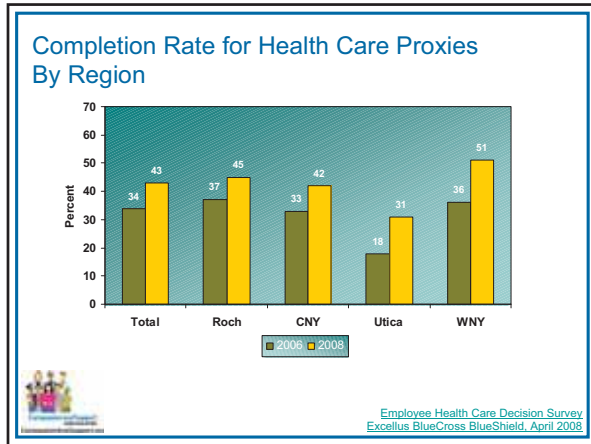
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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
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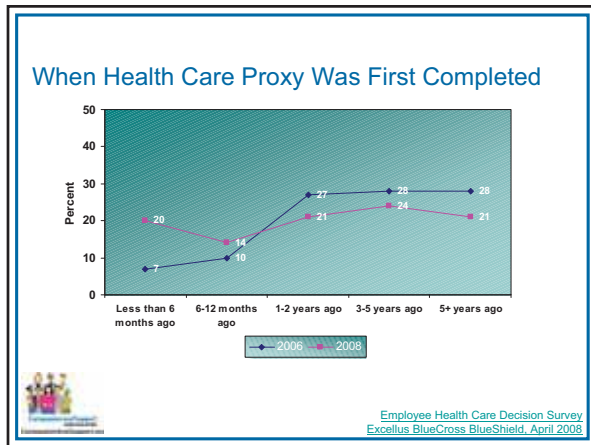
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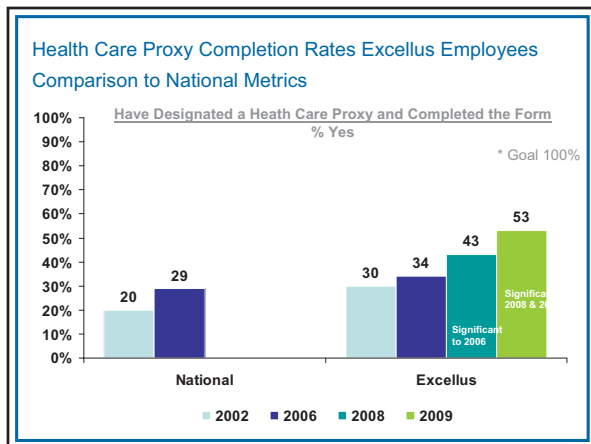
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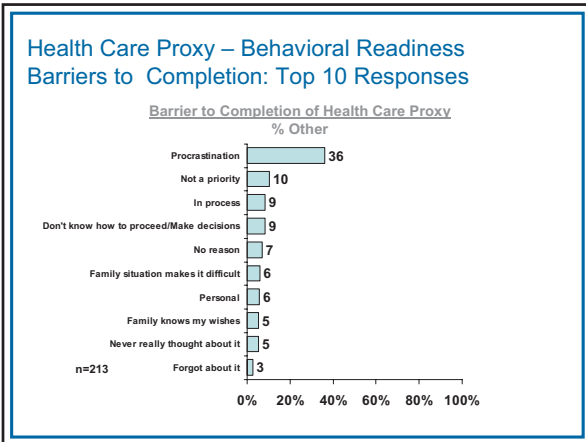
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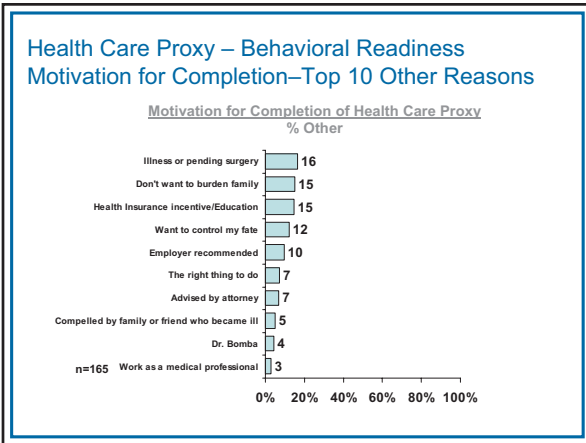
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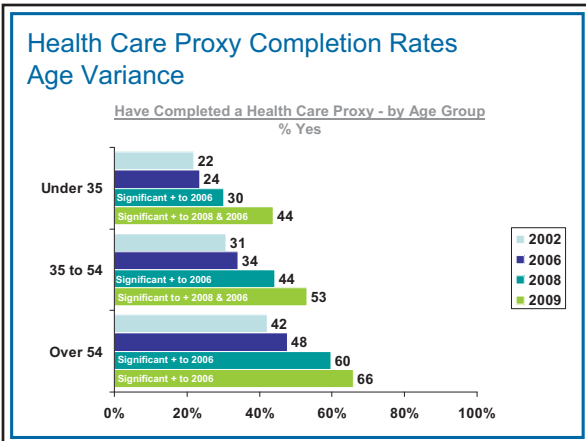
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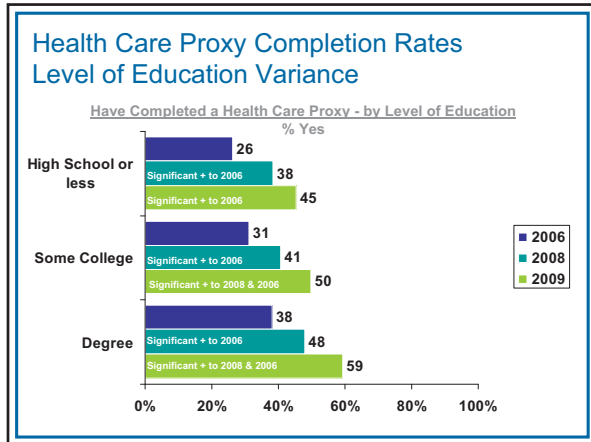
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*A Two-Step Approach to Advance Care Planning*

*The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life*




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- ### Community Conversations on Compassionate Care Advance Care Planning Employer Toolkit
- Cover Letter
  - Excellus BCBS Employee Healthcare Decisions Survey (2008) Summary Report
  - End-of-Life Care Survey of Upstate New Yorkers: Advance Care Planning Values and Actions, Summary Report, 2008
  - Community Conversations on Compassionate Care (CCCC) DVD
  - Advance Care Planning Public Service Announcements DVD
  - Advance Care Planning Booklet
  - Advance Care Planning Brochure
  - Advance Care Planning Table Topper
  - Advance Care Planning Poster
  - Web Bookmark (CompassionAndSupport.org)
  - Flash Drive (complete with resources to host a CCCC Advance Care Planning Employee Campaign)

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*Created by Patricia Bomba M.D., F.A.C.P. for the community-wide implementation of the MOLST Program*

*CompassionAndSupport.org*

*September 2009*

# ***MOLST:***

*Medical Orders for  
Life-Sustaining Treatment*



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## *Plenary 2:*

*Effective Communication:  
Using 8-Step MOLST Protocol  
to Explore Patient Goals and  
Guide MOLST Decisions*

***Patricia Bomba, MD, FACP***  
*Vice President and  
Medical Director, Geriatrics*

***Penny S. Weller, LCSW-R***  
*Program Implementation Manager*

White sheet with no verbiage



The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

## Effective Communication: Using the 8-Step MOLST Protocol

Patricia Bomba, M.D., F.A.C.P.  
Vice President and Medical Director, Geriatrics  
Chair, MOLST Statewide Implementation Team  
Leader, Community-wide End-of-life/Palliative Care Initiative  
Chair, National Healthcare Decisions Day New York State Coalition

[Patricia.Bomba@lifethc.com](mailto:Patricia.Bomba@lifethc.com)  
[CompassionAndSupport.org](http://CompassionAndSupport.org)

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## Objectives

- Explain critical need to explore patient/family goals and values in light of their medical condition and prognosis before approaching medical decision-making about DNR and life-sustaining treatment
- Use strategies for shared, informed medical decision-making
- Review the unintended consequences of the language we use.
- Describe strategies for approaching common pitfalls in these discussions

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## Healthcare Professional Communication Barriers

*"There's no easy way I can tell you this, so I'm sending you to someone who can."*

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### Health Care Professional Barriers



- Are you uncomfortable discussing death?
- Do you believe that "accepting mortality" is "giving up hope"?
- Are you afraid that a discussion about death will "make it happen"?
- Are you unwilling and/or unsure how to broach the topic?
- Do you understand the benefits of advance directives and advance care planning?
- Are you able to find reliable resources related to advance directives and advance care planning?
- Have you completed advance directives and shared your wishes with your family, your physician and trusted individuals?




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### Thoughtful EOLC Discussions Benefits



- Improve quality; reduce cost
- Only 31% of patients with advanced cancer at EOL had had discussions with physicians about EOLC
- Patients who had EOL conversations had significantly lower costs in their final week of life, over \$1,000 less
- "Higher costs were associated with worse quality of death"



Arch Intern Med. 2009;169(5):480-488

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### Thoughtful EOLC Discussions Benefits



- "End-of-life discussions are associated with less aggressive medical care near death and earlier hospice referrals."
- "Aggressive care is associated with worse patient quality of life and worse bereavement adjustment."



Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment  
JAMA. 2008;300(14):1665-1673

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Framework for the Conversation**  
**8-Step MOLST Protocol\***

1. Prepare for discussion
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  - Determine "Agent" (Spokesperson) or responsible party
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**Communicating Prognosis**



- Physicians markedly over-estimate prognosis
- Accurate information helps patient / family cope, plan
- Offer a range or average for life expectancy
  - days to weeks
  - weeks to 3 months
  - 3 – 6 months
  - 6 months to 1 year
  - > 1 year

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**Palliative Performance Scale**

- Modification of the Karnofsky Performance Scale
  - intended for evaluating patients requiring palliative care
- Items for the Score
  - Ambulation
  - Activity level
  - Evidence of disease
  - Self-care
  - Intake
  - Conscious level

Anderson, J Palliat Care. 1996; 12: 5-11

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**Palliative Performance Scale**

- Interpretation:
  - maximum score: 100%
  - minimum score: 0% (dead)
  - The lower the score, the more severe the illness.
- PPS Score: Average Survival in Hospice
  - 50%: 13.9 days
  - 40%: 10.3 days
  - 30%: 6.7 days
  - 20%: 2.6 days
  - 10%: 1.9 days

Anderson, J Palliat Care. 1996; 12: 5-11

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**Palliative Performance Scale**

- 80-100:** Full function; self-care full; intake normal; mental status normal
- 60-70:** Reduced function; self-care full to occasional assist; intake normal or reduced; mental status normal
- 40-50:** Mainly lie, sit or in bed; considerable assistance; normal or reduced intake; normal or confused
- 30:** Bed-bound; total care; reduced intake; normal, drowsy, or confused
- 10-20:** Bed-bound; total care; minimal sips and bites; normal, drowsy, or confused;

Anderson, J Palliat Care. 1996; 12: 5-11

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**8-Step MOLST Protocol**

- 2. Determine what the patient and family know
  - re: condition, prognosis
- 3. Explore goals, hopes and expectations
- 4. Suggest realistic goals
- 5. Respond empathetically

\*Developed for NYS MOLST, Bomba, 2005

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**Reviewing goals, treatment priorities**

- Goals guide care
- Assess priorities to develop initial plan of care
- Review with any change in
  - health status
  - advancing illness
  - setting of care
  - treatment preferences
- Gradual shift in focus of care
- Expected part of the continuum of medical care

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**Potential Goals of Care**

▪ Cure of disease	▪ Relief of suffering
▪ Avoidance of premature death	▪ Quality of life
▪ Maintenance or improvement in function	▪ Staying in control
▪ Prolongation of life	▪ A good death
	▪ Support for families and loved ones

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Language to Describe Goals of Care



- We'll do everything we can to help you maintain your independence
- We want to ensure that your father receives the kind of treatment he wants
- Your grandmother's comfort and dignity will be our top priority




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Language to Describe Goals of Care



- Hope for the best....plan for the worst
- No missed opportunities
- Meet your needs and goals, understanding what is possible and what we wish could happen, but cannot
- We want to give the best care possible until the day you die, enjoy the time remaining, how ever long that is




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Clarifying Possibilities, Negotiating Goals

- What do you understand about your father's condition?
- What do you hope we can accomplish with our medical care?
- I wish for that too....
- Unfortunately, no medicine, surgery or all the love you have for him...




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Listen through the Patient/ Family Ears

- He's "stable"
  - Pt on pressors, vent, dialysis, no changes
- He is getting better
- Do you want us to do CPR?
- She has a chance of surviving if we do CPR
- Do you want to "trach" him?
- He has a chance of coming off the ventilator and going home




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Avoid Language with Unintended Consequences

- Do you want us to do "everything"?
- Despite trying these treatments for several days, and around the clock, expert care, he is unfortunately too sick to respond.
- Will you agree to discontinue care?
- We will change goals of care to respect her wishes.
- It's time we talk about pulling back.
- We will intensify care; his comfort and dignity are our highest priorities.
- I think we should stop aggressive/ heroic therapy.
- Let's discontinue treatments that are not providing benefit.




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Communication Pearls  
Clarifying Hopes and Fears



- What does your illness mean to you?
- What do you hope we can accomplish with our medical care?
- What are your greatest hopes about your health?
- What are your greatest fears?
- How can I help you best today?
- How can I help you and your family cope?




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### Hoping and Preparing



- "Lets hope for the best..."
  - Join in the search for medical options
  - Open exploration of improbable/ experimental therapy
  - Ensure fully informed consent
- "...and prepare for the worst."
  - Make sure affairs (financial/personal) are settled
  - Think about unfinished business
  - Open spiritual and existential issues




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### 8-Step MOLST Protocol



- 6. Use MOLST to guide choices and have patient/family share wishes
  - Shared medical decision-making
  - Conflict resolution
- View stories on [Writing the Final Chapter](#)



\*Developed for NYS MOLST, Bomba, 2005

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### Shared, Informed Medical Decision Making



- Will treatment make a difference?
- Do burdens of treatment outweigh benefits?
- Is there hope of recovery?
  - If so, what will life be like afterward?
- What does the patient value?
  - What is the goal of care?




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### Conflict over Treatment



- Unresolved conflicts lead to misery
  - most can be resolved
- Try to resolve differences
- Support the patient / family
- Base decisions on
  - informed consent, advance care planning, goals of care




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### Moral Distress Is this a case of medical futility?



- Unequivocal cases of medical futility are rare
- Miscommunication common
- Value differences common
- Case resolution more important than definitions




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### What Futility Is



- Hard to define
- Cannot achieve the patient's goal
- Serves no legitimate goal of medical practice
- Ineffective more than 99% of the time
- Does not conform to accepted community standards




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### What Futility is Not



- Things that are impossible, implausible
- Not just description, but operational
- Distinguish from hopelessness
- Not an argument to limit resources




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### Reasons for Conflict Differential Diagnosis of Medical Futility



- Inappropriate surrogate
- Misunderstanding
- Personal factors
- Values conflict




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### Withdrawing Treatments That Are No Longer Beneficial



- Care is never futile.
- Certain treatments, under specific circumstances, may be inappropriate and futile.
- It is legally and ethically appropriate to discontinue medical treatments that are no longer beneficial.
- It is the underlying disease, not the act of withdrawing treatment, which causes death.




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### Withholding vs. Withdrawing Care

- The distinction often is made between not starting treatment and stopping treatment.
- However, no legal or ethical difference exists between withholding and withdrawing a medical treatment in accordance with a patient's wishes.
- If such a distinction existed in the clinical setting, a patient might refuse treatment that could be beneficial out of fear that once started it could not be stopped.




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### 8-Step MOLST Protocol

7. Complete and sign MOLST
8. Review and revise periodically



\*Developed for NYS MOLST, Bomba, 2005




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### Document the Conversation

- Conversations with the patient/resident, Health Care Agent or 'family', as defined by the patient/resident
- Patient/resident capacity assessments
- Evidence of 'clear and convincing' evidence
- Consider using the [MOLST Documentation Form](#)




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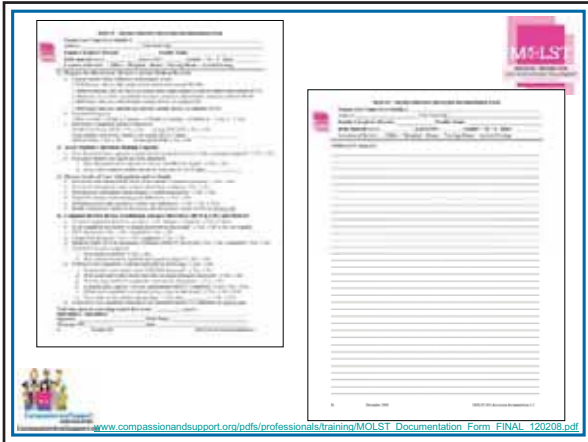
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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life



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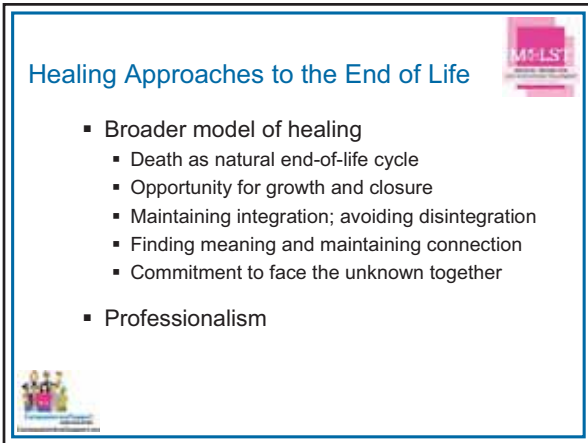
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Healing Approaches to the End of Life

- Broader model of healing
  - Death as natural end-of-life cycle
  - Opportunity for growth and closure
  - Maintaining integration; avoiding disintegration
  - Finding meaning and maintaining connection
  - Commitment to face the unknown together
- Professionalism

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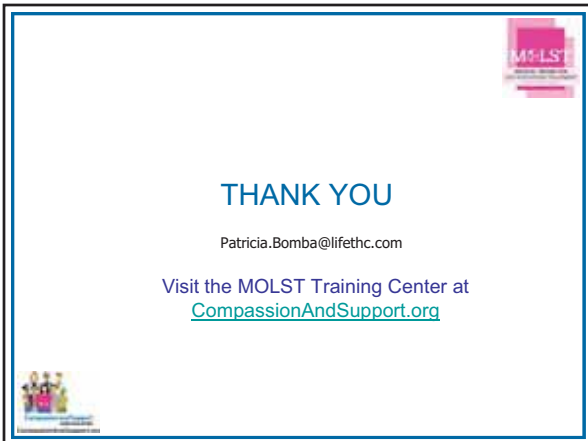
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THANK YOU

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# ***MOLST:***

*Medical Orders for  
Life Sustaining Treatment*



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## *Plenary 3:*

*Medical Decision-Making  
Capacity: Legal, Ethical, and  
Clinical Considerations*

***Patricia Bomba, MD, FACP***  
*Vice President and  
Medical Director, Geriatrics*

***Penny S. Weller, LCSW-R***  
*Program Implementation Manager*

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

## Medical Decision-Making Capacity: Legal, Ethical and Clinical Considerations

Patricia Bomba, M.D., F.A.C.P.  
Vice President and Medical Director, Geriatrics  
Chair, MOLST Statewide Implementation Team  
Leader, Community-wide End-of-life/Palliative Care Initiative  
Chair, National Healthcare Decisions Day New York State Coalition

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## Objectives

- Define capacity and decisional capacity to make health care decisions
- Illustrate how and when to activate traditional advance directives (health care proxy and living will)
- Follow a practical strategy for making decisions re: DNR and other LSTs when patient lacks capacity to make health care decisions, given the confines of NYS PH Law




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## Capacity Determination

- Capacity is the ability to:
  - take in information,
  - understand its meaning and
  - make an informed decision using the information
- Capacity allows us to function independently
- Both medical and legal determination




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### Legal Considerations



- Capacity depends on ability to
  - understand the act or transaction
  - understand the consequences of taking or not taking action
  - understand the consequences of making or not making the transaction
  - understand and weigh choices
  - make a decision and commitment




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### What Constitutes Capacity



- Cluster of mental skills people use in everyday life
  - memory
  - logic
  - ability to calculate
  - "flexibility" to turn attention from 1 task to another
- Capacity assessment
  - complex process
  - not simply the MMSE
  - no standard "tool"




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### Capacity Screening



- How Not To Screen for Capacity
  - ask someone else
  - just have a conversation
  - simply use expressions of a preference
  - apply a cutoff of the MMSE score
  - attribute abnormal answers as a lifestyle choice without evidence
  - disregard individual habits or standards of behavior
  - only use risky behavior as a marker




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### Capacity Assessment



- Elements – what is involved
  - detailed history from client
    - organize time relationships
    - recall facts
    - reason abstractly
    - assess for depression
  - collateral history
  - physical examination
  - cognitive, function and mood screen
  - tests to exclude reversible conditions




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### Capacity Assessment



- MMSE if very low
- Knowledge of risks and benefits
- Psychiatric interview
- Kels test
- Home visit
- Neuropsychiatric testing
- Forensic psychiatric consultation




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### Kohlman Evaluation of Living Skills (KELS)



- Self-care
- Safety and health
- Money management
- Transportation and telephone
- Work and leisure




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Physician Determination of Capacity**  
Advance Care Planning: Specific Tasks

- Capacity is task-specific
- Capacity to choose a health care agent vs. ability to make health care decisions
- Capacity to make medical decisions based on the complexity of the decisions
  - simple health care decisions
  - request for palliation (relief of pain and suffering)
  - complicated decisions regarding DNR and life-sustaining treatment




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**Medical Decision-Making Capacity**  
Physician Determination and Special Circumstances

- Capacity vs. competence
  - physicians assess capacity
  - competence decided by the courts
- Capacity determination by physicians involved in care
- Lack of capacity due to mental illness
  - role for psychiatric consultation
  - not required for dementia
- Lack of capacity due to developmental disability
  - special experience or training in developmental disabilities




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**Challenges**  
Interviewing Patients with Suspected Dementia

- Avoid ageism
- Separation from normal aging memory loss
- Challenge of remembering diagnosis or Rx
- Need to involve family
- Patient/ family may not acknowledge diagnosis




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**Challenges**

**Interviewing Patients with Suspected Dementia**



- Patient may hide or minimize deficits
- Diagnostic interview may seem invasive
  - clearly demonstrate deficits
  - may be confirming biggest fears
- The diagnosis of dementia is “bad news”
  - emotional impact
  - practical impact (live alone; drive, checkbook)




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**Practical Strategies**

**Addressing Patient, Family and Caregivers**



- Meet with the patient, family and key caregivers
- Allow each person to tell their story
- Integrate quantitative cognitive assessments
- Be honest and direct about the diagnosis
- Focus on the patient
- Respond to emotions elicited
- Identify areas of agreement and disagreement




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**Practical Strategies**

**Patient wishes when they lack capacity**



- To be respected and understood as people
- To have their goals and values honored
  - personhood
  - spirituality
  - dignity
- To lessen suffering and enhance quality of life




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Hierarchy of Decision-Makers  
Consent for DNR**

- Patient/Resident with capacity
- Health Care Agent, if patient/resident lacks medical decision-making capacity
- Choose from surrogate list, if patient/resident lacks medical decision-making capacity and has no Health Care Agent
  - Court-appointed committee or guardian
  - Spouse
  - Son or daughter, age 18 or older
  - Parent
  - Brother or sister, age 18 or older
  - Close friend or person, age 18 or older
  - No appropriate surrogate decision-maker available




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**Decision-Makers  
Consent for Life-Sustaining Treatment**

- Patient/Resident with capacity
- Health Care Agent if patient/resident lacks medical decision-making capacity
- Person with clear and convincing evidence
  - Living will
  - Repeated oral expression
- §1750-b Surrogate




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**Decision-Making Methods  
Patient Lacks Capacity**

- Substituted judgment
  - Making decisions as the patient would
  - Using the patients values and statements
  - Health care agent
- Best interests
  - Balancing benefits and burdens
  - Using our values and beliefs
  - If applicable; e.g. §1750-b Surrogate for patient who never had medical decision-making capacity




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Advance Directives**  
Challenges for Patients *with* Capacity

- Complete a health care proxy, if none exist
- Encourage patients / family members to do the same
- Develop goals for care with the patient/resident
- Discuss patient/resident goals for care with family and friends




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**Advance Directives**  
Challenges for Patients *without* Capacity

- Empower the designated health care agent
- If no health care proxy and patient/resident retains decisional capacity to choose a health care agent, complete a health care proxy
- Health care agent uses substituted judgment
- Engage families in the process
- **Always** consider the patient's/resident's goals
- Give both choice and guidance
- Consider quality of life and personhood for patients who cannot speak for themselves




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**Conclusion: Address Difficult Issues**  
While Patient has Capacity

- **Values history**
  - What makes life most worth living?
  - Are there situations when life would not be worth living?
- **Surrogate decision-maker - health care agent**
  - Who do you trust to make decisions if you can't?
  - What values/beliefs do you have to guide them?
- **Specific treatment preferences**
  - Do Not Resuscitate/Allow Natural Death
  - Life-Sustaining Treatment; especially feeding tube




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**MOLST**  
“Clear and Convincing” evidence



- MOLST is completed in consultation with a physician when the patient’s life expectancy is less than a year.
- Provides **better** proof that the patient holds a firm and settled commitment to the termination of life supports under the circumstances that actually exist when the decision whether to terminate life-sustaining treatment must be made.




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**Summary**



- Many patients face cognitive impairment late in life
- Patients and families become the focus of care
- Knowing what a patient would want is imprecise
- Quality-of-life concerns **must** be addressed
- A consensus-based process based on what is known about the patient’s values and wishes as interpreted by the family is the best approach
- Use available medical evidence
- Many challenging decisions will be needed over time, so the commitment not to abandon is critical




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**THANK YOU**

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# ***MOLST:***

*Medical Orders for  
Life Sustaining Treatment*



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## *Plenary 4:*

*Documentation of  
Conversation and Completion  
of the MOLST*

***Patricia Bomba, MD, FACP***  
*Vice President and  
Medical Director, Geriatrics*

***Penny S. Weller, LCSW-R***  
*Program Implementation Manager*

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Documentation of the Conversation and Completion of the MOLST

The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

## Documentation of the Conversation and Completion of the MOLST

Patricia Bomba, M.D., F.A.C.P.  
Vice President and Medical Director, Geriatrics  
Chair, MOLST Statewide Implementation Team  
Leader, Community-wide End-of-life/Palliative Care Initiative  
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## Objectives

- Review documentation of a thoughtful advance care planning conversation and the MOLST Program
- Summarize how to fill out the MOLST form
- Describe when and why to complete a Supplemental Documentation Form for Adults and Minors
- Discuss how and why to review and renew a MOLST form




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## 8-Step Protocol

1. Prepare for discussion
  - Understand the patient and family
  - Understand the patient's condition and prognosis
  - Retrieve completed Advance Care Directives
  - Determine "Agent" (Spokesperson) or responsible party
2. Determine what the patient and family know
  - re: condition, prognosis
3. Explore goals, hopes and expectations
4. Suggest realistic goals
5. Respond empathetically
6. Use MOLST to guide choices and have patient/family share wishes
  - Shared medical decision-making
  - Conflict resolution
7. **Complete and sign MOLST**
8. Review and revise periodically

Developed for NYS MOLST, Bomba, 2005




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Created by Patricia Bomba M.D., F.A.C.P. for the community-wide implementation of the MOLST Program

[www.CompassionAndSupport.org](http://www.CompassionAndSupport.org)

September 2009



### Document the Conversation

- Conversations with the patient/resident, Health Care Agent or 'family', as defined by the patient/resident
- Physician determination of the patient's/resident's medical decision-making capacity
- Evidence of 'clear and convincing' evidence
- Consider using the [MOLST Documentation Form](#)




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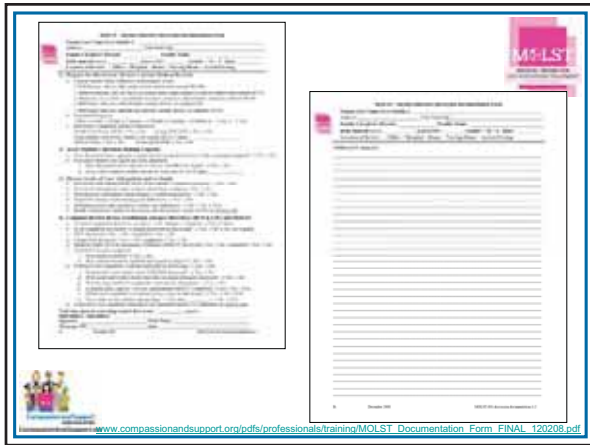
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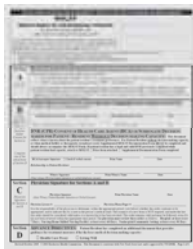
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### MOLST



- Page 1: **DNR**
- Complete Section A, B, C for DNR
  - Section D: Advance Directives
- Page 2: **Life-Sustaining Treatment**
- Page 3 and 4: **Renew/Review**
- Supplemental Documentation  
Forms for DNR: Adult and Minor

[CompassionAndSupport.org](http://CompassionAndSupport.org)




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**How to Complete a MOLST:  
Assess Capacity**



- Assess capacity to make complicated decisions regarding DNR and Life-Sustaining Treatment
- Assess ability to choose health care agent
  - If patient/resident lacks capacity to make complicated decisions regarding DNR and life-sustaining treatment, patient/resident may retain capacity to choose health care agent
  - If patient/resident retains capacity to choose health care agent, complete Health Care Proxy




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**Supplemental Documentation Forms for  
DNR: Adult and Minor**



- **NYS PHL requires documentation**
  - Physician determination of lack of medical decision-making capacity
  - Physician determination that cardiopulmonary resuscitation would not be clinically advisable
- **Exceptional Circumstances – Follow Mandatory Requirements**
  - Therapeutic Exception
  - Medical Futility and No Surrogate
  - Residents in, or transferred from OMH and OMRDD Facilities
  - Residents in, or transferred from Correctional Facilities




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**How to Complete a MOLST  
Consent for DNR**



- Consent for DNR must be obtained and documented in Section B of page 1
  - Patient/Resident with capacity
  - Health Care Agent, if patient/resident lacks medical decision-making capacity
  - Choose from surrogate list, if patient/resident lacks medical decision-making capacity and has no Health Care Agent
    - Court-appointed committee or guardian
    - Spouse
    - Son or daughter, age 18 or older
    - Parent
    - Brother or sister, age 18 or older
    - Close friend or person, age 18 or older
    - No appropriate surrogate decision-maker available




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### How to Complete a MOLST Consent for Life-Sustaining Treatment



- Consent for Life-Sustaining Treatment must be obtained and documented in Section E
  - Patient/Resident with capacity
  - Health Care Agent if patient/resident lacks medical decision-making capacity
  - Person with clear and convincing evidence
    - Living will
    - Repeated oral expression
  - §1750-b Surrogate




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### Who Can Complete a MOLST



- Must be completed by a health care professional, based on patient preferences
- Must be signed by a NYS licensed physician or a border state physician to be valid
  - Patient regularly receives care from a physician from Vermont, Pennsylvania, New Jersey, Connecticut or Massachusetts
- Verbal orders are acceptable with follow-up signature by a physician, in accordance with facility/community policy




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### How to Complete a MOLST



- Completion of the entire form is strongly recommended
  - Any section not completed implies full treatment
- The original form should remain in the patient's possession
  - Readily identifiable pink color easier to locate in emergency
- Photocopies and faxes of signed MOLST forms are legal and valid




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**What to Do with a Completed MOLST:  
MOLST Form Location**



- In the home
  - Front of refrigerator, by the phone in the kitchen
  - Individual's bedside table
  - Kept with patient between care settings
  
- Health care setting
  - Front of Medical Chart
  - Hospital and LTC facility
  - Kept with patient between care settings




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**What to Do at Time of Care Transition**



- In the home
  - EMS personnel are trained to look for MOLST
  - MOLST should accompany patient at time of transfer
  
- Health care setting
  - Make copy of the MOLST to keep in the medical chart
  - Original should accompany patient at time of transfer
  - Original should be placed in front of the patient's chart at new care setting




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**When Should Physician  
Review and Renew MOLST**



- Periodically
- If patient's/resident's preferences change
- If patient's/resident's health status changes
- If patient/resident is transferred to another care setting




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### Why Should Physician Review and Renew MOLST



- Public Health Law requires the physician to review DNR orders
  - Hospital: at least every 7 days
  - Nursing home/SNF: at least every 60 days
  - Community setting: at least every 90 days
- Life-Sustaining Treatment orders
  - Patient's/resident's medical condition, prognosis and goals for his/her care may change over time
  - Physician should review these orders at the same time as DNR/Allow Natural Death orders are reviewed




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### MOLST FAQs



- Compiled from MOLST use by early adopters
- Revisions Under Development with NYS DOH, OMRDD, and OMH: Sept. 2009
- FAQs on-line at the NYSDOH Web site
- [FAQs](#) on-line at the MOLST Training Center at [CompassionAndSupport.org](http://CompassionAndSupport.org)
- [EMS FAQs](#) on-line
- If question not found in FAQs, [Contact Us](#)




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THANK YOU

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# ***MOLST:***

## *Medical Orders for Life Sustaining Treatment*



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## *Plenary 5: The Critical Role of EMS*

***Patricia Bomba, MD, FACP***  
*Vice President and  
Medical Director, Geriatrics*

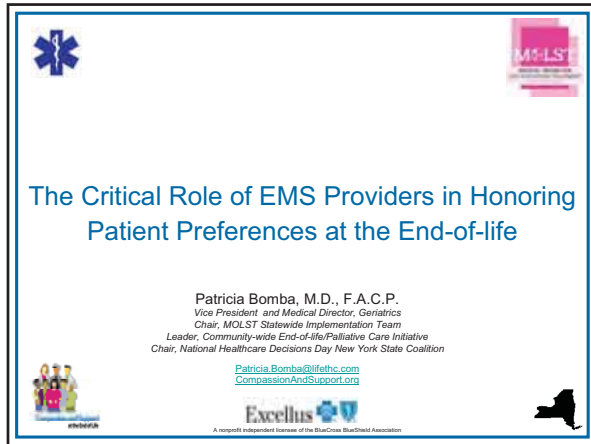
***Penny S. Weller, LCSW-R***  
*Program Implementation Manager*

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The Critical Role of EMS Providers in Honoring Patient Preferences at the End-of-life

The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life



**The Critical Role of EMS Providers in Honoring Patient Preferences at the End-of-life**

Patricia Bomba, M.D., F.A.C.P.  
Vice President and Medical Director, Geriatrics  
Chair, MOLST Statewide Implementation Team  
Leader, Community-wide End-of-life/Palliative Care Initiative  
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[CompassionAndSupport.org](http://CompassionAndSupport.org)

**Excellus**  
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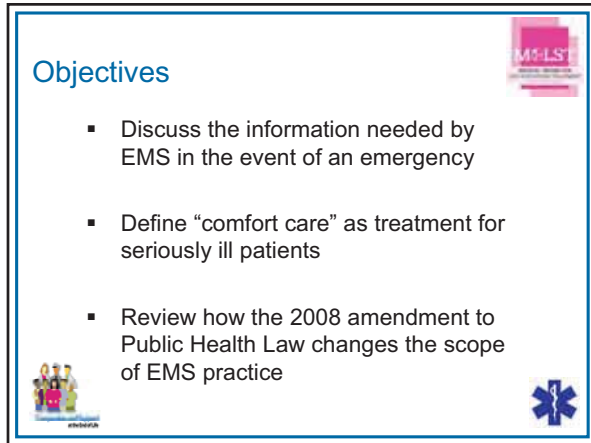
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**Objectives**

- Discuss the information needed by EMS in the event of an emergency
- Define “comfort care” as treatment for seriously ill patients
- Review how the 2008 amendment to Public Health Law changes the scope of EMS practice

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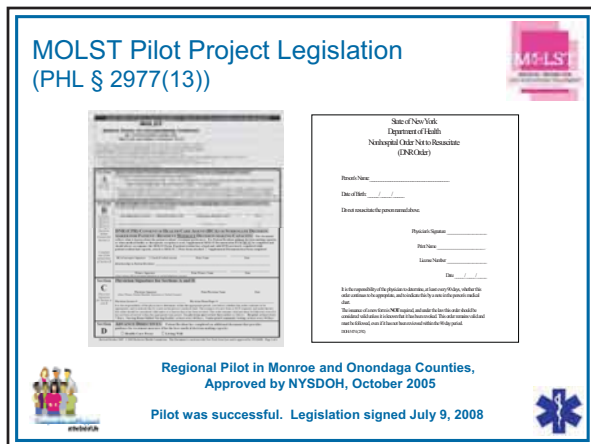
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**MOLST Pilot Project Legislation (PHL § 2977(13))**

Regional Pilot in Monroe and Onondaga Counties,  
Approved by NYSDOH, October 2005

Pilot was successful. Legislation signed July 9, 2008

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**EMS MOLST Community Pilot**

- Successful MOLST pilot
  - no untoward consequences
  - no major issues with MOLST
  - positive attributes and benefits outweigh any potential risks
  - MOLST is well-recognized
  - trained professionals can read it and understand its intent


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**EMS and MOLST Today**

- Gov Paterson signed bill 7/8/08
  - MOLST permanent and statewide
  - MOLST consistent with PHL§2977(3)
- Legislation is effective immediately with passage of the bill


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**EMS and MOLST Today**

- Permanent change in EMS scope of practice
- MOLST can be used in the community as DNR and DNI throughout New York State


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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

EMS Agency MOLST Implementation Steps

- Create a multi-disciplinary team
- Advise REMAC and Regional Council
- REMAC and REMSCO approve implementation
- Use protocol that includes Medical Control
- EMS Training is key component to success
- Incorporate Quality Assurance programs
- Train medical control physicians
- Include EMS Regions, if possible, to limit confusion
- Utilize [EMS MOLST Training](#)
- Use MOLST Training Center for EMS MOLST Implementation Steps, EMS Education and EMS Quality Assurance Work Plans
- Create a "contact list" of people who have implemented MOLST and can help; view [Find MOLST Trainers](#) at [CompassionAndSupport.org](#)




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EMS Agency MOLST Implementation Process

- Review and make necessary revisions to any existing policies or protocols regarding advanced directives
- Create internal MOLST experts through materials available at [CompassionAndSupport.org](#) and regional protocols




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EMS Agency MOLST Implementation Process

- Periodically review MOLST material with EMS staff to ensure continued success
- Develop Quality Improvement Plan regarding MOLST utilization




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life



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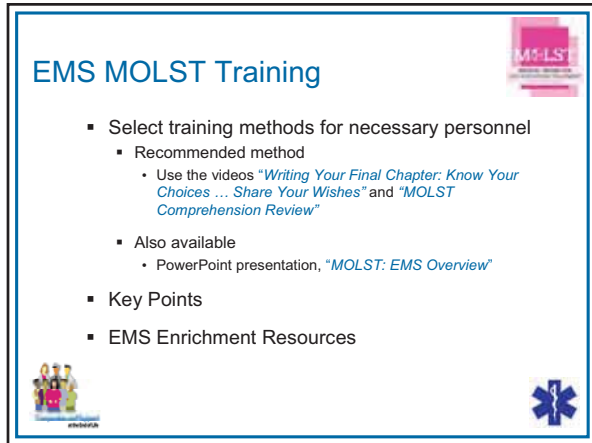
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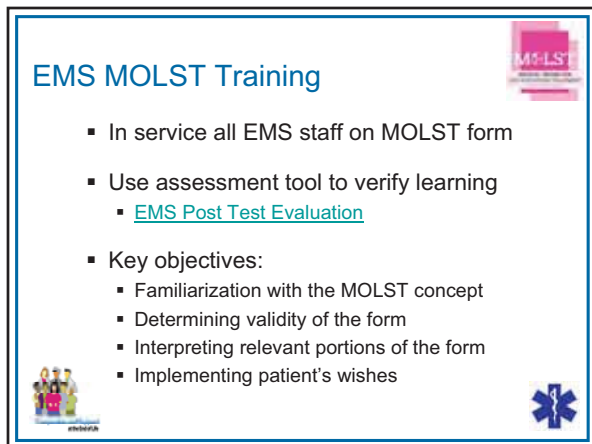
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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Key MOLST Points for EMS

- MOLST is distributed as a **BRIGHT PINK**, cardstock, multi-page form, but it can be photocopied and faxed
- It has the same legal effect as a NYS non-hospital Do Not Resuscitate (DNR) form and must be honored
- NYS non-hospital DNR form is still valid
- The MOLST form is valid throughout the State. It is no longer a community pilot project
- MOLST may provide orders limiting or preventing ALS care (including orders preventing intubation or the use of an IV to assist resuscitation)
- MOLST also includes information to be used in other health care settings such as the hospital (i.e. placement of feeding tubes, etc)




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### Key MOLST Points for EMS

- Ask to see the MOLST form when responding to a cardiac or respiratory arrest call
- Add "D" to the SAMPLE acronym
  - S - Signs and Symptoms
  - A - Allergies
  - M - Medication(s)
  - P - Pertinent past medical history
  - L - Last oral intake
  - E - Events leading up to contacting 911
  - D - Do you have advance directives (i.e. health care proxy and living will) and medical orders (i.e. non-hospital DNR or MOLST)?




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### Biggest Issue: Comfort Care

- "Do Nothing" . . . . .EMS and first responders are always rushing to save lives and improve outcomes . . . We are action oriented. This process, even with proper training will be a difficult adjustment for many.
- Recognizing importance of comfort measures...oxygen, suction, manual treatment of airway obstruction... as "Doing something".




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The Critical Role of EMS Providers in Honoring Patient Preferences at the End-of-life

The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Does the MOLST carry more weight in a non-hospital emergency situation than the Health Care Proxy or Living Will?

- **Absolutely.** The Health Care Proxy and the MOLST form are different documents used for different purposes based on the patient's condition and circumstances.
- MOLST contains actionable medical orders for seriously ill patients near the end of life that are followed by EMS personnel in the pre-hospital setting. Medical orders carry more weight in a non-hospital emergency situation, as medical orders are precise and can be easily interpreted in an emergency.
- If EMS personnel are presented with a MOLST form, they must honor it. If someone presents them with a health care proxy form and claims to be the health care agent, EMS personnel should follow the MOLST form. The health care proxy form is a legal document – not a medical order.


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

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Why can't EMS personnel rely on the Health Care Proxy in a non-hospital emergency situation?

- Authority of a health care agent to make decisions
  - Begins only after a physician has determined that the patient lacks capacity.
  - Health care agent must consult with qualified professionals to ensure informed decision-making.
- In an out-of-hospital emergency situation, it would be unusual for
  - Physician to be present to make the capacity decision
  - Health Care Agent to be present
  - Licensed professionals to be present to provide advice to the agent to assure informed decision-making.
- Therefore, it is very unlikely that an agent will be authorized to make immediate resuscitation decisions in an emergency.
- In the absence of a written DNR order or bracelet,
  - Pre-hospital personnel should follow their normal treatment protocols (i.e. treat and transport) when a proxy is presented or an agent is present for the same reasons noted above.
  - The destination hospital should be notified of the existence of the proxy, and it should be brought with the patient.
  - The agent should be advised of the hospital to which the patient will be taken, and the agent should be advised that emergency department personnel can determine if the proxy is valid, make capacity decisions and provide advice to the agent.


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Case Scenario #1 \*

- 911 Called for Non-responsive Cancer Patient
- Arrive on Scene - Spouse Searching for DNR
- Care Begins Against Spouse Wishes
- Unresponsive - low BP, Low Respiration's and Poor O2 Sat.

\* Based on actual field case


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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Case Scenario #1 \*



- Oxygen, Assisted Respiration, IV - with BG Check
- BG below 40
- Still No DNR
- Chair Incident as Dextrose Given
- Patient Becomes AOx3
- Patient Witness Spouse Behavior



\* Based on actual field case

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Case Scenario #1 \*



- DNR does not equal Do Not Treat



\* Based on actual field case

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Case Scenario # 2 \*



- 73 Y/O Male Come in From Barn Chores . . .
- 911 Called - Phone Cord Won't Reach
- BLS First Response With ALS From Nearby Town
- The Works - Defib - IV - ET Meds . . .
- The Question What Hospital?????



\* Based on actual field case

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Case Scenario # 2



- The Answer . . . .
- The Phone Call . . .
- Medical Control . . . .
- The END . . . .
- The Funeral Director and The Clergy
- The Wife . . . And



\* Based on actual field case

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Case Scenario # 2



- The Patient - Got His Wish Only Because
- The Family Knew the System . . . Impossible Otherwise
- The Right Thing
- The Honorable Thing
- View story on [Writing the Final Chapter](#)



\* Based on actual field case

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THANK YOU

Patricia.Bomba@lifethc.com

Visit the MOLST Training Center at  
[www.CompassionAndSupport.org](http://www.CompassionAndSupport.org)




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# ***MOLST:***

## *Medical Orders for Life Sustaining Treatment*



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## *Plenary 6: The Confines of NYS Law*


***Patricia Bomba, MD, FACP***  
*Vice President and  
Medical Director, Geriatrics*

***Penny S. Weller, LCSW-R***  
*Program Implementation Manager*

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life



## The Confines of New York State Public Health Law

Patricia Bomba, M.D., F.A.C.P.  
Vice President and Medical Director, Geriatrics  
Chair, MOLST Statewide Implementation Team  
Leader, Community-wide End-of-life/Palliative Care Initiative  
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[CompassionAndSupport.org](http://CompassionAndSupport.org)


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## Objectives

- Identify traditional advance directives used in NYS, the legal roles and responsibilities of the Health Care Agent identified in the Health Care Proxy and the physician's responsibility
- Review New York State Public Health Law regarding Nonhospital DNR Law (PHL § 2977) before and after initiation of the MOLST Program
- Describe the legislation enacted to launch the Monroe and Onondaga Counties MOLST Community Pilot and results of the community pilot
- Explain informed consent process and illustrate how the MOLST represents "clear and convincing evidence."




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## Advance Directives

<p><b>Traditional ADs</b></p> <p><u>For All Adults</u> Community Conversations on Compassionate Care (CCCC)</p> <ul style="list-style-type: none"> <li>▪ New York           <ul style="list-style-type: none"> <li>▪ Health Care Proxy</li> <li>▪ Living Will</li> </ul> </li> <li>▪ Organ Donation</li> <li>▪ State-specific forms</li> </ul> <p><a href="http://CompassionAndSupport.org">CompassionAndSupport.org</a> <a href="http://CaringInfo.org">CaringInfo.org</a></p>	<p><b>Actionable Medical Orders</b></p> <p><u>For Those Who Are Seriously Ill or Near the End of Their Lives</u> Medical Orders for Life-Sustaining Treatment (MOLST) Program</p> <ul style="list-style-type: none"> <li>▪ Do Not Resuscitate (DNR) Order</li> <li>▪ Medical Orders for Life Sustaining Treatment (MOLST)</li> <li>▪ Physician Orders for Life Sustaining Treatment (POLST) Paradigm</li> </ul> <p><a href="http://CompassionAndSupport.org">CompassionAndSupport.org</a> <a href="http://POLST.org">POLST.org</a></p>
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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Health Care Proxy



- Formally designated person (Health Care Agent) makes decisions on behalf of individual if person lacks capacity to make health care decisions
- Agent's responsibility: make decisions based on
  - patient's/resident's known values and beliefs
  - substituted judgment
- Agent empowered to represent individual and make all medical decisions
  - NY- legal restrictions apply to feeding tube decisions
- Signed, dated and two witnesses




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### Health Care Proxy



- Authority of Agent is triggered by loss of capacity
- Agent stands in shoes of patient
- Agent is presumed to know patient/resident wishes (no need for evidence of knowledge)
- Written instructions, separate or included, serve as guidance for Agent
- Agent must act in accordance with patient wishes
- Decision about nutrition and hydration based upon "reasonable knowledge" of patient wishes




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### Artificial Hydration and Nutrition



- Level of Evidence of the Patient's Preferences Needed to Forego Artificial Hydration and Nutrition
  - Health Care Agent
    - "reasonable" evidence
  - Other Surrogate Decision-Maker
    - "clear and convincing" evidence




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Living Will

- Statement of values, beliefs, and goals for care
- Made while capacity intact to guide treatment if decisional capacity lost
- Deals with "incurable" or "irreversible" mental or physical condition with no reasonable expectation of recovery
- May include circumstances (terminal illness, dementia, PVS) as well as specific treatments
- **Very hard to predict the future**
- **Often difficult to define "incurable" or "irreversible" and thus ambiguous in clinical situations**




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### Organ Donation

- Permission to donate organs
  - in setting of irreversible brain damage
  - in the setting of treatment withdrawal if it results in death
- Can specify which organs are permissible
- [New York State Donate Life Registry](#)
  - registered intent to be an organ donor




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### Shared, Informed Medical Decision Making

- Will treatment make a difference?
- Do burdens of treatment outweigh benefits?
- Is there hope of recovery?
  - If so, what will life be like afterward?
- What does the patient value?
  - What is the goal of care?




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**MOLST**  
“Clear and Convincing” evidence

- MOLST is completed in consultation with a physician when the patient’s life expectancy is less than a year.
- Provides better proof that the patient holds a firm and settled commitment to the termination of life supports under the circumstances that actually exist when the decision whether to terminate life-sustaining treatment must be made.


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**MOLST**



- Page 1: **DNR**
  - Complete Section A, B, C for DNR
  - Section D: Advance Directives
- Page 2: **Life-Sustaining Treatment**
- Page 3 and 4: **Renew/Review**
- Supplemental Documentation  
Forms for DNR: Adult and Minor

[CompassionAndSupport.org](http://CompassionAndSupport.org)


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**Nonhospital DNR Law before MOLST**  
(PHL § 2977)

- Nonhospital DNR – Must be on “standard form” issued by the Department of Health (by contrast, hospital-based DNR order can be on any form)
- “Standard form” – one page form with little detail beyond instruction not to resuscitate
- Nonhospital DNR – Can be honored ONLY if patient is in FULL cardiopulmonary arrest
- If patient is NOT in full cardiac or respiratory arrest, FULL treatment must be provided
- DNI was NOT covered in nonhospital DNR law


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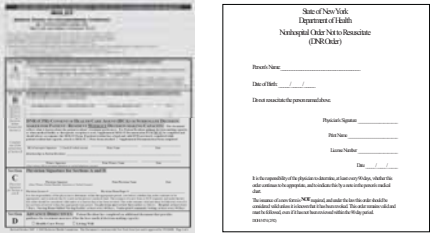
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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**MOLST Pilot Project Legislation (PHL § 2977(13))**



**Regional Pilot in Monroe and Onondaga Counties, Approved by NYSDOH, October 2005**

**Pilot was successful. Legislation signed July 9, 2008**

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**MOLST Community Pilot Project**

- NYSDOH approved use of the MOLST form in health care facilities across New York State in October 2005
- Use of the MOLST form and program in the community required legislation
  - initially established as a community pilot program in Monroe and Onondaga Counties on October 11, 2005
  - original legislation allowed for the use of the MOLST form in lieu of the NYS Nonhospital Do Not Resuscitate (DNR) form
  - Community Pilot was officially launched on May 1, 2006
- Amendment to the law permitted EMS to honor Do Not Intubate (DNI) instructions prior to full cardiopulmonary arrest
  - only in Monroe and Onondaga Counties
  - took effect on July 26, 2006
  - authorized a carve-out for persons with developmental disabilities *without capacity*
  - individuals with developmental disabilities *with capacity* can complete a MOLST form

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**EMS and MOLST Today**

- Successful MOLST Community Pilot
  - no untoward consequences
  - no major issues with MOLST
  - positive attributes and benefits outweigh any potential risks
  - MOLST is well-recognized
  - trained professionals can read it and understand its intent
- Gov Paterson signed bill 7/8/08
  - MOLST permanent and statewide, effective immediately
  - MOLST consistent with PHL§2977(3)
- Permanent change in EMS scope of practice
  - MOLST can be used in the community as DNR and DNI throughout New York State

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Legal Issues: MOLST Today

- Consistent with New York State Law
- Approved by NYSDOH for use in ALL settings, including the community throughout New York State
- MOLST provides “clear and convincing evidence” of a patient’s wishes regarding life-sustaining treatment.
- Persons with developmental disability need to complete a NYSDOH Non-Hospital DNR form in the community




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Health Care Decisions Act for  
Persons with Mental Retardation

- Allows a guardian of a mentally retarded person to make end-of-life health care decisions
- Patient with MR with capacity can complete MOLST form
- Physician should consult legal counsel for MR patients without capacity. See Surrogate’s Court Procedure Act § 1750-b.




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Health Care Decisions Act for  
Persons with Developmental Disabilities

- Allows a guardian of a developmentally disabled person, who are also mentally retarded or unable to make health care decisions, to make end-of-life health care decisions
- Patient with DD with capacity can complete MOLST form
- Physician should consult legal counsel for DD patients without capacity. See Surrogate’s Court Procedure Act §§ 1750-a, 1750-b.




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

“Clear and Convincing Evidence”

- People have a constitutional right not to receive treatments they do not want.
- Providers are obligated to provide patients with life-sustaining treatment unless they have “clear and convincing evidence”




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Matter of O'Connor (72NY2d 517)

- 1988 New York State Court of Appeals case
- Provided definition of “clear and convincing evidence” of an incompetent patient’s desire to terminate artificial life supports.
- Requires proof that the patient held a firm and settled commitment to the termination of life supports under circumstances presented.
- Court endorsed Living Will or repeated oral expression as evidence of “clear and convincing evidence.”



In the Matter of Westchester County Medical Center, on behalf of Mary O'Connor, p8




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MOLST Annual Review

- The MOLST form is reviewed annually and will be modified as needed to conform to revision, if any, in New York State law.
- Up-to-date information and an array of web-based tools are located in the MOLST Training Center at [CompassionAndSupport.org](http://CompassionAndSupport.org).




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Advance Care Planning Needs Assessment  
Existing NYS Law



- New York State does not explicitly recognize the authority of family members to consent to treatment for adult patients unable to decide for themselves
- Health care professionals routinely turn to family members for consent
- Family members or others cannot decide about life-sustaining treatment except for individuals who have signed a Health Care Proxy, aside from DNR vs. CPR
- In NYS, in the absence of a Health Care Proxy, we must have "clear and convincing evidence"
- Advocate for Family Health Care Decisions Act



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THANK YOU

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Visit the MOLST Training Center at  
[CompassionAndSupport.org](http://CompassionAndSupport.org)



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# ***MOLST:***

*Medical Orders for  
Life Sustaining Treatment*



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*Plenary 7:*

*Myths and Truths of CPR:  
Conversations Based on  
Evidence*

***Patricia Bomba, MD, FACP***  
*Vice President and  
Medical Director, Geriatrics*

***Penny S. Weller, LCSW-R***  
*Program Implementation Manager*

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*Myths and Truths of CPR: Conversations Based on Evidence*

*The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life*

## Myths and Truths of CPR: Conversations Based on Evidence

Patricia Bomba, M.D., F.A.C.P.  
Vice President and Medical Director, Geriatrics  
Chair, MOLST Statewide Implementation Team  
Leader, Community-wide End-of-life/Palliative Care Initiative  
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## Objectives

- Describe the purpose of cardiopulmonary resuscitation
- Recognize the lack of improvement in survival rates after in-hospital CPR despite steady increase in application of technology and techniques
- Identify the effect of age and other risk factors as outcome predictors for patients who experience cardiac arrest in various settings




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## Cardiopulmonary Resuscitation

- The purpose of cardiopulmonary resuscitation is the prevention of sudden, unexpected death.
- Cardiopulmonary resuscitation is not indicated in . . .cases of terminal irreversible illness where death is expected or where prolonged cardiac arrest dictates the futility of resuscitation efforts.

JAMA1974; 227(7) Standards for CPR and ECC




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*Created by Patricia Bomba M.D., F.A.C.P. for the community-wide implementation of the MOLST Program*

*www.CompassionAndSupport.org*

*September 2009*



**Cardiopulmonary Resuscitation**

- For many people the last beat of their heart should be the last beat of their heart.
- These people simply have reached the end of their life. A disease process reaches the end of its clinical course and a human life stops.

ACLS Provider Manual, American Heart Association, 2001

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**Cardiopulmonary Resuscitation**

- In these circumstances resuscitation is unwanted, unneeded and impossible. If started, resuscitative efforts for those people are inappropriate, futile and undignified.
- They are demeaning to both the patient and rescuers.

ACLS Provider Manual, American Heart Association, 2001

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**Cardiopulmonary Resuscitation**

- Good ACLS requires careful thought about when to stop resuscitative efforts and- even more important- when not to start.

ACLS Provider Manual, American Heart Association, 2001

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### Cardiopulmonary Resuscitation



- Without oxygen, the human brain begins to suffer irreversible brain damage after about 5 minutes. The heart loses the ability to maintain a normal rhythm.
- Current standards reflect a more conservative view of the success of potential bystander CPR and stress the importance of rapid defibrillation.



Standards, American Heart Association, 2000

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### CPR: In-hospital



- 1960-introduction of closed cardiac massage
- Steady increase in application of technology and techniques
- However, no improvement in hospital survival rates of CPR in the past 40 years



Anesthesiology 2003; 99(2): 248-50  
CMAJ 2002;167(4):343-8

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### CPR: In-hospital Arrests



- Physicians overestimate the likelihood of survival to hospital discharge
- Literature
  - survival 6.5%-32% - average 15%
- At least 44% of survivors have significant decline in functional status



Arch Intern Med 1993; 153:1999-2003  
Arch Intern Med 2000; 160:1969-1973

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### CPR Good Outcomes: In-hospital

- Improved survival rates with good functional recovery
  - duration of CPR shorter than 5 minutes
  - CPR in the ICU



Mayo Clin Proc 2004; 79(11):1391-1395

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### CPR Poor Outcomes: All sites

- Unwitnessed Arrest
- Asystole
- Electrical-Mechanical Dissociation
- >15 minutes resuscitation
- Metastatic Cancer
- Multiple Chronic Diseases
- Sepsis




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### CPR and Elderly

- 22% may survive initial resuscitation
- 10-17% may survive to discharge, most with impaired function
- Chronic illness, more than age, determines prognosis (<5% survival)



Annals Int Med 1989; 111:199-205  
JAMA 1990; 264:2109-2110  
EPEC Project RWJ Foundation, 1999

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### CPR Outcomes: LTC



- Prospective cohort study reviewing EMS system characteristics and outcomes between nursing home (NH) and out-of-hospital cardiac arrest (OHCA)
- July 1989 to December 1993
- Variables
  - age, witnessed arrest, response intervals, AED use and arrest rhythms
- Outcomes
  - hospital admission and discharge



Prehosp Emerg Care 1997 Apr-June;1(2):120-2

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### CPR Outcomes: LTC



- 2,348 arrests: 182 at NH; 2,166 at home
- NH patients
  - more likely to receive CPR on collapse
  - older (73.1 vs. 67.5 years p<0.001)
  - less likely AED use (9.9% vs 30.0%, p<0.001)
  - more likely bradysystolic (74.7% vs 51.5%)
  - less likely to survive to hospital admission (10.4% vs 18.5%, p<0.006)
  - less likely to survive to discharge (0.0% vs 5.6%, p<0.001)



Prehosp Emerg Care 1997 Apr-June;1(2):120-2

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### CPR Outcomes



- |  |        |
|--|--------|
| 1. Average rate of success (overall)   | 15%    |
| 2. Ventricular fibrillation after myocardial infarction  | 26-46% |
| 3. Drug reaction or overdose   | 22-28% |
| 4. Acute stroke  | 0-3%   |
| 5. Bedfast patients with metastatic cancer who are spending fifty percent of their time in bed | 0-3%   |
| 6. End stage liver disease   | 0-3%   |




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**CPR Outcomes**

7. Dementia requiring long-term care	0-3%
8. Coma (traumatic or non-traumatic)	0-3%
9. Multiple (2 or more) organ system failure with no improvement after 3 consecutive days in the ICU	0-3%
10. Unsuccessful out-of-hospital CPR	0-3%
11. Acute and chronic renal failure	0-10%
12. Elderly patients	Same as general population
13. Chronically ill elderly	0-5%




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**Physician determination:  
CPR would not be clinically advisable <sup>ii</sup>**

- Poor chance CPR will be successful (no medical benefit) <sup>i</sup>
- Poor outcome expected following CPR <sup>i</sup>
- Poor quality of life currently, according to the patient/surrogate <sup>i</sup>
- "CPR would be unsuccessful in restoring cardiac and respiratory function; or the patient/resident would experience repeated arrests in a short time period before death occurs." <sup>ii</sup>

<sup>i</sup> Tomlinson N Engl J Med, 1988  
<sup>ii</sup> NYS Public Health Law




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**Patient Treatment Preferences Based on Burden of Treatment, Outcome**

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graph TD
    A[Low Burden, Return to Current Health] --> B[Wants RX 98.7%]
    A --> C[No RX 1.3%]
    B --> D[High Burden Return to Current Health]
    B --> E[Low Burden Severe fxnl impairment]
    B --> F[Low Burden Severe CNS impairment]
    D --> D1[RX 88.8%]
    D --> D2[No RX 11.2%]
    E --> E1[RX 25.6%]
    E --> E2[no RX 74.4%]
    F --> F1[RX 11.2%]
    F --> F2[no RX 88.8%]
  
```

Fried TR, et al. NEJM, 2002




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**Patient Treatment Preferences Based on Public Perceptions**

- 67% of resuscitations are successful on TV
- Educating patients
  - 371 patients, age >60yrs
  - 41% wanted CPR
  - after learning the probability of survival only 22% wanted CPR





NEJM 1996; 334:1578-1582  
NEJM 1994; 330:545-549  
Acad Emer Med 2000; 7(1):48-53

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**MD-Patient DNR Discussions**

- In conversations with patients, physicians speak 75% of the time and use medical jargon
- After discussions
  - 66% did not know that many patients need mechanical ventilation after resuscitation
  - 37% thought ventilated patients could talk
  - 20% thought ventilators were O2 tanks





JGIM 1995; 10:436-442  
JGIM 1998; 13:447-454

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**CPR: Functional Health Illiteracy**

- Effect of a multimedia educational intervention on knowledge base and resuscitation preferences among lay public
  - 8-minute video
  - median estimates of predicted postcardiac arrest survival rate:
    - 50% before and 16% after video
  - series of hypothetical scenarios:
    - significantly more participants indicated that they would refuse CPR in scenarios involving terminal illness post video





Ann Emerg Med 2003; 42(2): 256-60

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### Physician Barriers to DNR Discussion

- Personal discomfort with confronting mortality
- Fear of damaging the doctor-patient relationship
- Fear of harming the patient by raising the topic of death
- Limited time to establish trust
- Difficulty in managing complex family dynamics



CMAJ 2000; 163(10)

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### Language Issues

- How we talk about DNR orders is important
  - “The message behind the term ‘do not resuscitate’ is predominantly negative, suggesting an absence of treatment and care. The reality is that comfort care and palliative care are affirmative and, for these patients, more appropriate interventions”.



Charlie Sabatino, American Bar Association Commission on Law and Aging

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### Language Issues

- “Do Not Resuscitate” means “Allow Natural Death”
- “Do Not Resuscitate” does **NOT** mean “Do Not Treat”



Bomba, NYS MOLST

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Discussing DNR



- A 53 year old woman is admitted to the hospital because of lower extremity swelling and pain. She has a history of breast cancer, metastatic to bone and liver. She has been treated with several different courses of combination chemotherapy.
- There is no record of existing advance directives or evidence of any discussion about advance care planning in the medical record.
- The diagnostic workup reveals an extensive DVT.



J Clin Onc. 2001; 19(5) pp 1576-1581

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### DNR Discussion: Scenario 1



*A resident physician, looking preoccupied, enters the room.*

- **MD:** Mrs. B, according to hospital rules, I need to discuss your code status with you. Do you wish to be a full code or a no code?
- **Mrs. B:** (looking pensive) Oooh, I don't know...I've never thought about this before...I don't want to die. I still have relatively young children.
- **MD:** So you want to be a full code?
- **Mrs. B:** Yes, I guess so...
- **MD:** OK



*The physician leaves the room.*

J Clin Onc. 2001; 19(5) pp 1576-1581

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### DNR Discussion: Scenario 2



*A resident physician, looking uneasy, enters the room.*

- **MD:** Mrs. B, umm, uhhh, if anything were to happen, do you want us to do everything?
- **Mrs. B:** (tentatively, after a pause) I don't understand.
- **MD:** (speaking quickly) Well, if your heart and lungs were to stop, would you want us to use shocks to start your heart and put you on a breathing machine?
- **Mrs. B:** Yes, I guess so...



J Clin Onc. 2001; 19(5) pp 1576-1581

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program: A Community Approach to Improving Care at the End-of-life

DNR Discussion: Scenario 2

MD: (with increased volume and forcefulness) You mean you want us to jump up and down and break your ribs and put in a big plastic tube down your throat and do a lot of aggressive and invasive measures only to die in the intensive care unit?!

Mrs. B: (meekly and seeming a bit frightened) Oh, I guess not.

MD: (in original tone) OK, so you want DNR status.



The physician leaves the room.

J Clin Onc. 2001; 19(5) pp 1576-1581

Horizontal lines for notes



Horizontal lines for notes



Horizontal lines for notes

# ***MOLST:***

*Medical Orders for  
Life Sustaining Treatment*



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## *Plenary 8:*

*A Practical Approach to  
Discussing Artificial Nutrition*

***Patricia Bomba, MD, FACP***  
*Vice President and  
Medical Director, Geriatrics*

***Penny S. Weller, LCSW-R***  
*Program Implementation Manager*

White sheet with no verbiage





## Discussions About Artificial Hydration and Nutrition: A Practical Approach

Patricia Bomba, M.D., F.A.C.P.  
Vice President and Medical Director, Geriatrics  
Chair, MOLST Statewide Implementation Team  
Leader, Community-wide End-of-life/Palliative Care Initiative  
Chair, National Healthcare Decisions Day New York State Coalition

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[CompassionAndSupport.org](http://www.CompassionAndSupport.org)

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## Objectives

- Describe the expectations of patients, families, and their physicians regarding the use of PEGs
- Define the benefits, burdens and outcomes of PEG use, relative to those expectations
- Recognize and use strategies helpful in guiding a patient-centered, evidence-based MOLST discussion when a decision about the use of PEGs is discussed




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## History of Artificial Feeding

- Hypodermoclysis: 1851 (Pravez)
  - hypodermic syringe
- Proctoclysis (Murphy's drip)
  - Surgeon, Thomas Murphy (1857-1917)
  - constant drip enema (up to 24 Liters/day!)
- Gastrostomy Feeding: 1875
- Venous Access: 1890's
- Central Venous Line: 1960
  - TPN
  - Hickman
- Nasogastric and Percutaneous Gastrostomy Tubes




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
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### PEG Use Increasing

- 1988 15,000 in patients 65 and older
  - 1992 75,000
  - 1995 123,000
  - 2001 >187,000
- Are feeding tubes becoming a replacement for careful hand feeding?




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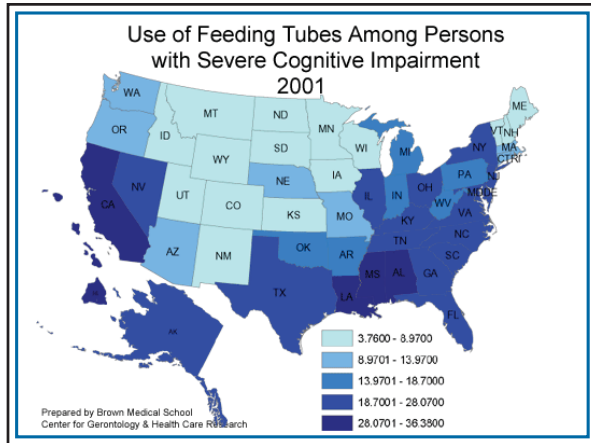
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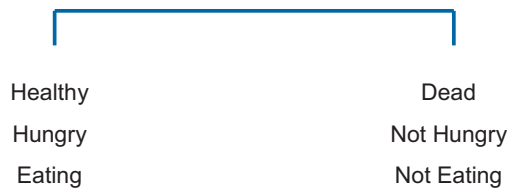
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### Life Cycle



Colleen Christmas, MD; ACP 2004




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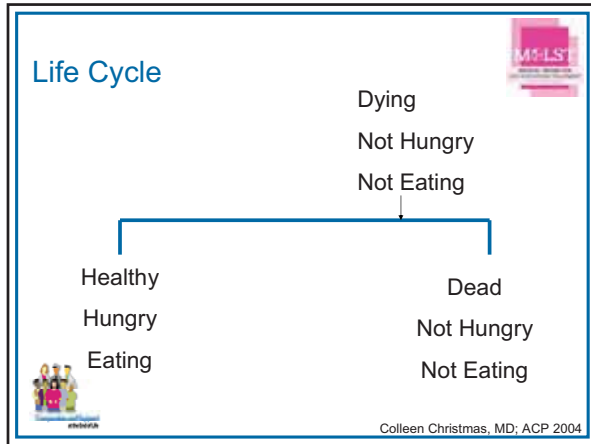
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**Cruzan v. Director, MO. DOH (1990)**



- Nancy's accident 1983 left her in a persistent vegetative state; breathing on her own
- Parents sought to discontinue tube feeding
- State court ruled, relying on related statutes, that there must be clear and convincing evidence to stop treatment
- US Supreme Court ruled right to refuse unwanted treatment (including ANH) is protected by the 14th amendment
- Not an absolute right; can be outweighed by state interests
- State interest in preserving life can justify clear and convincing evidence standard, especially because Nancy not terminally ill




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**Cruzan v. Director, MO. DOH (1990) Postscript**

- Supreme Court Decision June 26, 1990
- Nov 1, 1990 Nancy's parents presented new evidence in state court
- Dec 14, 1990, state court ruled on the basis of clear and convincing evidence that treatment could be stopped
- Tube removed two hours later
- Nancy died Dec 26, 1990




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**Long Term Artificial Hydration and Nutrition**

- Risks and benefits vary in the individual
  - depend on age, overall health status, goals for care, timing and course of disease
- Often hard to predict outcome
- Decision should be based on patient's/resident's goals for care
- When someone is dying, AHN
  - does not prevent aspiration
  - does not improve comfort
  - does not change prognosis or prevent dying




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**Long Term Artificial Hydration and Nutrition**

- **Can be discontinued at any time**
  - can be difficult for family
  - discuss goals for care/treatment ahead of time
  - need to know decision-maker
- **When burden outweighs benefits**
  - patient repeatedly pulls out tube
  - quality of life deteriorates
  - excessive agitation
  - terminal condition
  - recurrent aspiration




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**Withholding vs. Withdrawing Care**

- The distinction often is made between not starting treatment and stopping treatment.
- **However, no legal or ethical difference exists between withholding and withdrawing a medical treatment in accordance with a patient's wishes.**
- If such a distinction existed in the clinical setting, a patient might refuse treatment that could be beneficial out of fear that once started it could not be stopped.




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**Artificial Hydration and Nutrition**  
Patient/Family Discussion

- Focus on the underlying disease process as cause of decline and loss of appetite
- Emphasize the active nature of providing comfort care
- Recognize concerns about "starvation", inadequate nutrition or hydration and potentially hastening death that many individuals deal with in facing this decision and address these issues
- Clarify that withholding or withdrawing artificial nutrition and hydration is NOT the same as denying food and drink




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**Resident and NH Characteristics:**  
Tube Feedings in Patients with Severe Dementia

- Resident characteristics (34 % had TF)
  - younger age
  - no Advance Directives
  - nonwhite race
  - recent decrease function
  - male
  - divorced
  - no diagnosis of AD
- Nursing Home Characteristics
  - for Profit
  - greater than 100 Beds
  - lacking Dementia Care Unit
  - smaller proportion of Residents with DNR Orders
  - no NP or PA on Staff

Mitchell, JAMA. 2003; 290(1): 73-80




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**Impact on Aspiration Prevention**

- Tube feeding has *not* been shown to reduce aspiration pneumonia
- No RCT have been done
- No reason to believe that feeding tubes prevent aspiration or oral secretions or gastric fluids

Finucane and Bynum. Lancet 1996.




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Impact on Nutritional Status



- Callahan Prospective Study
  - no improvement in BMI, weight, albumin, cholesterol
- Henderson
  - 40 LTC patients with tube feedings
  - most with neurologic impairment
  - provision of adequate calories and protein did not prevent weight loss or depletion of lean and fat body mass
- No published studies suggesting tube feeding improves pressure sore outcomes.
  - bed bound TF patients may make more urine and stool potentially worsening pressure sores




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### Impact on Comfort



- Symptoms over the course of a year in PEG fed patients:
  - vomiting 20%
  - diarrhea 22 %
  - nausea 13%
  - aspiration 17%
  - insertion site irritation, infection, leaking 21%
- Comfort, or the lack of it, might be inferred by looking at prescribed medications.
  - opioids 18%
  - sedatives 31%
  - antipsychotics 16%
  - antidepressants 28%
- Restraints used in 2% of patients



Callahan JAGS 2000; 48(9):1048-54  
Callahan JAGS 1999; 47(9): 1105-9

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### Impact on Comfort: Thirst and Hunger



- Mentally aware patients with intact capacity admitted to NH comfort care unit followed from admission to death.
- 63% never experienced hunger (34% only initially)
- 62% experienced either no thirst or experienced thirst only initially
- In all patients, symptoms of thirst, dry mouth or hunger could be alleviated with small amounts of food, fluids, ice chips and/or lubrication of lips.



McCann, JAMA 1994;272:12627-1270

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**Impact on Mortality Rates:**  
Overall Survival is Poor

- Indianapolis
  - at 30 days, 22%
  - at 1 year, 50%
- Medicare
  - at 1 year, 63%
  - at 3 yrs 81%
- VA
  - at 1 year 59%
  - at 2 years, 71%
  - at 3 years, 77%




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**Impact on Survival Rates:**  
Patients with Dementia

- 1386 patients with severe cognitive impairment
- No survival difference between groups treated with or without tube feeding
- Using the same data set
  - 5266 patients in LTC with chewing and swallowing problems
  - mortality rate was increased in the tube fed patients



Mitchell, JAGS. 2000; 48(4): 391-7.

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**Impact on Survival Rates:**  
Patients with Dementia

- Prospective, observational study of 71 patients in a 2 year hand feeding program
- No difference in mortality rates among 4 groups of patients
  - patients who fed themselves
  - those who needed assistance but had no swallowing problems
  - those who refused to eat
  - those who coughed and choked on food




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Impact on Survival Rates:**  
Patients with Stroke

- James, Skelly
  - 25% will die in the first 30 days
  - 36% will die in follow-up
- Elia
  - 44% will remain bedridden
  - additional 30% homebound
- Sanders
  - 40% will show no improvement
  - 24% will experience significant improvement
- Wijidicks
  - 25-29% will regain their swallow and in 2-3 years.

James, Age and Aging. 1998 Nov; 27(6): 671-6  
Skelly, Clin Nutr. 2002 Oct; 21(5): 389-94.  
Elia, Clin Nutr. 2001 Feb; 20(1): 27-30  
Sanders, J Nutr Health Aging. 2000; 4(1): 58-60  
Wijidicks, Cerebrovasc Dis. 1999 Mar-Apr; 9(2): 109-11.

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**Impact on Survival Rates**  
Summary

- Swallowing disorder portends a poor prognosis
- No data to tell us that the usual stated goals can be met with PEG placement
- Cancer patients have the lowest survival regardless of age
- 24% of patients with dysphagic stroke who have PEG placed can have a good functional recovery

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**Recommendations**  
Patients with Dementia

- Careful hand feeding
- Family support and helping them to understand that the inability to eat or lack of desire to is part of advanced illness and the dying process
- Liberalize diet (sweets, sours)
- Xerostomia (sips of liquid, meds)
- More frequent feedings

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### Recommendations

Patients with Dysphagic Stroke (poor prognosis)



- Define poor prognostic groups
  - age >75
  - severe disability (unconscious)
  - pre-existing conditions associated with poor prognosis: decreased function, poor nutritional status
- Discuss goals for care
- Recommend Comfort Care




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### Recommendations

Patients with Dysphagic Stroke (better prognosis)



- For the patient who may have a better prognosis, usually younger with minimal pre-existing co-morbidities discuss the chance of functional recovery
- A "trial" of tube feeding may be appropriate
- One should consider what outcomes will determine success or failure *prior* to initiation of tube feedings




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### Role of Health Care Providers



- Educate and support families
- Elicit patient values and document advance directives
- Develop informed interdisciplinary teams
- Educate nursing home administrators
- Work with Regulators
- Follow [Community-wide Clinical Guidelines on PEGS/Tube feeding](#)




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**Tube Feeding/ PEG Tubes**

- **Provider Resources**
  - [Approach to Adult Unable to Maintain Nutrition](#)
  - [Flow Chart Reference Sheet](#)
  - [Checklist for Global Assessment](#)
  - [Tube Feeding Worksheet](#)
  - [Benefits and Burdens of PEG Placement](#)
  - [Legal and Ethical Issues](#)
- **Patient/Family Resources**
  - [Community-wide Clinical Guidelines on PEGS/Tube feeding](#)


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**THANK YOU**

Patricia.Bomba@lifethc.com

Visit the MOLST Training Center at  
[CompassionAndSupport.org](http://CompassionAndSupport.org)


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# ***MOLST:***

*Medical Orders for  
Life Sustaining Treatment*



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## *Plenary 9:*

*Lessons Learned and  
Available Resources to  
Implement the MOLST*

***Patricia Bomba, MD, FACP***  
*Vice President and  
Medical Director, Geriatrics*

***Penny S. Weller, LCSW-R***  
*Program Implementation Manager*

White sheet with no verbiage



*Lessons Learned and Available Resources: Patients, Families and Professionals*

*The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life*

**Lessons Learned and Available Resources:  
Patients, Families and Professionals**

Patricia Bomba, M.D., F.A.C.P.  
Vice President and Medical Director, Geriatrics  
Chair, MOLST Statewide Implementation Team  
Leader, Community-wide End-of-life/Palliative Care Initiative  
Chair, National Healthcare Decisions Day New York State Coalition

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[CompassionAndSupport.org](http://CompassionAndSupport.org)

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**Objectives**

- Apply the lessons learned from successful implementation of the MOLST Program in other regions in your practice setting
- Define appropriate use of Advance Care Planning and MOLST resources, including the CCC and MOLST videos, MOLST FAQs and [CompassionAndSupport.org](http://CompassionAndSupport.org)
- Use the MOLST Training Center to prepare for implementation, including use of the videos, policies and procedures, quality improvement tools, educational plans

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*Created by Patricia Bomba M.D., F.A.C.P. for the community-wide implementation of the MOLST Program*

*[www.CompassionAndSupport.org](http://www.CompassionAndSupport.org)*

*September 2009*





The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Lessons Learned

Long Term Care Barriers

- Families not ready to have discussions
- Physicians not prepared to have discussions
- Physicians expect SW to have conversation
- Similar to DNR issues
- No identified "Agent" or Surrogate
- No available finances for guardianship
- Language with unintended consequences
- Cultural barriers and health illiteracy




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Lessons Learned

Long Term Care Feedback

- "Education makes using forms less intimidating"
- "Very helpful to nursing and families"
- "Very helpful in framing the discussion on advance care directives"
- "Easier to locate advance directives quickly when needed."
- "Physicians must be engaged in the discussion."




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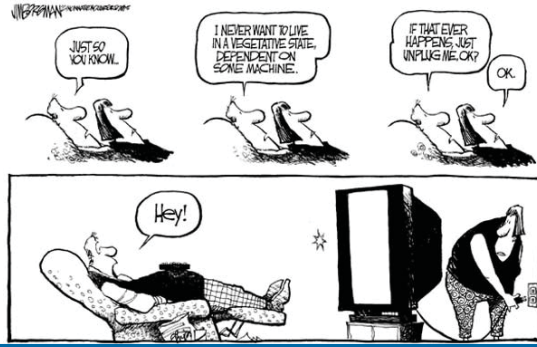
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Language and Functional Health Literacy




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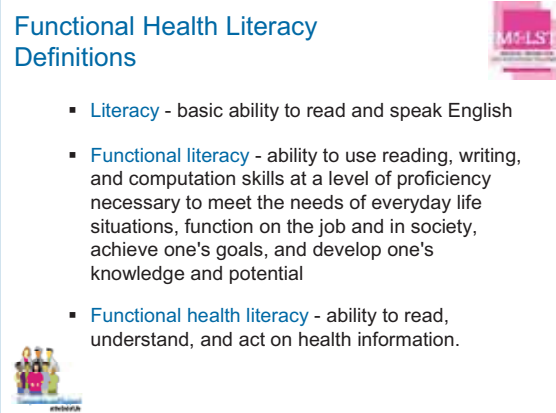
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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Functional Health Literacy Definitions**

- **Literacy** - basic ability to read and speak English
- **Functional literacy** - ability to use reading, writing, and computation skills at a level of proficiency necessary to meet the needs of everyday life situations, function on the job and in society, achieve one's goals, and develop one's knowledge and potential
- **Functional health literacy** - ability to read, understand, and act on health information.




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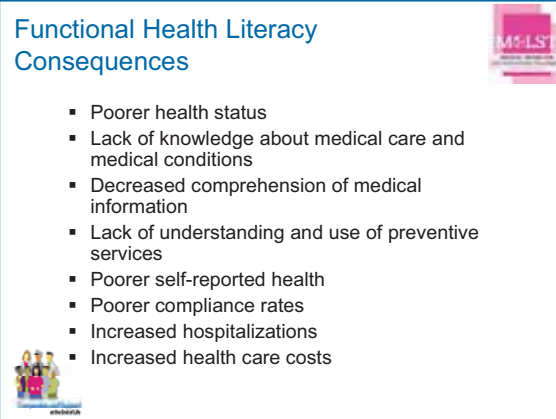
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**Functional Health Literacy Consequences**

- Poorer health status
- Lack of knowledge about medical care and medical conditions
- Decreased comprehension of medical information
- Lack of understanding and use of preventive services
- Poorer self-reported health
- Poorer compliance rates
- Increased hospitalizations
- Increased health care costs




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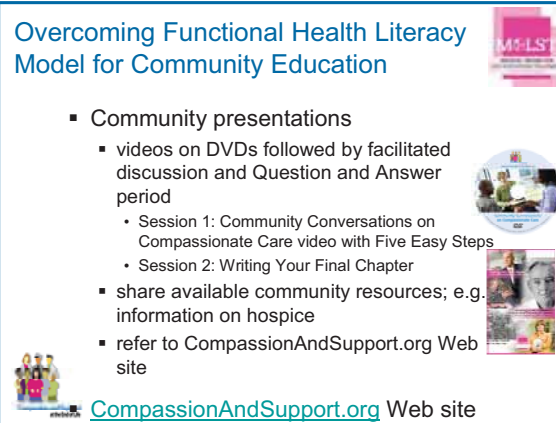
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**Overcoming Functional Health Literacy Model for Community Education**

- **Community presentations**
  - videos on DVDs followed by facilitated discussion and Question and Answer period
    - Session 1: Community Conversations on Compassionate Care video with Five Easy Steps
    - Session 2: Writing Your Final Chapter
  - share available community resources; e.g. information on hospice
  - refer to [CompassionAndSupport.org](http://CompassionAndSupport.org) Web site

[CompassionAndSupport.org](http://CompassionAndSupport.org) Web site




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Community Conversations on Compassionate Care  
Five Easy Steps**



1. Learn about advance directives
  - NYS Health Care Proxy
  - NYS Living Will
2. Remove barriers
3. Motivate yourself
4. Complete your documents
  - Have a conversation with your family
  - Choose the right Health Care Agent
  - Discuss what is important to you
  - Understand life-sustaining treatment
  - Share copies of your directives
5. Review and Update

[CCCC video on-line with Five Easy Steps](#)

A Project of the Community-Wide End-of-life/Palliative Care Initiative

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**Community Conversations on Compassionate Care  
Advance Care Planning Community Resources**

- Advance Care Planning Booklet (English, Spanish)
- Advance Care Planning Brochure, Poster and Table Topper
- Advance Care Planning Facilitator Training
- Advance Care Planning Clinical Pathways
- Behavioral Readiness "tools"
- Community Conversations on Compassionate Care (CCCC) workshop
- Community Conversations on Compassionate Care (CCCC) DVD
- Advance Care Planning Public Service Announcements DVD
- CCCC video on-line with Five Easy Steps
- On-line resources at [CompassionAndSupport.org](http://CompassionAndSupport.org)
- Internal tracking and evaluation

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**Community Resources  
Medical Orders for Life-Sustaining Treatment**



- MOLST 8-Step Protocol
- MOLST Guidebook including FAQs
- MOLST Patient & Family Brochure (English, Spanish)
- Sample Facility Policies & Procedures
- Sample Facility Implementation Workplans
- Sample Facility Education Workplans
- MOLST Training Manual
- MOLST Train-the-Trainer Sessions
- MOLST Conferences
- MOLST DVD and web-based tools
- MOLST Training Center: [CompassionAndSupport.org](http://CompassionAndSupport.org)  
– New York State repository for MOLST resources

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program: A Community Approach to Improving Care at the End-of-life



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Created by Patricia Bomba M.D., F.A.C.P. for the community-wide implementation of the MOLST Program

www.CompassionAndSupport.org

September 2009





The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program: A Community Approach to Improving Care at the End-of-life



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Horizontal lines for notes corresponding to the third screenshot.





The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life



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The MOLST (Medical Orders for Life-Sustaining Treatment) Program: A Community Approach to Improving Care at the End-of-life



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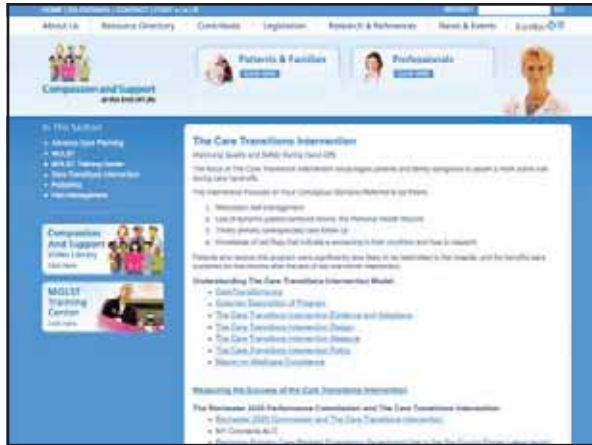
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# ***MOLST:***

*Medical Orders for  
Life Sustaining Treatment*



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*Next Steps:*

*Implementing MOLST as an  
End-of-Life Care Transitions  
Program in Your Community*

***Patricia Bomba, MD, FACP***  
*Vice President and  
Medical Director, Geriatrics*

***Penny S. Weller, LCSW-R***  
*Program Implementation Manager*

White sheet with no verbiage



Implementing MOLST as an End-of-life Care Transitions Program in Your Community




The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Implementing the MOLST Program as an End-of-life Care Transitions Program in Your Community**

Patricia Bomba, M.D., F.A.C.P.  
Vice President and Medical Director, Geriatrics  
Chair, MOLST Statewide Implementation Team  
Leader, Community-wide End-of-life/Palliative Care Initiative  
Chair, National Healthcare Decisions Day New York State Coalition

[Patricia.Bomba@lifethc.com](mailto:Patricia.Bomba@lifethc.com)  
[CompassionAndSupport.org](http://CompassionAndSupport.org)

**Excelsus**  
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**Objectives**

- Recognize the MOLST as an End-of-life Care Transitions Program
- Outline the barriers to implementation of the MOLST program and the methods used to overcome these obstacles.
- Establish next steps needed to implement the MOLST Program in your practice setting.




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**Facility Implementation of MOLST**

**Hospital**      **LTC**      **Office**


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Created by Patricia Bomba M.D., F.A.C.P. for the community-wide implementation of the MOLST Program

[www.CompassionAndSupport.org](http://www.CompassionAndSupport.org)

September 2009



The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

Six Steps to Develop and Implement

Community-wide End-of-life/Palliative Care Initiative

- Define Vision, Mission, Values
- Employ results-oriented approach
- Design effective, inclusive coalition membership
- Create effective leadership
- Demonstrate strong commitment to purpose
- Monitor performance



[http://www.compassionandsupport.org/index.php/about\\_us](http://www.compassionandsupport.org/index.php/about_us)

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History of MOLST Program



- Work initiated Fall 2001
- Created November 2003
- Adapted from Oregon's POLST
- Combines DNR, DNI, and other LST
- Incorporates NYS law
- Collaboration with NYSDOH – 3/04
- Revised 10/05
- Approved Inpatient DNR form
- Legislation passed 2005
- Community Pilot launched
- Chapter Amendment 2006
- Gov Paterson signed bill 7/8/08
- MOLST consistent with PHL§2977(3)
- Permanent change in EMS scope of practice, 7/08
- **MOLST permanent and statewide**




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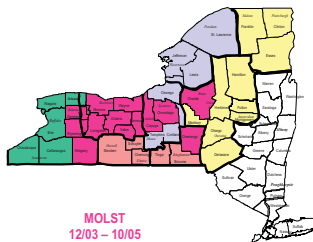
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Implementation - Early



- Initial MOLST form
- Pre-NYSDOH approval
- 12/03 – 10/05
- Began in Rochester
- Spread to Syracuse
- Areas surrounding

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**Implementation - Current**

- Revised MOLST, 11/05
- Consistent with NYS PHL
- NYSDOH approval for use in all healthcare facilities
- DOH DAL sent 1/06
- Statewide interest
- Consistent with PHL§2977(3), 7/08
- Permanent change in EMS scope of practice, 7/08
- 11/05 – Present

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**MOLST Program Project Dissemination**

**Systems Integration**

- NYS Healthcare Facilities
- Community Pilot
- Care Management

**Partnerships**

- 39 county service region
- Collaborators
- EPEC Faculty & Attendees
- Trained ACP Facilitators
- Regional EOL Coalitions
- NYSDOH
- Professional Associations
- SEMAC/SEMSCO

[CompassionAndSupport.org/index.php/about\\_us](http://CompassionAndSupport.org/index.php/about_us)  
[CompassionAndSupport.org/index.php/about\\_us/collaborators](http://CompassionAndSupport.org/index.php/about_us/collaborators)

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**MOLST Program Implementation Steps**

- Needs Assessment
- Core Working Group
- Task Force – Collaborative Model
- Program Coordination
- Key Components
- Approvals; Legal Issues
- Community Pilot Project - successful
- Education and Training
- Distribution and Fulfillment
- Program Requirements
- Relationship to Media
- Available Resources

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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Needs Assessment



- System responsiveness
- Honoring patient preferences for EOL care
  - DNR, Life-sustaining Treatment, Site of Death
- Interdisciplinary Approach
  - facilities: hospitals, SNFs, ALFs DM programs
  - disciplines: MD, RN, SW, EMS, Atty, consumers
- Data-driven
- Build on current research and conference




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### Core Working Group



- Assemble a workgroup
- Educate and empower
  - research - evidence base
  - NQF Preferred Practices
  - web resources: [CompassionAndSupport.org](http://CompassionAndSupport.org)
- Broad representation – interdisciplinary
- Leadership, passion, commitment
- Willing to outreach and educate
- Sustainability
- Expand collaboration




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### Task Force – Collaborative Model



- Broad representation
  - Local Department of Health
  - EMS
  - Hospitals
  - Long-term Care Facilities: SNF, ALF
  - Hospice and Home Care Agencies
  - County Office for Aging
  - Ombudsmen
  - Medical Society
  - Bar Association




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Program Coordination



- Leadership
- Operations: [CompassionAndSupport.org](http://CompassionAndSupport.org)
  - distribution and fulfillment of educational resources
  - training
  - quality improvement
  - share best practices & lessons learned
- Funding
- Sustainability




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### Key Components



- Standardized practices, policies and form
- Education and Training
  - advance care planning facilitators
  - system implementation
  - community education
- Timely discussions along continuum prompted by:
  - identification of appropriate cohort
  - prognosis
- Clear, specific language on actionable form
- Bright colored, easily recognized form
- Medical orders honored throughout the system
- Quality improvement process for form and system




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### MOLST Quality Audit Tool




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Approvals

- Legal Review
- Administrator
- Ethics Committee
- Forms Committee
- Policy Committee
- [MOLST NYSDOH Approval Letter](#) 1/16/06




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### Legal Issues

- MOLST use in the community required legislation
  - approved by NYSDOH for use in health care facilities across New York State in October 2005
  - approved by NYSDOH for use in ALL settings, including the community throughout New York State in July 2008
- Mandatory signatures for consent
  - varies for DNR and Life-Sustaining Treatment
- Physician Signature required
  - NP/PA would need legislation
  - acceptable policies & procedures with current regulations




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### MOLST Education and Training

Two-Step Approach to Advance Care Planning

- Advance Care Planning Facilitators
  - Community Conversations on Compassionate Care Program
  - MOLST Program
  - goal-based, patient-centered discussions
  - patient-centered program and process
  - educational resources on [CompassionAndSupport.org](#)
- Program Implementation
  - facility: hospital, long term care, home care, hospice
  - physician practice – opportunity for process improvement
- Community education
  - CCCC, MOLST, reliable information on web site




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

**MOLST Education and Training**  
Two-Step Approach to Advance Care Planning

- Use CCCC, MOLST videos and Web site
- Obtain standardized educational materials from [CompassionAndSupport.org](http://CompassionAndSupport.org)
- Medical and Dental Staff
  - mail educational materials to each provider
  - present at various business meetings
  - publish article in provider newsletter
  - educational materials available at different units
  - encourage use of [on-line MOLST training](#)





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**MOLST Education and Training**  
Two-Step Approach to Advance Care Planning

- Nursing
  - present at various meetings
  - present on each unit
  - send in-service packet as resource to each unit
  - establish Advance Directive liaisons as resource individuals
    - one for each nursing unit
    - attend educational program
    - meet monthly
- Social Work / Care Managers
  - present at standing meetings


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**MOLST Education and Training**  
Two-Step Approach to Advance Care Planning

- Staff
  - letters to physicians from medical director
    - role of physician, RN, NP, PA, SW, Unit Clerk
    - how to initiate conversation
- Family
  - integrate video into admission/discharge process
  - family/surrogate at patient care conferences
  - share CCCC and MOLST videos on facility TV
  - link to [CompassionAndSupport.org](http://CompassionAndSupport.org) Web site
  - videos in facility library
  - family council meetings and articles in newsletters





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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Distribution and Fulfillment



- Distribution Center
  - centralized process to order forms, educational and training resources
  - tracking utilization and implementation
- [CompassionAndSupport.org](http://CompassionAndSupport.org) home page
  - MOLST videos with CME/CE
  - MOLST Training Center
  - MOLST Trainers
  - Order MOLST Forms and other educational resources




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### Communication Plan



- Communication Plan
  - internal
  - external
- Messaging
  - consistent message
- Prepare for interviews
  - consider 3 key messages




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### MOLST Program Initiation



- Establish multidisciplinary team
- Engage physician and system champions
- Develop implementation plan
  - template at MOLST Training Center
  - [MOLST LTC Implementation Process](#)
  - interviews on MOLST video [Honoring Patient Preferences](#)
- Develop educational training plan
  - template at MOLST Training Center
  - [Educational Plan for Advance Directives and MOLST](#)




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The MOLST (Medical Orders for Life-Sustaining Treatment) Program:  
A Community Approach to Improving Care at the End-of-life

### Implementation

- Establish start date
- Start with all new admissions on all units
- Provide units with supply of revised 2008 MOLST forms
- Depending on degree of implementation, remove all old MOLST forms and/or old "DNR" forms and provide units with supply of revised 2008 MOLST forms
- Scan into electronic medical record, as per protocol
- Institute QI process to ensure accurate form completion




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### Lesson Learned: EMS Key to Success

- Work in tandem with EMS
- Have an EMS champion
- Know how EMS works in your state and the regulations that bind them (state mandated out-of-hospital DNR forms)
- Work with EMS medical directors
- Listen to colleagues' concerns




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