ECHO MOLST + eMOLST: Honoring Preferences at End-of-life
Session 1
MOLST: A Key Pillar of Palliative Care

Presenter

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The speaker has no significant financial conflicts of interest to disclose.
Learning Objectives

• Explain how MOLST is a key pillar of palliative care and an integral component of the practice of medicine

• Review a population health approach to advance care planning

• Describe differences between standard care, advance directives & medical orders
Advance Care Planning
A Key Pillar of Palliative Care
Palliative Care

Interdisciplinary care

• aims to relieve suffering and improve quality of life for patients with advanced illness and their families
• offered simultaneously with all other appropriate medical treatment from the time of diagnosis
• focuses on quality of life and provides an extra layer of support for patients and families
Three Key Pillars

1. Advance Care Planning
   - Advance directives (HCP)
   - Medical orders (MOLST)

2. Pain and symptom management

3. Caregiver education and support
Advance Care Planning
A Population Health Approach
Advance Care Planning Conversations

- Occur with a person, their health care agent and primary clinician, and other members of the clinical team
- Are recorded and updated as needed
- Allow for flexible decision making in the context of the patient’s current medical situation.

Advance Care Planning
A Population Health Approach

Advance Directives
(18 and older)
- Health Care Proxy
- Living Will

Medical Orders (MOLST)
(Advanced illness/frailty)
- Resuscitation
- Respiratory Support
- Hospitalization
- Life-Sustaining Treatment
Community Conversations on Compassionate Care
Storytelling and Five Easy Steps

1. Learn about advance directives
   - NYS Health Care Proxy
   - Living Will

2. Remove barriers

3. Motivate yourself
   - Stories
   - View CCCC videos

4. Complete your HCP
   - Have a conversation
   - Choose the right HCA
   - Discuss what matters
   - Understand LST
   - Put it in writing
   - Share copies

5. Review and Update

Community Conversations on Compassionate Care, a project of the Community-wide End-of-life/Palliative Care Initiative
How to Choose a Health Care Agent
Applies to Choosing a Guardian Who Makes Medical Decisions
Applies to Choosing a Supporter Who Will Help Make Medical Decisions

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
Value of Advance Care Planning
Complete a Health Care Proxy and Family Discussion

Yes: Patient Wishes Honored. Family at Peace

No: Patient and Family Suffered

Community Conversations on Compassionate Care, a project of the Community-wide End-of-life/Palliative Care Initiative
Acute Illness, Patient Lacks Decision Making Capacity
Patient Recovers

Choose the Right HCA. Share What Matters Most

Knowing What Matters Most

Community Conversations on Compassionate Care, a project of the Community-wide End-of-life/Palliative Care Initiative
Advance Care Planning: For Everyone 18 years and Older
Community Conversations on Compassionate Care

Who Will Speak for You?

If you can't make your own health care decisions?

For everyone ages 18 years and older

Advance Care Planning lets you authorize someone you trust to make your health decisions if or when you can't.

5 easy steps to Advance Care Planning:

1. Learn about advance directives (health care proxy and living will).
2. Remove barriers to completing advance directives.
3. Motivate yourself by watching testimonial videos at CompassionAndSupport.org.
4. Complete your health care proxy and living will. Talk to your family and physician or nurse practitioner about what matters to you.
5. Periodically review and update your advance directives.

Learn more at CompassionAndSupport.org.
Ask your physician or nurse practitioner for our free Advance Care Planning booklet.

Conversations change lives. Start your conversation today.
Medical Orders for Life-Sustaining Treatment (MOLST)

- Standardized communication process
- **CURRENT** patient health status, prognosis, values & goals for care
- Shared medical decision-making
- Ethical-legal requirements (PHL: HCP & FHCDA and SCPA §1750-b)
- Physician Accountability: Patients with I/DD who lack capacity
- Documentation of discussion
- Result: portable medical orders
  - reflect resident preferences for LST they wish to receive and/or avoid
  - common community-wide form
  - **ONLY** form EMS can follow DNR, DNI and Do Not Hospitalize
- Palliative care plan and caregiver support

A project of the Community-wide End-of-life/Palliative Care Initiative
Who is Appropriate for MOLST

• MOLST is generally for patients with advanced illness who require long-term care services and/or who might die within 1-2 years

• The MOLST may also be used for individuals who wish to avoid and/or receive specific life-sustaining treatments
Examples of Advanced Illness

- Severe Heart Disease
- Metastatic Cancer or Malignant Brain Tumor
- Advanced Lung Disease
- Advanced Renal Disease
- Advanced Liver Disease
- Advanced Frailty
- Advanced Neurodegenerative Disease (e.g., Dementia, Parkinson’s Disease, ALS)
Frailty

- Common clinical syndrome in older adults; can occur in individuals with advancing illness of any age
- Carries an increased risk for poor health outcomes including falls, disability, hospitalization, and mortality
- Results from aging-associated decline in reserve and function across multiple physiologic systems such that the ability to cope with every day or acute stressors is compromised
- Clinical features: weak grip, low energy, low physical activity, walks slowly, and may have unintentional weight loss
Individuals at Highest Risk

Advanced chronic conditions coupled with frailty are people at highest risk for

- recurrent hospitalizations
- worsening frailty
- diminished functional status in everyday life
- mortality

These individuals deserve to be offered the opportunity to learn about and complete a MOLST
Who is Appropriate for MOLST

1. Patients whose physician, NP or PA would not be surprised if they die in the next 1-2 years
2. Patients who live in a nursing home or receive long-term care services at home or in an adult care facility (e.g. assisted living)
3. Patients who want to avoid and/or receive any or all life-sustaining treatment today
4. Patients who have one or more advanced chronic conditions or a new diagnosis with a poor prognosis
5. Patients who have had two or more unplanned hospital admissions in the last 12 months, coupled with increasing frailty, decreasing functionality, progressive weight loss or lack of social support
Appropriate to Offer MOLST

• If a person is in one or more of the MOLST screening categories, it is a clinical quality trigger that the person is appropriate for a thoughtful MOLST discussion.
Primary Care
Specialty Practices
FQHC
Populations: Post-Acute vs. Custodial Care

Screen and Offer Discussion: Admission, Follow-up, Change in Health Status

All Post-Acute residents NOT appropriate
Screen Post-Acute (Rehab) Admissions

All Custodial Residents Appropriate
MOLST is Voluntary
Populations: Skilled Nursing vs. Assisted Living

Screen at Admission, Regular Follow-up and Change in Health Status
Populations: Special Needs

- Intellectual/Developmental Disabilities
- Dementia
- Psychiatric
- Pediatrics
- Unbefriended Adults
Special Populations:

Long-term Non-invasive (BIPAP/CPAP)

Mechanical Ventilation (ventilator)
8-Step MOLST Protocol

1. Prepare for discussion
   - Understand patient’s health status, prognosis & ability to consent
   - Retrieve completed Advance Directives
   - Determine decision-maker & PHL legal requirements

2. Determine what the patient/family know

3. Explore goals, hopes and expectations

4. Suggest realistic goals

5. Respond empathetically

6. Use MOLST to guide choices & finalize patient wishes
   - Shared, informed medical decision-making and conflict resolution

7. **Complete and sign MOLST**
   - Follow PHL, SCPA §1750-b and document conversation
   - If person lacks capacity & no HCA, physician signs MOLST **After** OPWDD Checklist is completed and **No objection** is raised

8. Review and revise periodically

Developed for NYS MOLST, Bomba, 2005; revised 2011

• Developed Based on My Clinical Practice since 1979
• Prior to NY MOLST
MOLST Instructions and Checklists
Ethical Framework/Legal Requirements

**Checklist #1** - Adult patients with medical decision-making capacity *(any setting)*

**Checklist #2** - Adult patients without medical decision-making capacity who have a health care proxy *(any setting)*

**Checklist #3** - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is a Public Health Law Surrogate (surrogate selected from the surrogate list); includes hospice

**Checklist #4** - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy or a Public Health Law Surrogate *(+/- hospice eligible)*

**Checklist #5** - Adult patients without medical decision-making capacity who do not have a health care proxy, and the MOLST form is being completed in the *community*.

**Checklist for Minor Patients** - *(any setting)*

**Checklist for Developmentally Disabled who lack capacity** – *(any setting)* must travel with the patient’s MOLST

http://www.nyhealth.gov/professionals/patients/patient_rights/molst/
Care Plan

- Palliation
  - Pain and symptom management
- Who Will Assess in an Emergency
- Supportive care
  - Patient
  - Family
  - Staff
Differences between standard care, advance directives & medical orders
Flow of Emergency Care: Standard Medical Care
Flow of Emergency Care: MOLST
### Differences Between MOLST and Advance Directives

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<tr>
<th>Characteristics</th>
<th>MOLST</th>
<th>Advance Directives</th>
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<tbody>
<tr>
<td>Population</td>
<td>For seriously ill with advanced illness, advanced frailty</td>
<td>All adults</td>
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<tr>
<td>Timeframe</td>
<td><strong>Current care</strong></td>
<td>Future care</td>
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<td>Who completes the form</td>
<td>Physicians, NPs, PAs</td>
<td>Patients</td>
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<tr>
<td>Resulting form</td>
<td>Medical Orders (MOLST)</td>
<td>Advance Directives</td>
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<tr>
<td>Health Care Agent or Surrogate role</td>
<td>Can engage in discussion if patient lacks capacity</td>
<td>Cannot complete</td>
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<tr>
<td>Portability</td>
<td>Physicians, NPs, PAs responsibility</td>
<td>Patient/family responsibility</td>
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<td><strong>Physician only</strong> for Patients with IDD</td>
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<tr>
<td>Periodic review</td>
<td>Physicians, NPs, PAs responsibility</td>
<td>Patient/family responsibility</td>
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Adapted from Bomba PA, Black J. The POLST: An improvement over traditional advance directives. Cleveland Clinic Journal of Medicine. 2012; 79(7): 457-64
Advance Care Planning Population Based Screening Questions

Everyone 18 & Older

- Health Care Proxy
- Living Will
- Oral Advance Directive
- Guardianship
  Person and/or property
- HIPAA
  Release

What is the patient’s capacity to appoint a health care agent?

Patients with Advanced Illness/Advanced Frailty

- Does patient with advanced illness/frailty have an MOLST/eMOLST?
- What is the patient’s capacity to make EOL MOLST decisions?

If yes, is MOLST reviewed regularly, considering current health status, prognosis, resident goals for care, COVID-19?

If no, why not?
Advance Care Planning is a continuous communication process.

There are differences between standard medical care, advance directives and MOLST.

MOLST is a set of medical orders and not an advance directive.

MOLST is not merely a form to be completed.

MOLST is not for everyone.
Resources
Redesigned CompassionAndSupport.org

A project of the Community-wide End-of-life/Palliative Care Initiative
How MOLST is Done

MOLST is based on communication between the patient and their team. The 8-step MOLST Protocol outlines the necessary steps.

Subscribe to NY MOLST Update on MOLST.org
Videos

CompassionAndSupportYouTubeChannel (ACP/MOLST video playlists)
http://www.youtube.com/user/CompassionAndSupport?feature=mhee

Demonstrating Thoughtful MOLST Discussions
Hospital & Hospice Settings
Nursing Home Setting

Patient & Family Education
Writing Your Final Chapter: Know Your Choices. Share Your Wishes - Original release 2007; revised to comply with FHCDA - MOLST Video Revised 2015! (28:14)
https://youtu.be/ClTAG19RX8w
Community Partners in Advance Care Planning
https://youtu.be/JKEvouEgGh8
References


• Bomba PA, Black J. The POLST: An improvement over traditional advance directives. *Cleveland Clinic Journal of Medicine*. 2012; 79(7): 457-64

• More at Resources on MOLST.org