OBJECTIVES

1. Define MOLST & historical development in United States and in CT
2. Define CT MOLST goals & aims
3. Describe process for completing MOLST
4. Differentiate between MOLST & Living Will
5. Identify specific considerations for those with racial, ethnic, linguistic, & cultural differences as well as those with disabilities
6. Describe CT’s MOLST Pilot Program
MOLST
MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENTS

A process resulting from conversations between a person & health clinician that serves as medical orders for preferences regarding life-sustaining interventions near the end-of-life.

MOLST Documents
End-of-Life Conversations

The Conversation
A REVOLUTIONARY PLAN FOR END-OF-LIFE CARE

ANGELO E. VOLANDES, M.D.

What people need most on this journey is not the promise of the next new technology but rather a guide to help navigate this dark forest in which they will undoubtedly find themselves.

- Angelo Volandes, MD
The Conversation
DEFINITION OF CT MOLST

Special Act No. 14-5, State of Connecticut - 2014

“Medical order for life-sustaining treatment”

- “... a written medical order by a physician (MD/DO), advanced practice registered nurse (APRN) or physician assistant (PA)
- to effectuate a patient’s request for life-sustaining treatment
- when the patient has been determined by a physician to be approaching the end stage of a serious, life limiting illness or is in a condition of advanced, chronic progressive frailty;”
MOLST & POLST HISTORY

• National POLST: Physician Orders for Life-Sustaining Treatment
  • MOLST (Medical Orders for Life Sustaining Treatment)
  • POLST Started in Oregon 1991

• States Nationally Involved:
  • 3 “mature” – CA, OR, WV
  • 19 “endorsed” CA, OR, WV, PA, GA, CO, HI, ID, IA, LA, ME, MT, NC, NY, TN, UT, VA, WA, WI,
  • 25 “developing” AL, AZ, CT, DE, FL, IL, IN, KS, KY, MI, MN, MS, MO, NW, NH, NJ, NM, NV, ND, RI, SC, TX, OK, OH, WY
  • 2 + DC with “Contracts” – AL, AR, DC
  • 3 not conform to National POLST Paradigm – MD, MA, VT

CT BACKGROUND AND HISTORY

• DPH planning for MOLST was stimulated by documentation of underutilization of hospice services

• Connecticut ranks 50th in the United States in the use of hospice care

• Patients as well as practitioners may be confused by the meaning of terms such as Advance Directives, living wills, and DNR orders

• A clearly-articulated MOLST will decrease ambiguity when caring for patients at the end of life
CT HISTORY

• At Request of CT DPH Commissioner MOLST work group formed in 2012

• CT DPH created MOLST Task Force with representatives from stakeholder groups in 2013

• First legislative proposal submitted in 2013
  • Raised concerns based on problems with POLST in some other states
  • Did not pass out of committee

• Second proposal submitted in 2014 by DPH

• Legislation for pilot passed 2014 §67 of Public Act 14-231

• MOLST Advisory Committee formed in 2014

INTENDED MOLST OUTCOMES

1. Documentation of preferences on a state-wide CT DPH approved MOLST form – preferences to be honored

2. Translation of the conversation(s) into medical orders that will be

3. Transferrable with the patient across healthcare settings
**CT MOLST GOALS**

1. Encourage discussion;

2. Respect patient autonomy;

3. Ensure patient’s choices about life-sustaining interventions & end of life care options are documented as standardized medical orders that are portable & respected across health care settings.

**MOLST ELIGIBILITY**

1. Approaching end stage serious, life limiting illness
2. In a condition of advanced chronic progressive frailty.

If the patient is incapable of making healthcare decisions a legally authorized representative may do so in the best interest of the patient.
“Legally authorized representatives” mean:

1. Parent or
2. Guardian or
3. Health Care Representative

Fill out completely, but decisions do not need to be reached in all sections.

If a section was not discussed check “did not discuss” or decision not reached check “undecided”

The form must be signed by all 3 parties for it to be valid:

1. The patient or legally authorized representative
2. MD/DO, APRN or PA
3. One witness
Top of First Page

1. Patient Information
2. Diagnosis
3. Goals of Care
   - Full treatment for all and every problem;
   - Partial treatment for some problems;
   - Only treatments that enhance comfort but have no curative value will manage symptoms, e.g., pain; no life support interventions.

Section A

CPR or No CPR

Section B

Decisions about:
- Hospitalization
- Mechanical/invasive intubation & ventilation
- Non-invasive ventilation

Section C

- For some options the patient may decide on a defined trial period
- “Other Treatment Options” - any other interventions are recorded, e.g., vasopressor medications or antibiotics, etc.

Section D

- Names & signatures of patient or legally authorized representative, physician (MD/DO), APRN or PA who completed the form and witness (required by law).
- Interpreter name or ID number and/or service (as appropriate)

Section E

- Review & revisions of the MOLST form are documented
AFTER COMPLETION OF MOLST FORM

1. Medical provider will write specific orders based on the MOLST
2. Original & additional copy to the patient
3. Copy filed in the patient’s medical record
4. Agreement to Participate in the Pilot Program filed in the provider’s medical record

MOLST CONVERSATIONS

1. Goals of Care
2. Diagnosis, prognosis, treatment options
3. Values, preferences, beliefs
4. Choices regarding life-sustaining interventions as options within the context of one’s current health
5. Benefits, risks, burdens of each option

Reach informed, shared decisions & document them on the form
**MOLST AND ADVANCED CARE PLANNING**

**Step 1**
Complete Advance Directive (> age 18)

**Step 2**
Update Advance Directive periodically

**Step 3**
Diagnosed w/serious life limiting illness or chronic progressive frailty (any age)

**Step 4**
Complete MOLST when eligible

**Step 5**
End of Life wishes honored

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**DIFFERENCES BETWEEN MOLST & THE LIVING WILL**

**MOLST**
1. Choices are discussed with a medical clinician;
2. Form is completed after a shared decision-making conversation;
3. Requires clinician’s, patient’s (or legally authorized representative’s) signature & witness signature;
4. Used by persons whose health status includes an end stage serious life-limiting illness or an advanced chronic progressive disease with accompanying medical frailty;
5. Form includes medical orders

**LIVING WILL**
(type of advance directive)
1. Choices need not be discussed with anyone;
2. Can list preferences for any aspect of health care including life support; preferences are only triggered when one lacks decisional capacity & is either in a terminal condition or permanently unconscious;
3. Requires declarant’s signature & two witnesses;
4. Anyone ≥ 18 years of age regardless of health status can complete living will
1. We have been talking about your medical problems. Tell me your understanding of these problems, specifically the illness causing them, and where you feel you are now with your illness.

2. I can share with you where I think you are now. Would you like more information about what may be ahead of you?

3. Have you thought about how you would like to be treated if you may be close to the end of your life?

4. We often refer to goals of care that are related to different categories of treatment. Would you like me to explain these categories?

**POINTS TO CONFIRM WITH PATIENT CONSIDERING MOLST**

Completing a MOLST form is voluntary;

Decisions documented on a MOLST form may be changed or completely revoked at any time by the patient or the patient’s legally authorized representative

Knowing the patient’s preferences & values for end of life care in advance helps other health professionals design an appropriate plan of care when situations arise requiring decisions about options.
Decisions on a MOLST form are considered medical orders and will be followed by health professionals wherever the patient resides unless a new discussion or conversation is documented.

MOLST is a CT Department of Public Health Initiative and is endorsed by the Connecticut General Assembly.

MOLST is not a substitute for a Living Will or Appointment of a Health Care Representative – a Living Will can only be completed by a patient capable of making health care decisions whereas a patient’s legally authorized representative may complete a MOLST on the patient’s behalf.

A Legally authorized representative ought to be aware of choices a patient may have documented in a Living Will.

MOLST & UNDERSERVED POPULATIONS

- DPH’s Special Emphasis on:
  - Groups described as:
    - having “health disparities,” “socially disadvantaged,”
    - “vulnerable” or “at risk” have historically experienced barriers to health care services.
  - Health disparity groups as those based on:
    - race, ethnicity, age, gender, socioeconomic position,
    - immigrant status, sexual minority status, language, disability,
    - homelessness, mental illness, geographical area of residence

Specifically, health disparities refer to those avoidable differences in health that result from cumulative social disadvantage.
MOLST & UNDERSERVED POPULATIONS

Evidenced-Based Reality:
Members of certain groups have had limited access to quality health care.

1. Recognizing whether someone is “approaching the end stages of serious life-limiting illness” may be complicated if the person has been undertreated over time for chronic conditions.

2. Acknowledging biases about someone’s potential to understand and tolerate treatment can also complicate determinations regarding the end stages of illness.

Guidelines for end of life conversations:

• Do not rush end of life conversations

• Be sensitive to potential cultural & linguistic barriers

• Recognize & respect cultural & faith-based values as they may impact personal & family beliefs as reflected in goals of care & decision making
• **MOLST is not intended** for those with significant disabilities who have the potential to live with the assistance of life-supporting technologies or medical interventions such as feeding tubes & ventilators.

• **Persons ought not to be “steered” away from interventions** that can make lives easier, improve health, or sustain life because one thinks the patient is “suffering” or has a poor “quality of life.”

• **These subjective determinations are determined by the patient.**

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For people with long term, relatively stable or slowly progressive disabilities who *already use life-supporting technologies*, consider:

• **Is the person “approaching the end stages of a terminal illness,”** as opposed to simply losing some functional capacities for which compensatory adjustments could be made?

• **Is the person experiencing a significant decline/deterioration in health** (e.g. frequent aspiration pneumonias, fevers of unknown origin) such that medical or surgical intervention will not significantly impact the process of decline?
MOLST PILOT PROGRAM

• MOLST Pilot Participants
  • UCONN Health
  • Hartford HealthCare at Home
  • Windham/Willimantic
  • Apple Rehabilitation
  • iCare
  • Middlesex Hospital
  • St Vincent’s Hospital
  • St Francis Hospital
  • Bridgeport Hospital

1. Patient must:
   1. be informed
   2. agree to participate
   3. have the MOLST conversation & complete the form
   4. sign an “Agreement to Participate” (filed in provider’s office)

2. Site must:
   Collect Data
   Send to DPH
PARTICIPANTS IN THE MOLST PILOT PROGRAM

1. Patients
2. Primary Care & Other Providers
3. Hospitals
4. Extended or Long Term Care Facilities
5. Home Health Agencies
6. Emergency Medical Services (EMS)
7. Hospice Agencies

PILOT PROGRAM PHASES

Education First:

1. Administrative & clinical persons in designated regions
2. Public
3. Educational Tools Developed by the CT MOLST Task Force & Connecticut Coalition to Improve End of Life Care
4. Formation of DPH MOLST Website

April 16, 2015 – Pilot Program Launch

April 15, 2017 – Pilot Program Ends & Data Analysis Begins
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<td>5.</td>
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<td>12.</td>
<td>Ethnicity</td>
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<td>13.</td>
<td>Disability Question</td>
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**MOLST DATA ELEMENTS (13) ONE FORM/MOLST**

**ALL INFORMATION AVAILABLE ON LINE**

[www.ct.gov/dph](http://www.ct.gov/dph)  
*Click on* - Featured Links  
*Click on* - Medical Orders for Life-sustaining Treatment
MOLST is:

a) Medical Orders for Life-Sustaining Treatment  **TRUE**

b) a document to replace a Do Not Resuscitate order  **FALSE**

c) Mandatory Obligations to provide Life-Sustaining Treatment to all persons in cardiac arrest  **FALSE**

When discussing MOLST with those who have pre-existing disabilities, which would be considered best practice:

a) Do not rush the conversation  **TRUE**

b) Provide gentle suggestions to steer towards choosing limitations on life-sustaining care  **FALSE**

c) Cultural & linguistic barriers are not usually of concern  **FALSE**
MOLST in CT:

a) Designed after the national POLST paradigm **TRUE**
b) Developed due to the low use of living wills in **FALSE**
c) Signed into law by the Governor of **FALSE**

The goal of MOLST is to:

a) ensure patient autonomy through discussions with health care providers **TRUE**
b) substitute MOLST for an existing living will **FALSE**
c) limit medically futile aggressive care **FALSE**
The process of advanced care planning using the MOLST is to:

a) Have an end-of-life conversation with health care provider to establish options for treatments that coincide with stated goals of care **TRUE**

b) Complete the MOLST form and bring it to a health care provider **FALSE**

c) Discuss end-of-life care preferences with physician and ask him/her to record them in the medical record **FALSE**

A MOLST form & a living will:

a) are two different documents **TRUE**

b) are the same documents **FALSE**

c) can be used interchangeably as they contain the same information **FALSE**
Conditions for eligibility for a MOLST are:

a) end-stage serious life-limiting illnesses or conditions of advanced chronic progressive frailty - **TRUE**
b) early stages of all potentially terminal cancers - **FALSE**
c) any condition the patient reports - **FALSE**

A “legally authorized representative” is:

a) Parent, guardian, or health care representative - **TRUE**
b) Next-of-kin or conservator - **FALSE**
c) Spouse, next-of-kin or health care agent - **FALSE**
QUESTIONS?

“In case of emergency, do you have a DNR — Do Not Recycle?”