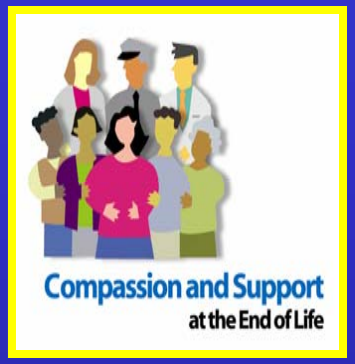


Opening Remarks
Honoring Preferences, The Role of MOLST
Medical Orders for Life-Sustaining Treatment

Patricia Bomba, M.D., F.A.C.P.

Vice President and Medical Director, Geriatrics

Director, Education for Physicians on End-of-life Care

Director, Honoring Patient Preferences, The Role of MOLST

Co-Director, Community-wide End-of-life/Palliative Care Initiative

Excellus

Collaborators

- Community-Wide End-of-Life/Palliative Care Initiative
- Rochester Health Comission
- URMC Palliative Care Program
- Lifetime Care
- MedAmerica Insurance Company
- Long Term Care Executive Council
- Utica Palliative Care Consultation Service

Acknowledgements

- Co-leaders, Community-Wide End-of-life/Palliative Care Initiative
- Co-chairs and Members, MOLST workgroup
- MOLST Hospital and LTC Facility Champions
- New York State Department of Health
- Medical Society State of New York, Ethics Committee
- MOLST Conference Faculty
  - Presenters and Syllabus Development
- MOLST Conference Implementation Team
- MOLST Conference Attendees

MOLST Program

- The purpose of the MOLST program is to express patients' treatment goals based on communication with patients and/or surrogates acting in their capacity according to NYS Law (i.e. informed consent process).
- It is not just a form but also a program that brings together multiple professionals and institutional providers from across the health care system to meet the goals of patients.

Background

- *Approaching Death: Improving Care at the End of Life*
  - Institute of Medicine Report, 1997
- *Community End-of-Life Survey Report*
  - RIPA/EBCBSRR EOL/Palliative Care Professional Advisory Committee, January 2001
- *Community-wide End-of-life/Palliative Care Initiative*
  - Rochester Health Care Forum, March 2001
- *Community-wide Guidelines Initiative*
  - Community Principles of Pain Management, December 2001

Community-wide End-of-life/ Palliative Care Initiative

Advance Care Planning

- Community Conversations on Compassionate Care

Honoring Preferences

- Medical Orders for Life-Sustaining Treatment (MOLST)

Pain Management and Palliative Care

- Community Principles of Pain Management
- *CompassionNet*

Education and Communication

- *Education for Physicians on End-of-life Care (EPEC)*
- Community web site: www.compassionandsupport.org

MOLST Development: Goals

- To promote patient autonomy by documenting a person's treatment preferences with regard to CPR (both inside and outside of hospitals and long-term care facilities), mechanical ventilation and other life-sustaining treatment, and coordinating these with physician orders.
- To enhance and facilitate the authorized transfer of these patient preferences between facilities in a form that can be used across all sectors of the health care system.

MOLST Development: Goals

- To facilitate appropriate treatment by EMS personnel.
- To reduce repetitive documentation in complying with New York State law and the federal Patient Self-Determination Act.

POLST

- A decade of research in Oregon has proven that the POLST Program more accurately conveys end-of-life preferences and yields higher adherence by medical professionals.

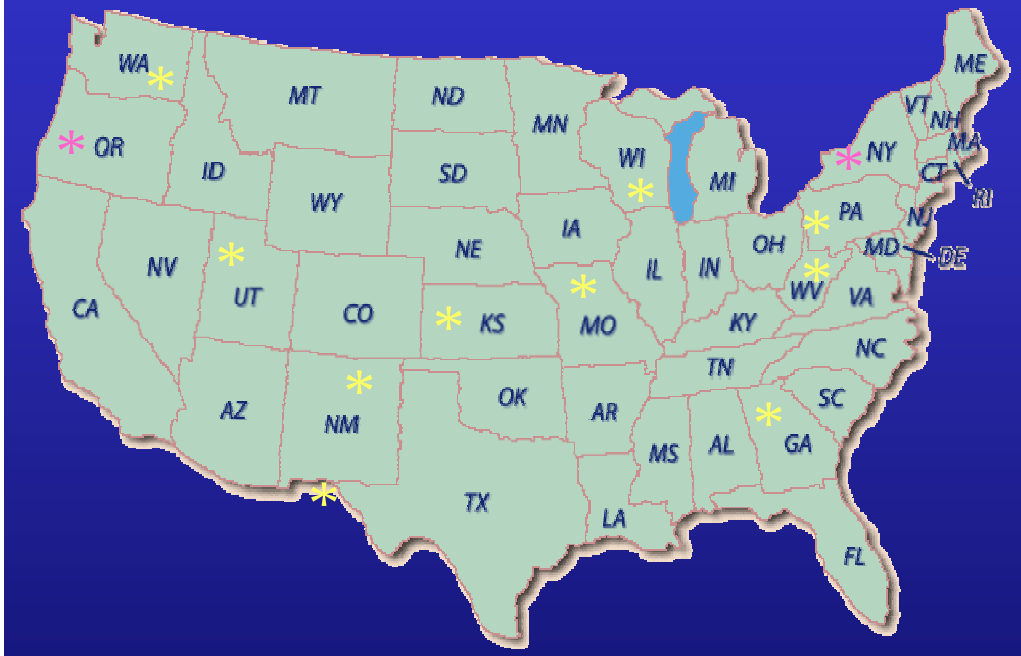
Lee, Brummel-Smith, et al. JAGS. 2000; 48(10): 1219-1225
Meyers, et al. J Gerontol Nurs. 2004; 30(9): 37-46
Schmidt, Hickman, Tolle, Brooks. JAGS. 2004; 52(9): 1430-1434

POLST

- The POLST Program has been a key vehicle in Oregon's successful efforts to increase the effectiveness of advance care planning and decrease unwanted hospitalizations at the end of life.

Tolle SW, Tilden VP. J Palliative Med. 2002; 5(2): 311-317

POLST is Spreading



Parts of:

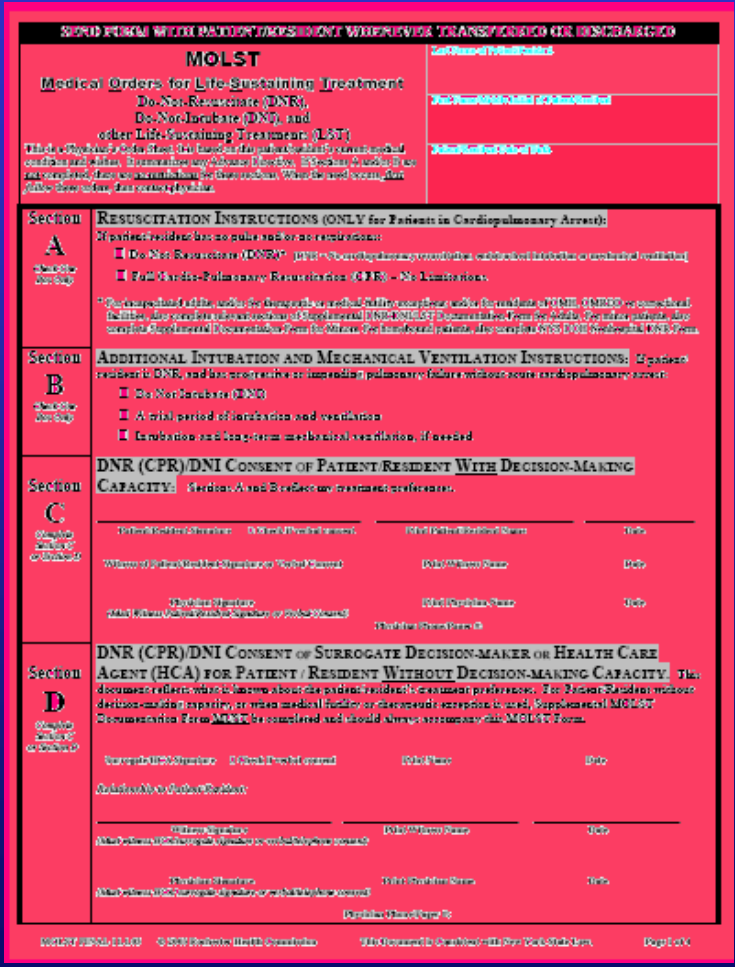
Georgia, Kansas, Missouri, New Mexico, Utah, Washington, West Virginia, Wisconsin, New York, Pennsylvania

National POLST Paradigm Initiative

Paradigm of communication, documentation, and system responsiveness

POLST Paradigm, 2005.www.polst.org

MOLST



MOLST

Medical Orders for Life-Sustaining Treatment

Do-Not-Resuscitate (DNR),
Do-Not-Intubate (DNI), and
other Life-Sustaining Treatment (LST)

Section A — Resuscitation Instructions (ONLY for Patients in Cardiopulmonary Arrest):

Section B — Additional Intubation and Mechanical Ventilation Instructions:

Section C — DNR (CPR)/DNI Consent of Patient/Resident With Decision-Making Capacity:

Section D — DNR (CPR)/DNI Consent of Surrogate Decision-Maker or Health Care Agent (HCA) for Patient / Resident Without Decision-Making Capacity:

- Created by the Community-wide End-of-Life/Palliative Care Initiative
- Adapted from Oregon's POLST form
- Combines DNR, DNI, and other Life-Sustaining Treatments
- Incorporates NYS law

November 2003

Core Elements of MOLST

- The form is actionable medical order.
- The process includes training of health care professional across the continuum of care about the goals of the program as well as the creation and use of the form.

Core Elements of MOLST

- Completion of the form is recommended for use in persons who have advanced chronic progressive illness and anyone interested in further defining their care wishes.

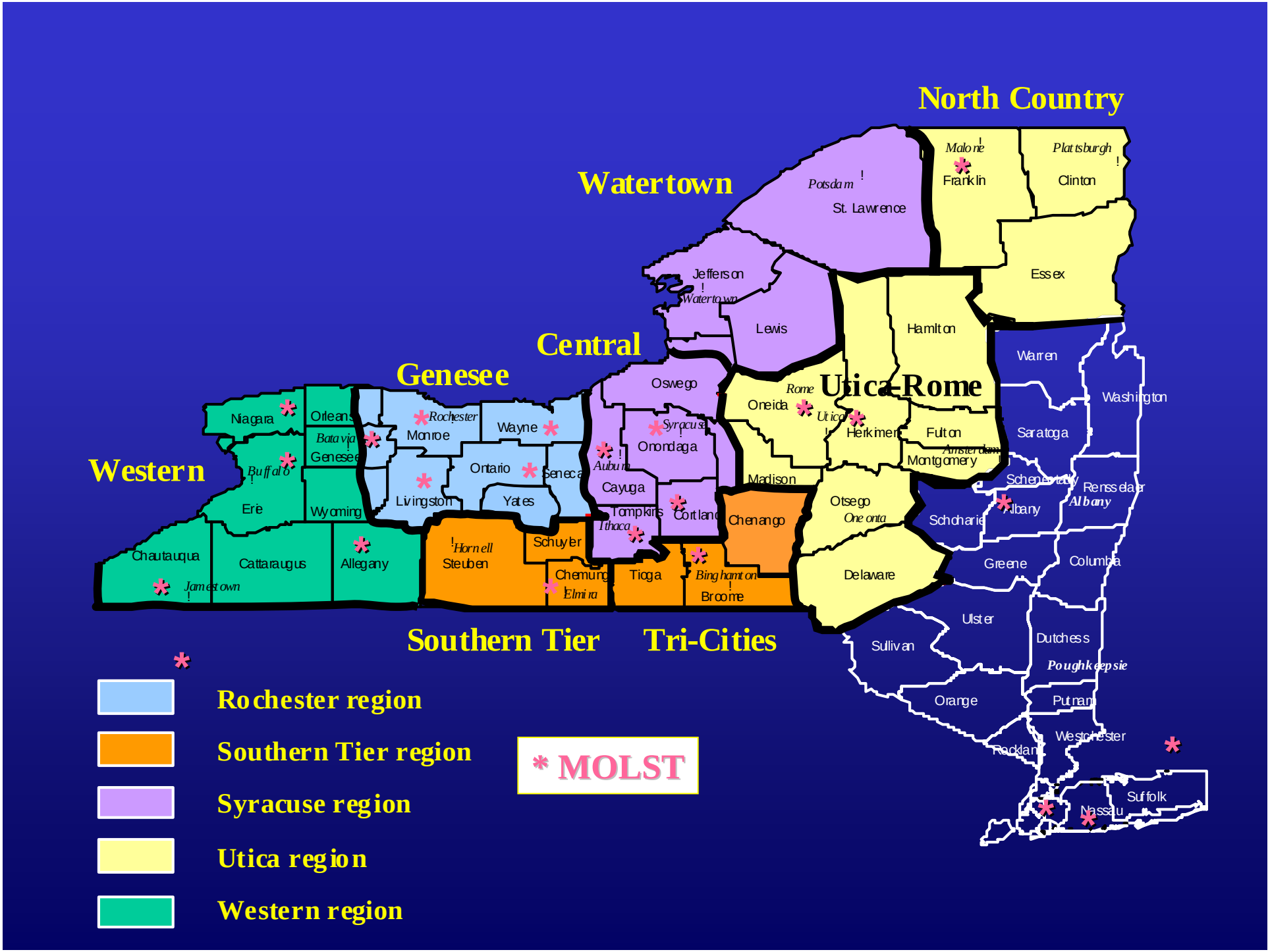
- The form may be used either to limit medical interventions or to clarify a request for all medically indicated treatments including resuscitation.

Core Elements of MOLST

- The form provides explicit direction about resuscitation status if the patient is pulseless and apneic.
- The form also includes directions about other types of intervention that the patient may or may not want. For example, decisions about transport, ICU care, antibiotics, artificial nutrition, etc.

Core Elements of MOLST

- The form accompanies the patient, and is transferable and applicable across care settings (i.e. long-term care, EMS, hospital).
- The form is uniquely identifiable, standardized, and a uniform pink color.
- There is a plan for ongoing monitoring of the program and its implementation.


North Country
Watertown
Central
Genesee
Western
Utica-Rome
Southern Tier
Tri-Cities
Potsdam
St. Lawrence
Malone
Franklin
Plattsburgh
Clinton
Essex
Jefferson
Watertown
Lewis
Hamlton
Warren
Washington
Saratoga
Oswego
Rome
Oneida
Utica
Herkimer
Fulton
Amsterdam
Montgomery
Schenectady
Rensselaer
Albany
Niagara
Orleans
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Rochester
Monroe
Wayne
Buffalo
Erie
Wyoming
Livingston
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Binghamton
Broome
Ulster
Sullivan
Dutchess
Poughkeepsie
Orange
Putnam
Westchester
Rockland
Suffolk
Nassau
Rochester region
Southern Tier region
Syracuse region
Utica region
Western region
* MOLST

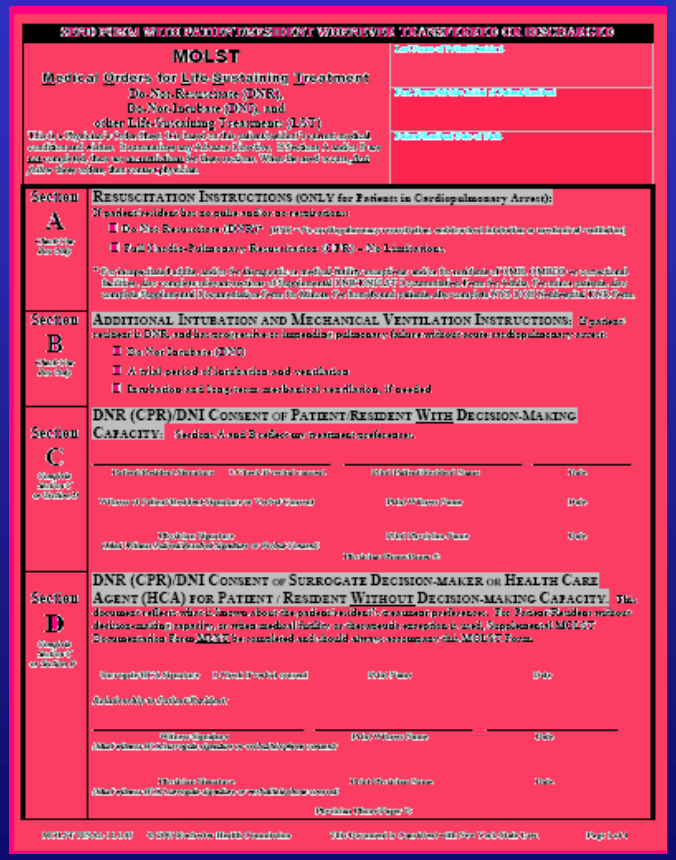
MOLST 2005 Review and Revision

- New York State Department of Health
- Community-Wide End-of-Life/Palliative Care Initiative
- Medical Society of State of New York Ethics Committee

Day 1 Systems Approach

- Plenary 1: Advance Care Planning: Where does MOLST fit?
  MOLST Revision and NYS Law
- Plenary 2: Decisional Capacity: Legal, Ethical & Clinical Considerations
- Plenary 3: The Critical Role of EMS in Community Implementation of MOLST
- WORKSHOPS - Implementation of MOLST in Care Settings
- Panel: Community Implementation Across Care Settings
- Keynote: Quality Improvement, Monitoring to Achieve Success

MOLST Community Pilot



MOLST

Medical Orders for Life-Sustaining Treatment
Do-Not-Resuscitate (DNR),
Do-Not-Intubate (DNI) and
other Life-Sustaining Treatment (LST)

Section A — Resuscitation Instructions (ONLY for Patients in Cardiopulmonary Arrest):
- Do Not Resuscitate (DNR)
- Full Cardio-Pulmonary Resuscitation (CPR) – No Limitations

Section B — Additional Intubation and Mechanical Ventilation Instructions:
- Do Not Intubate (DNI)
- A trial period of intubation and ventilation
- Intubation and long-term mechanical ventilation, if needed

Section C — DNR (CPR)/DNI Consent of Patient/Resident With Decision-Making Capacity:

Section D — DNR (CPR)/DNI Consent of Surrogate Decision-Maker or Health Care Agent (HCA) for Patient / Resident Without Decision-Making Capacity

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)

Regional Pilot in Monroe and Onondaga Counties, Approved NYSDOH, October 2005

Governor signed MOLST bill, October 11, 2005

Day 2 Patient Approach

- Plenary 4: Myths and Truths of CPR: Conversations Based on Evidence
- Plenary 5: Exploring the Goals and Values that Guide Decisions about DNR and Other Potentially Life-Sustaining Treatments
- WORKSHOPS - Putting it Together to Meet the Patient's Goals
- WORKSHOPS - Discussions about Artificial Nutrition: A Practical Approach

8-Step Protocol

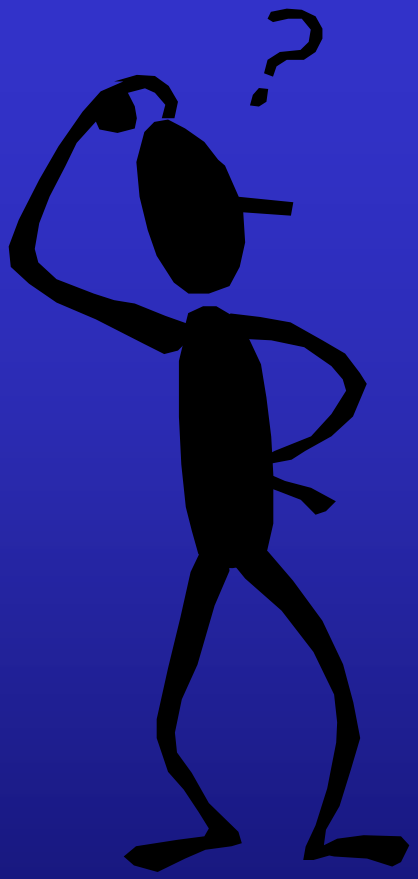
1. Prepare for discussion
   - Understand the patient and family
   - Understand the patient's condition and prognosis
   - Retrieve completed Advance Care Directives
   - Determine "Agent" (Spokesperson) or responsible party
2. Determine what the patient and family know
   - re: condition, prognosis
3. Explore goals, hopes and expectations

Developed for NYS MOLST, Bomba, 2005

8-Step Protocol

4. Suggest realistic goals
5. Respond empathetically
6. Use MOLST to guide choices and have patient/family share wishes
   - Shared medical decision making
   - Conflict resolution
7. Complete and sign MOLST
8. Review and revise periodically

Developed for NYS MOLST, Bomba, 2005



Questions?

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"Knowing is not enough; we must apply.
Willing is not enough; we must do."

Goethe