ECHO® MOLST:
Honoring Preferences at End-of-life

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

• Review a population health approach to advance care planning

• Describe differences between standard care, advance directives & medical orders

• Explain how MOLST is a key pillar of palliative care and an integral component of the practice of medicine
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 with Psychosocial & Spiritual Support
– Advance Care Planning and Goals for Care
  Step 1: Community Conversations on Compassionate Care*
  Step 2: Medical Orders for Life-Sustaining Treatment (MOLST)*
– Pain and Symptom Management
– Caregiver Support

*A Project of the Community-Wide End-of-life/Palliative Care Initiative
Hospice Palliative Care (PC): Advance care planning & goals for care, pain and symptom control, caregiver support

Diagnosis → Progression of Serious Illness → Hospice

Continuum of Care Model for Patients with Serious Illness

Medical Management of Chronic Disease

Integrated with Palliative Care

Goals for Care shift

12 mo → 6 mo

Bereavement
Chronic disease or functional decline

Advancing chronic illness

Multiple co-morbidities, with increasing frailty

Healthy and independent

Maintain & maximize health and independence

Death

Compassion, Support and Education along the Health-Illness Continuum
Advance Directives and Actionable Medical Orders

Traditional ADs

For All Adults

Community Conversations on Compassionate Care (CCCC)

- New York
  - Health Care Proxy
  - Living Will
- Organ Donation
- State-specific forms: e.g. Durable POA for Healthcare

Actionable Medical Orders

For Those Who Are Seriously Ill or Near the End of Their Lives

Medical Orders for Life-Sustaining Treatment (MOLST) Program

- Do Not Resuscitate (DNR) Order
- Medical Orders for Life Sustaining Treatment (MOLST)
- Physician Orders for Life Sustaining Treatment (POLST) Paradigm Programs

CompassionAndSupport.org
CaringInfo.org

MOLST.org & CompassionAndSupport.org
POLST.org

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Community Conversations on Compassionate Care 

Storytelling and **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

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**BlueWorks**

Leading the Future of Healthcare
Medical Orders for Life-Sustaining Treatment (MOLST) Program – More Than a NYSDOH Form

Standardized clinical process

Discussion of patient’s values & goals for care

Shared medical decision-making between health care professionals and seriously ill patients (ethical framework/legal requirements)

Physician/NP Accountability for medical orders

Documentation of discussion

Result: portable medical orders

– reflect the patient’s preference for life-sustaining treatment they wish to receive and/or avoid

– common community-wide form

– **ONLY** form EMS can follow DNR, DNI and Do Not Hospitalize

Flow of Emergency Care: Standard Medical Care
Flow of Emergency Care: MOLST
Advance Care Planning Screening Questions*

- Does my patient have a health care proxy?
- Do I have a copy of the health care proxy?
- Has the patient shared their values, beliefs and goals for their care?
- Has the person spoken with their Health Care Agent, family & loved ones?
- Is my patient appropriate for MOLST?

*Appropriate for Medicare and other Wellness Visits, Hospital, LTC, Hospice pre-admission & admissions
MOLST Intended Population

• Healthy people are **NOT** appropriate for MOLST and should complete an advance directive and have a discussion with family and loved ones.

• Patients who have a chronic condition or multiple chronic conditions but have a long life expectancy are **NOT** appropriate for MOLST.

• Patients who are receiving **post-acute care in a skilled nursing facility** **may or may not** be appropriate for MOLST. They should be screened to see if they fit any of the categories of patients who should consider MOLST.
MOLST Intended Population

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

• **Frailty**: weak grip, low energy, low physical activity, walks slowly, and may have unintentional weight loss; carries an increased risk for poor health outcomes including falls, disability, hospitalization, and mortality.

• **Advanced chronic conditions coupled with frailty**: patients at highest risk for recurrent hospitalizations, worsening frailty, diminished functional status and ultimately, mortality.
MOLST Screening Questions

• Would the physician or nurse practitioner not be surprised if the patient dies in the next year?
• Does the patient live in a nursing home or receive long-term care services at home or assisted living?
• Does the patient want to avoid or receive any or all life-sustaining treatment today?
• Does the patient have one or more advanced chronic conditions or a new diagnosis with a poor prognosis?
• Has the patient 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?
Key Points

• Advance Care Planning is a continuous communication process.
• There are differences between standard medical care, advance directives and MOLST.
• MOLST is not an advance directive.
• MOLST is not merely a form to be completed.
• MOLST is not for everyone.
### Differences Between MOLST/POLST and Advance Directives

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<th>Characteristics</th>
<th>POLST</th>
<th>Advance Directives</th>
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<td>For the seriously ill</td>
<td>All adults</td>
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<td>Timeframe</td>
<td><strong>Current care</strong></td>
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<td>Who completes the form</td>
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<td>Health Care Agent or Surrogate role</td>
<td>Can engage in discussion if patient lacks capacity</td>
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<td>Periodic review</td>
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References

See https://molst.org/implementation-tools/research-references/

- **Websites:** MOLST.org and CompassionAndSupport.org
  - "Writing Your Final Chapter: Know Your Choices. Share Your Wishes“
    - Original release 2007; revised to comply with FHCDA
- **CompassionAndSupport YouTube Channel** ACP and MOLST playlists
  - http://www.youtube.com/user/CompassionAndSupport?feature=mhee