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

More than a Form – It’s a Process
Presenter

Patricia A. Bomba, MD, MACP
Vice President & Medical Director, Excellus BlueCross BlueShield
Chair, MOLST Statewide Implementation Team; eMOLST Program Director
Founding Member, National POLST Paradigm
Lead, ECHO MOLST

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

• Explain the 8-Step MOLST Protocol

• Describe how a standardized process improves quality and prevents medical errors

• Define the key elements of the MOLST form
MOLST Requires Thoughtful Discussion
Questions to Help an Individual Prepare for a MOLST Discussion

• What do you understand about your current health condition?
• What do you expect for the future?
• What makes life worth living?
• What is important to you?
• What matters most to you?
• How do you define quality of life?
• Would you trade quality of life for more time?
• Would you trade time for quality of life?
8-Step MOLST Protocol

1. Prepare for discussion
   - Understand patient’s health status, prognosis & ability to consent
   - Retrieve completed Advance Directives
   - Determine decision-maker and NYSPHL legal requirements, based on who makes decision and setting

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 finalize patient wishes
   - Shared, informed medical decision-making
   - Conflict resolution

7. Complete and sign MOLST
   - Follow NYSPHL and document conversation

8. Review and revise periodically

Developed for NYS MOLST, Bomba, 2005; revised 2011

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)

• **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

• **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/]
State of New York
Department of Health
Nonhospital Order Not to Resuscitate (DNR Order)

Person's Name: _______________________

Date of Birth: _____/_____/_____

Do not resuscitate the person named above.

Physician's Signature ___________________

Print Name _______________________

License Number ______________________

Date _____/_____/_____

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart.

The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90 day period.

DOH-3474 (2/92)

Care Plan Supports MOLST

MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT
A POLST Paradigm Program
Review and Renew MOLST

• The physician or nurse practitioner must review, sign & date the MOLST form from time to time, in accordance with policies & procedures, but at least every 90 days
Review and Renew MOLST

• The physician or nurse practitioner must also review, sign & date the MOLST form if any of these apply:
  – If the patient moves from one location to another to receive care
  – If the patient has a major change in health status (for better or worse)
  – If the patient or decision-maker (Health Care Agent, FHCDA or §1750-b Surrogate, Parent or Guardian) changes their mind about a treatment decision they made
Key Points

• MOLST requires thoughtful discussion that ensures well informed shared decision-making.
• Physicians and nurse practitioners are accountable for MOLST (as of May 28, 2018 for FHCDA Surrogates and as of February 3, 2019 for Health Care Agents).
• Only a physician and not a nurse practitioner is accountable and can sign the MOLST for Persons with DD/DD who lack capacity.
• MOLST is not completed by checking off boxes on a form.
• MOLST needs to be reviewed and reviewed as it represents medical orders.
Learn more on MOLST.org
References


- How to Complete a MOLST/Thoughtful MOLST Discussions

- MOLST.org