



FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

MOLST Demonstration Project

Medical Orders for Life-Sustaining Treatment

Care Transitions Seminar

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MOLST Steering Committee
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Part 1: Background

- What is the MOLST Program?
- Why do MOLST?
 - ✓ The national evidence
 - ✓ The need in MA

Part 2: MOLST Program

- MOLST form and core principles
- Steering Committee
- Project Structure
- Demonstration Project
- Deliverables / Timeframe
- Communication
- Challenges and Next Steps
- MOLST and Transitions in Care

What is MOLST?

- **Definition:** “Medical Orders for Life Sustaining Treatment”: a portable medical form signed by both patient and health care providers (MD, RN, or PA) after discussion with the patient or surrogate; The form translates a patient’s wishes for end of life care into immediately actionable medical orders respected across health care settings.
- **Goal:** To implement a process in MA for communicating patients’ wishes for care at the end of life similar to the Physician Order for Life Sustaining Treatment (POLST) Program started in Oregon(1995) and now in states such as WA, NC, WI, NY, WV, and CA.

Why do this?

There is national evidence...

- Many patients and families are not aware of their options for medical care at the end of life and have not discussed their wishes surrounding invasive or other end of life treatments, hospice and palliative care^{1,2}.
- MOLST allows you to discuss AND document your specific life-sustaining treatments.
- Even patients and families who are aware of their service options and who have communicated their wishes to their PCP may not have those wishes honored, due to failure of communication among providers or of documents to transfer across settings³.
- The MOLST form is intended to accompany the patient from setting to setting as a medical order. DPH will allow OEMS to honor MOLST in the demonstration area while encouraging other regulated entities/regulators to accept MOLST.
- 70% of Americans have indicated a preference to die at home⁴ and significant resources have been devoted to this goal the last 20 years including enacting laws to make it easier for individual preferences to be honored.
- In MA there has been a considerable shift in location of death mostly from hospital to nursing home⁵. In addition, by defining preferences for life-sustaining treatment using MOLST, you are possibly defining where you will spend your last days or hours.

1.

2. Cherlin E, et al. Communication between physicians and family caregivers about care at the end of life: when do discussion occur and what is said? *J Palliat Med.* 2005; 8(6):1176-85.

3. Lee, MA, et al. Physician orders for life-sustaining treatment (POLST): outcomes in a PACE program. Program of All-Inclusive Care for the Elderly. *J Am Geriatr Soc.* 2000; 48(10):1219-25.

4. Means to a better end: A report on dying in America today. *Last Acts, Robert Wood Johnson Foundation.* November, 2002

5. Data from Jean Teno

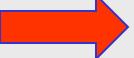
- In 1997, the proportion of deaths at home ranged from 15% to 36% across the 50 states, with a national mean of 24.9%⁵;
- In MA, 20% of deaths in MA occurred in homes, and in 2005, the number had only risen to 22%⁵.
- That said, with over 62 hospices providing care for terminally ill people throughout MA, in 2007 Massachusetts hospices cared for approximately **full 40%** of all deaths in Massachusetts. (21,258 patients, up from 5,359 patient in 1991)⁶
- Paralleling the 2008 Dartmouth Atlas study findings, the Massachusetts Division of Health Care Finance and Policy found significant variation in resource use at the end of life from one MA hospital to another, with patient preference unlikely to explain most of this variation⁷.

5. Means to a better end: A report on dying in America today. *Last Acts*, Robert Wood Johnson Foundation. November, 2002.

6. NHPCO National Data Set 2007, H&PCFM Membership Applications 2008

7. DHCFP, Analysis in Brief, Analysis in Brief: Hospital Resource Use on End-of-Life Patients Varies; No. 9, July, 2006.

In April, 2008, HCQCC release its first annual report.

- **6 Goals with strategies** (“recommendations”) for insurers, employers, and consumers to improve health care quality while reducing costs
- **1 Goal for end of life care:** “Develop processes and measures to improve adherence to patient wishes for care at the end of life.”
 **1st recommendation acted on:** “hospitals, nursing homes, physicians, and other providers should implement by 2010 a process for communicating patients’ wishes for end of life care SIMILAR to Oregon’s POLST Program (Physician Orders for Life Sustaining Treatment); The POLST Paradigm program is now used in other states including NY, CA, WI, WV, NC, and WA.

Part 2: How will MOLST work?



- MOLST form and core principles
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Oregon's POLST form



HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT		
Physician Orders for Life-Sustaining Treatment (POLST)		
<p>First follow these orders, then contact physician, NP, or PA. These medical orders are based on the person's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.</p>		
A <input checked="" type="checkbox"/> Check One	<p>CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse <u>and</u> is not breathing.</p> <p><input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (<u>Allow Natural Death</u>)</p> <p>When not in cardiopulmonary arrest, follow orders in B, C and D.</p>	
B <input checked="" type="checkbox"/> Check One	<p>MEDICAL INTERVENTIONS: Person has pulse <u>and/or</u> is breathing.</p> <p><input type="checkbox"/> Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.</i></p> <p><input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). <i>Transfer to hospital if indicated. Avoid intensive care.</i></p> <p><input type="checkbox"/> Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <i>Transfer to hospital if indicated. Includes intensive care.</i></p> <p><i>Additional Orders:</i> _____</p>	
C <input checked="" type="checkbox"/> Check One	<p>ANTIBIOTICS</p> <p><input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms.</p> <p><input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs.</p> <p><input type="checkbox"/> Use antibiotics if medically indicated.</p> <p><i>Additional Orders:</i> _____</p>	
D <input checked="" type="checkbox"/> Check One	<p>ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.</p> <p><input type="checkbox"/> No artificial nutrition by tube.</p> <p><input type="checkbox"/> Defined trial period of artificial nutrition by tube.</p> <p><input type="checkbox"/> Long-term artificial nutrition by tube.</p> <p><i>Additional Orders:</i> _____</p>	
E	<p>REASON FOR ORDERS AND SIGNATURES</p> <p>My signature below indicates to the best of my knowledge that these orders are consistent with the person's current medical condition and preferences as indicated by the discussion with:</p> <p><input type="checkbox"/> Patient <input type="checkbox"/> HealthCare Representative <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other _____</p>	
<p>Print Primary Care Professional Name _____</p> <p>Print Signing Physician / NP / PA Name and Phone Number _____ ()</p> <p>Physician / NP / PA Signature (mandatory) _____ Date _____</p>		<p>Office Use Only</p>
<p>SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED</p>		

DRAFT MOLST form for Massachusetts- Sections



1. CPR (person not breathing; has no pulse)
2. Intubation and mechanical ventilation (person has pulse and may or may not be breathing)
3. Transfer to hospital (yes, yes but not to ICU, no)
4. Signature of MD or authorized NP or PA
5. Signature of the person OR the surrogate decision-maker (can be parent of minor child, health care agent appointed by the person, court-appointed guardian)
6. “Other preferences”: Checkboxes for: dialysis, artificial nutrition, IV Fluid, and blood products.

Core principles



1. MOLST must be completed by a healthcare professional based on the *current medical condition* and treatment preferences of the patient/resident and the patient/resident.
1. Form is reviewed and a new form completed if:
 1. Patient/resident transferred from 1 care setting or level to another
 2. Substantial change in health status, or
 3. The patient/resident's treatment preferences change.
1. Patient/resident OR surrogate (if patient incapacitated) can revoke the form at any time and request different treatment.
1. Form should be sent with patient/resident whenever transferred or discharged.
1. Use of original form encouraged but copies, faxes, or electronic copies valid.

How will MOLST build upon our current system of documenting patient wishes in MA?



- The MA CC/DNR protocol is a protocol authorized and mandated by the MA DPH.
- The MOLST Worcester demonstration does **not** change the role of this Protocol in MA.
- *MOLST is an improvement on the MA Comfort Care/Do Not Resuscitate program in that it covers more types of treatment and within/across more treatment settings.*
 - During the demonstration project, providers will be encouraged to use both forms as complements.

MOLST Steering Committee Core Organizations*



- U. Mass Memorial Medical Center (UMMMC)
 - University Campus
 - Memorial Campus
 - Marlboro Hospital (participation TBD)
 - Ethics Committee
- EOHHS-Executive Office of Elder Affairs
- EOHHS- MassHealth
- MA Department of Public Health
- Partners HealthCare System

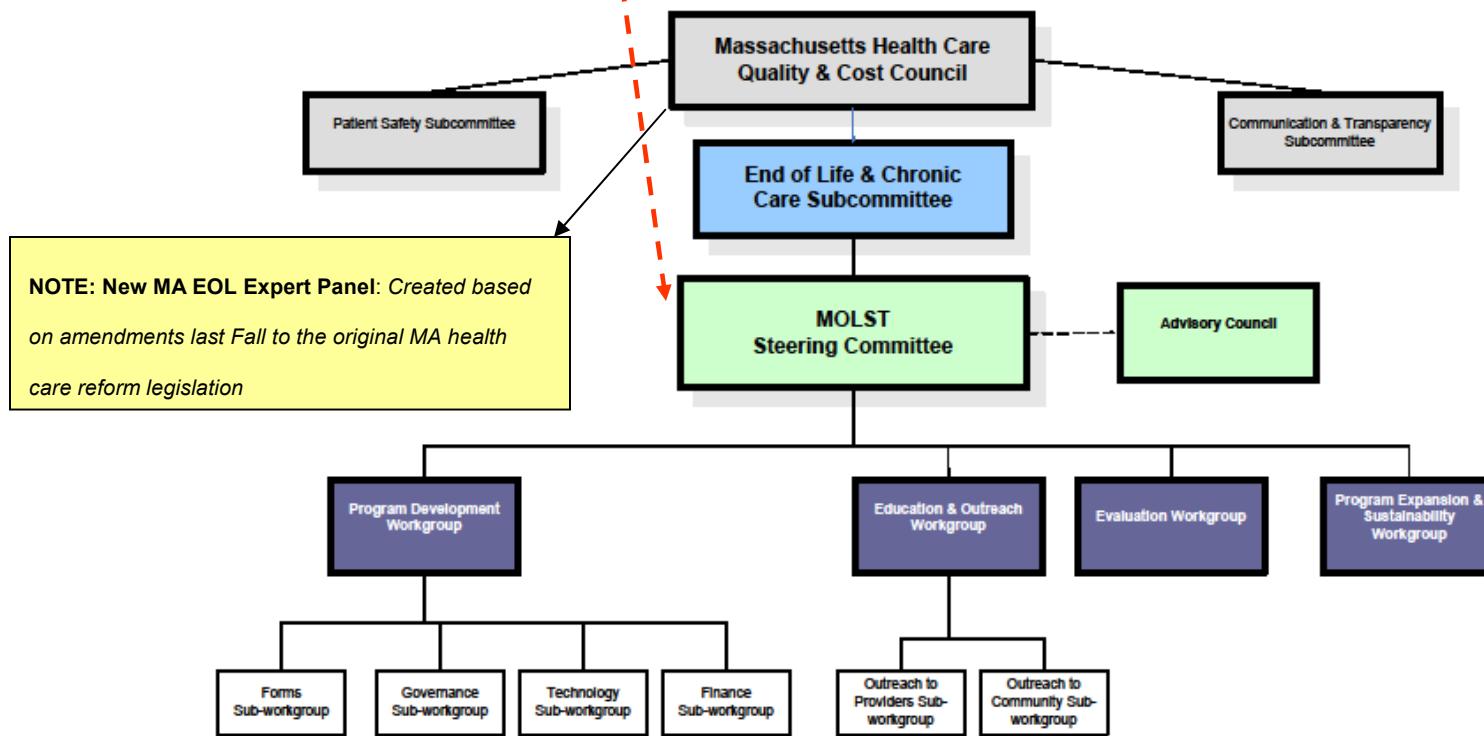
Other partners: Governor's Office, VNA Hospice and Hospice, Palliative Care Federation of Massachusetts, Long-term Care Foundation, Mass Health Data Consortium, Better Endings Partnership (Worcester).

MOLST Project Origins



DRAFT 12/12/2008

MOLST PROJECT – ORGANIZATIONAL STRUCTURE



MOLST Project Committee Structure



MOLST

Steering Committee

Chairs: Andy Epstein and Ruth Palombo

Work Groups

Program Development

Chairs: Mary Valliere and Dominique Kim

Evaluation

Chair: Rick McManus

Education & Outreach

Chair: Pauline Edmonds

EOHHS

Andy Epstein
Programmatic Liaison
EOHHS Dept. of Public Health
• OEMS
• Legal aspects
• Regulatory aspects

Ruth Palombo
Programmatic Liaison EOHHS
Executive Office of Elder Affairs
• Legislative
• EOHHS
• Leadership

Rick McManus
Evaluation Liaison UMMS CHPR
• Academic research
• Program evaluation

UMMS Center for Health Policy Research

Tom McLaughlin, *Senior Director*
Richard McManus, *Project Lead*
Jena Adams, *MOLST Project Director*

Pam Macleod
Senior Program Development Associate
(until 6/09)

Peg Metzger, *Project Consultant*

Clinical Liaisons

Mary Valliere
Clinical Liaison UMMC
• University campus
• Memorial campus
• Marlboro Hospital ? (TBD)
• Ethics committee

Marc Restuccia
Clinical Liaison EMS
• UMMHC EMS
• First responders
• Town/private EMS

TBD
Clinical Liaison sub-acute care
• Shrewsbury N & R
• Notre Dame LTCC
• Jewish Healthcare Center

TBD

Clinical Liaison home care
• VNA Care Network
Hospice
• UMMC Home Health
& Hospice
• **Jewish Home Hospice?**

Demonstration project local participants

U. Mass Worcester community (Central MA)



Hospitals (U. Mass Memorial Medical Center- UMMC)

- University Campus
- Memorial Campus
- Marlboro Hospital (TBD)
- Ethics Committee

Long-term acute care

- Parkview
- Whittier
- Fairlawn

Sub-acute care

- Shrewsbury Nursing & Rehabilitation (short & long-term care)
- Jewish Health Care Center (1 assisted living and 1 long term care facility)
- Notre Dame Long Term Care Center & Hospice

Home Care

- UMMC Home Health & Hospice
- Jewish Home Hospice
- Visiting Nurse Agency Care Network & Hospice

EMS

- EMS Services (Worcester office)
- First responders and town/private EMS
- Local supporting senior care and related organizations

Demonstration Project Deliverables

Timeframe: CY2009 - CY2010



- **Program Development Workgroup:**
 - Completion of MOLST form for MA
 - Create administrative policies and procedures per local setting
 - Train providers on use and implementation of program
 - Maintain ongoing communication with local providers/stakeholder participants in demonstration project
 - Work with DPH and legal experts to address policy/legal/regulatory issues.
- **Education and Outreach Workgroup:**
 - Initial and ongoing consumer education on palliative care and MOLST.
- **Evaluation Workgroup:**
 - Process and outcome measurement to assess the attitudes and effectiveness of the MOLST program in the demonstration project.
 - Results to serve as the basis for spread of the MOLST program state-wide.

All workgroups, not just evaluation, incorporate communication to stakeholders and sustainability of the model into their planning and timelines.

DHHS/State level:

- Health Care Quality and Cost Council (HCQCC)
 - JudyAnn Bigby, MD: Secretary of Executive Office of HHS (MA)
- End of Life Subcommittee of the HCQCC
- The MA Panel on End of Life Care (1st meeting 4/27)
- MOLST Steering Committee

Local demonstration project area:

- Task Force clinical members/groups
- Non-clinical stakeholders (administrators, community agencies/organizations) impacted by the MOLST project, e.g. neighboring primary and tertiary care providers

A Big Challenge:

- Clarify the legal implications of MOLST *in practice*
 - When there is no proxy and the patient is incapacitated, will the default surrogate be permitted to sign the MOLST form and make decisions on behalf of the patient?
 - Will default surrogate status be “honored” across ***all*** settings along the continuum? Has to be for MOLST to be fully effective.

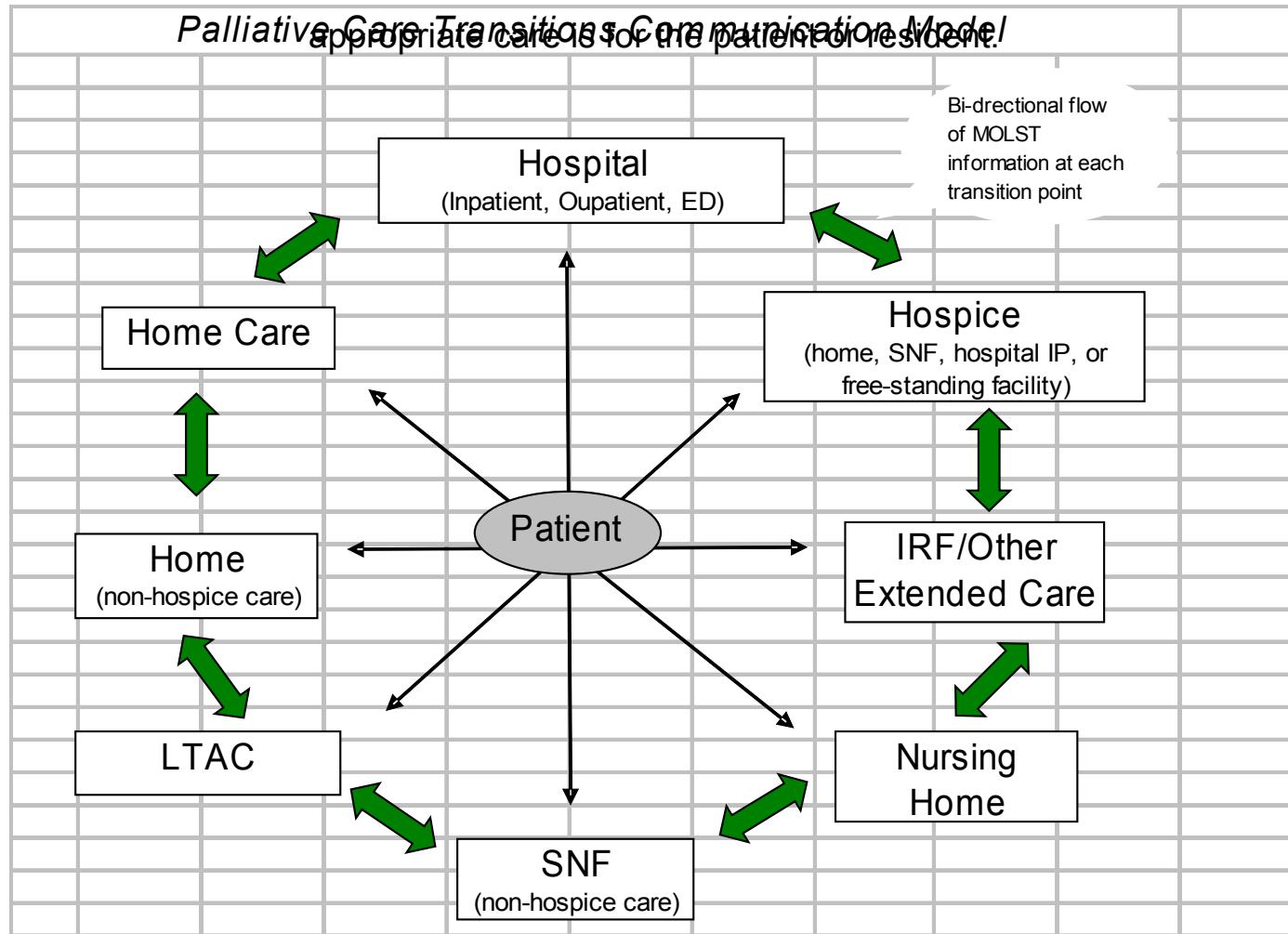
Next Steps:

- Complete demonstration project and evaluation
- Spread MOLST program throughout MA
- Electronic registry
 - Since POLST started in 1995, Oregon is now developing a registry.
 - With the new Federal regulation surrounding EMR adoption, **now** is the time to include information about MOLST.

How MOLST addresses care at the transitions...



Provides clarity and prevents indecision about what a patient's preferences are at the end of life; Makes it clear to providers and families what the next step and setting of care will be.



1. Preventing Unnecessary Hospitalizations Project (IHI)

- Commonwealth Fund grant to study ways to reduce avoidable hospital readmissions.
- Focus on process improvements for hospital discharge and technical assistance for reducing re-hospitalizations.
- MA is one of many project states.
- 4-year project starts in May, after the 9-mth planning phase
- The project is about improving the community-oriented continuum of care but will initially focus on hospital discharges.
- IHI encouraging hospitals to create local teams with nursing homes, home health agencies, and other providers.
- Related Potentially Preventable Readmissions Project- DHCFP)

1. Continuum of Care Consortium (Cooley Dickinson)

“People-intensive model” to reduce readmissions by congestive heart failure patients admitted 4-5 times a month, including their palliative needs have to be addressed; “*We’re desperately waiting for the MOLST tool!*”

The full potential of the MOLST Program to improve the care and quality of life for patients at the end of life and their families in MA will only be realized through interdisciplinary collaboration, education, and partnerships spanning *across* the borders of our multi-faceted and complex health care system...

THANK YOU!

Appendix 1: Research support for MOLST



These and more citations at www.polst.org, link:
<http://www.ohsu.edu/polst/resources/research+references.htm>)

- In hospices in OR, WI, and WV, POLST is well regarded by hospice staff and allows for greater individualization of care plans than traditional approaches focused on code status. In the hospice population, DNR does not equal “do not treat.”¹
- EMTs in OR find the POLST Program useful in making treatment decisions for seriously ill patients and often use the form, when present, to change treatment decisions.²
- In a sample of nursing homes across OR, WV, and WI³:
 1. POLST is effective at limiting use of unwanted list-sustaining treatments, and
 2. POLST is effective at translating treatment patients of dying patients into immediately actionable medical orders.
 - Patient preferences are *documented as treatment orders* that can be followed.
 - A wide *range* of treatments can be discussed.
 - Among nursing home residents, those with POLST orders HAD many more medical orders about LST than residents with more traditional ADs.

1. Hickman, S.E., Nelson, C.A., Moss, A., Hammes, B.J., Terwilliger, A., Jackson, A., & Tolle, S.W. (2009). Use of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program in the Hospice Setting. *Journal of Palliative Medicine*, 12(1), 1-6.
2. Schmidt TA, Hickman SE, Tolle SW, Brooks HS. (2004). The Physician Orders for Life-Sustaining Treatment (POLST) Program: Oregon Emergency Medical Technicians' Practical Experiences and Attitudes. *Journal of the American Geriatrics Society*, 52, 1430- 1434.
3. National Institute of Nursing Research-funded study in 139 hospice programs and 685 nursing homes in OR, WV, and WI(Lacrosse area)