

Massachusetts MOLST Implementation Tool Kit



Tools, Resources & Lessons Learned for Implementing MOLST Use into Clinical Care Practice

This Tool Kit was developed to assist any type of clinical care institution prepare for and establish institutional policies and procedures to guide the appropriate use of the Massachusetts MOLST form. The Tool Kit includes work plans, sample policies, training overviews and other practical tools and resources that have proven useful to clinical care settings in the Commonwealth. The Tool Kit was developed in consultation with the MOLST expansion team and with input from statewide stakeholders by Jena Bauman Adams, MPH and Mary Valliere, MD.



Step One: PREPARATION

- ❖ MOLST can be implemented effectively in most institutions in a relatively short period of time with the appropriate commitment of time and other resources
- ❖ Adequate time must be invested in the preparatory work of developing MOLST policies and procedures, and approval processes
- ❖ Institutions need an on-site “MOLST champion” to succeed with MOLST implementation.

- From “Lessons Learned, MOLST Demonstration Program Recommendations for Statewide Expansion, Pilot Results 2011”

Step One: Preparation – Overview

Key tasks for Preparation include:

- 1) Identifying Institutional MOLST Champion(s)
- 2) Establishing Institutional Readiness
- 3) Establishing an Institutional MOLST Task Force

If MOLST is being implemented in multiple locations – either in multiple settings of a single institution or in other collaborating institutions (e.g. as with cross -continuum team) – also consider which preparatory activities should be carried out at each locale and plan accordingly.

-  [Tool 1–1 Preparation Task Checklist](#) - Outline of all recommended activities for Preparation
-  [Tool 1–2 MOLST Video](#) – Patients, clinicians, EMTs, clergy and others talk about MOLST (13 minutes)

Task 1: Identify Institutional Champion(s)

Implementing MOLST in an institution requires agreement and support from within. This means securing prior approval and commitment from institutional leadership, as well as designating key personnel as “MOLST Clinical Champion(s)” to actively champion and steer site-level implementation activities.

The Clinical Champion serves as the institution’s MOLST expert and coordinator. Clinical Champions engage in the tasks of preparing institutional policies, protocols and infrastructure; identifying strategies and venues for staff education and training; creating tools and methods for tracking MOLST activity; and performing oversight and troubleshooting during the MOLST implementation process.

If the institution has multiple patient care sites, or is implementing MOLST in collaboration with other institutions (e.g. facilities that send or receive patients to or from the institution to receive care), each site or institution should designate a MOLST Clinical Champion.

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- [Tool 1–3 MOLST Clinical Champion Role Description](#) - Specific tasks of the role
 - [Tool 1-4 Clinical Champion Orientation Materials](#) – Key MOLST information Champions need to know

Task 2: Establish Institutional Readiness

Most institutions are complex with many “moving parts.” Implementing MOLST requires engaging and informing patient care providers and other stakeholders throughout the institution. This can be accomplished during a series of “institutional readiness meetings” conducted by the Clinical Champion(s) with key individuals and groups, to engage and inform them about MOLST implementation.

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- [Tool 1–5 Institutional Readiness Meetings](#) – Key individuals and groups to engage; suggested meeting content and resources to share

Task 3: Establish Institutional MOLST Task Force

The Clinical Champion role includes recruiting, facilitating and coordinating the activities of an Institutional MOLST Task Force. The Task Force is comprised of key participants from throughout the institution who are willing and available to meet over a period of several months. The Task Force role is to advise, support, make decisions about, and support site-level MOLST implementation.

For institutions with multiple sites or groups of institutions implementing MOLST together, the Task Force should include members from each site. It may also be advisable to consider forming a MOLST Task Force in each institution.

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- [Tool 1–6 Key Membership for MOLST Task Force](#) – Disciplines and departments to engage

STEP ONE: *PREPARATION* TOOLS



1-1	Preparation Task Checklist
1-2	MOLST video
1-3	MOLST Clinical Champion Role Description
1-4	Clinical Champion Orientation Materials
1-5	Institutional Readiness Meetings
1-6	Key Membership for MOLST Task Force



TASK 1: Identify Institutional Champion(s)

- Approach likely groups with interest in MOLST, e.g. Palliative Care; Ethics Committee; Committees/initiatives with similar goals (e.g. STAAR, INTERACT, Project IMPACT); Quality and Patient Safety Improvement Groups

TASK 2: Establish Institutional Readiness

- Meet with key institutional leaders to educate and gain support
 - CEO, CNO, CMO, CQO, CIO
 - Directors of Nursing, Medicine, Social Work, Care Management, others as needed
- Designate institutional contact person(s) and responsible entity to develop MOLST
 - Palliative Care Program
 - Ethics Committee
 - Office of Clinical Quality Improvement
- Determine Institutional Capacity to Implement MOLST
 - Champion identified and available
 - Institutional contact/administrative support available
 - Project Management support available
 - Institutional Reporting relationship determined
- Consider Conducting an Institutional Needs Assessment with: Patients, Families, Clinicians, Administrators, Nurses, Others

TASK 3: Establish Institutional Task Force

Include essential clinical, administrative, health information technology, ethics and policy representatives, as well as patient/family representatives. Consider representatives from these categories to include from other sites (e.g. other locations of your institution, or other institutions that send or receive patients to/from your institution).

- Leadership – Chief Medical Officer or representative; Chief Nursing Officer or representative; Chief Quality Officer or representative; Chief Information Officer or representative
- Physicians – Medical, Emergency Medicine, Hospitalists, Specialists, Pediatrics, Dialysis, Generalists, Geriatrics, Critical Care, Psychiatry
- Nursing - Critical Care, Palliative Care, Medical/Surgical, Pediatric
- Care Coordination/Case Management/Social work
- Pastoral Care/Chaplaincy
- Health Information Management
- Risk Management/Legal services
- Ethicist
- Patient/Family representatives



"Massachusetts Medical Orders for Life-Sustaining Treatment: A way to make choices about your end-of-life medical care." An original 13-minute video about how MOLST can make a difference for patients, families and health care providers in Massachusetts



The MOLST video is accessible online at www.molst-ma.org

DVD copies may be requested from the MOLST office at 508-856-5890



An institution's MOLST Clinical Champion must be well-positioned and able to engage, educate and lead others in site-level MOLST implementation.

Because the MOLST process and form is a *“standardized process and form for discussing, writing, and communicating Medical Orders for Life-Sustaining Treatment across health care settings,”* it is generally (but not always) most suitable for the MOLST Clinical Champion(s) to be a clinician with experience in and passion for improving patient-centered, end-of-life and palliative care.

Specific tasks of the Clinical Champion Role include:

- Engaging and advocating for MOLST implementation with institutional stakeholders, leaders and sponsors and providing periodic progress updates or reports about implementation status
- Recruiting, organizing and facilitating a MOLST Implementation Task Force and working meetings to accomplish the goals set out in the site implementation work plan (e.g. MOLST planning, training, implementation and evaluation)
- Establishing institutional MOLST policy, guidance and processes
- Maintaining integrity of the MOLST process and form use during MOLST implementation
- Accessing support, training and materials from the MOLST program office at UMass Medical School
- Establishing and implementing a plan for MOLST training and orientation throughout the institution
- Monitoring and troubleshooting implementation
- Establishing a plan for MOLST sustainability within the institution



Before meeting with others to promote and coordinate MOLST implementation, the Clinical Champion should become very familiar with the background and details of MOLST. It is *highly recommended* that MOLST Clinical Champion(s) review the following information to educate themselves thoroughly about MOLST:

Information and Resources	Where to find it
<p>MOLST in Massachusetts</p> <ul style="list-style-type: none"> • <i>MOLST Overview for Health Professionals</i> – PowerPoint overview with basic information about MOLST (excellent for orienting groups about MOLST) • <i>MOLST Implementation Overview</i> – PowerPoint overview of how to implement MOLST policy and use within clinical care institutions • The Massachusetts MOLST form and Clinician checklist for using the form • Differences between MOLST and a health care proxy form • MOLST training resources for health professionals • Patient and family education materials • MOLST video (13 minutes) featuring MA patients, health providers and others 	<p>www.molst-ma.org</p> <p>www.mass.gov/eohhs/gov/departments/dph Search MOLST</p>
<p>POLST Paradigm</p> <ul style="list-style-type: none"> • History and explanation of the POLST paradigm • Descriptions of POLST paradigm programs and forms from other U.S. states • National POLST Task Force information, contacts and resources • POLST research, references, legal, policy, spiritual and cultural perspectives 	<p>www.polst.org</p>
<p>Massachusetts support for MOLST</p> <ul style="list-style-type: none"> • Massachusetts Department of Health and Human Services <ul style="list-style-type: none"> ○ Circular Letter about MOLST ○ Health Care Quality and Cost Council Expert Panel 2010 Report on End of Life Care - <i>Patient Centered Care and Human Mortality</i> ○ Final report and recommendations from MOLST demonstration program ○ Office of Emergency Medical Services MOLST information • Massachusetts Medical Society audio recording of December 2011 MOLST webinar by Dr. Susan Block 	<p>www.mass.gov Search MOLST and then search by topic</p> <p>www.massmed.org</p>



Who to Engage¹

Meet with the people inside your institution *with whom you will need to cooperate* to implement MOLST. Depending on your institutional setting, these may include some of the people listed below:

Leadership, for example:

- President/CEO/Executive Director
- Chief Medical Officer, Medical Director
- Medical Group President/Director
- Chief Nursing Officer, Director of Nursing
- Chief Quality Officer
- Chief Information Officer
- Board of Directors

MOLST Signers: Physicians, Nurse Practitioners, Physician Assistants, Dept. Chairs, Physician Groups, etc.

Nurses, for example: Associate CNOs; Nurse Managers, Nurse Educators, Resource Nurses, Nurses working in Specialty areas most relevant to MOLST (e.g. Emergency, Critical care, Dialysis, etc.) and/or other Nurses in leadership or related roles.

Others, for example, Directors and Staff from: Rehabilitation; Pastoral Care; Ethics; Social Work; Care Coordination; Interpreter Services; Health Info. Management; Patient Access Services; Marketing & Communications; Legal Services; Risk Management; Patient Experience; Quality Improvement.

Suggested Content for Readiness Meetings²

Suggested talking points

- Per DPH recommendation, MOLST has begun expansion throughout Massachusetts.
- MA EMTs are currently required to honor valid MOLST forms per (OEMS) protocol; MOLST forms will begin to arrive with patients in the ED and throughout departments and facilities
- Introductory info about MOLST (in brief – these meetings are not a substitution for training)
- Similarities/differences from CC/DNR and health care proxy forms
- Projected timeline for implementation in the institution and launch date (form goes into use)
- MOLST contacts in the institution (e.g. Clinical Champion, Task Force members, etc.)
- MOLST website address (www.molst-ma.org) for additional information and resources

If time permits, show the following presentations; if not, encourage others to view them on their own.

- “MOLST 101” for health professionals at: <http://www.molst-ma.org/molst-training-line>
- 13-minute video about MOLST in Massachusetts at : <http://www.molst-ma.org/molst-stories>

Suggested Handouts:

- Sample MOLST form - www.molst-ma.org/sites/molst-ma.org/files/final_MOLST_expansion_form_with_sample%20%281%29.pdf
- DPH Circular Letter - www.molst-ma.org/sites/molst-ma.org/files/DHCQ_560.pdf
- FAQ for Health Professionals - www.molst-ma.org/health-care-professionals/faq
- Clinician Checklist for Using MOLST - http://www.molst-ma.org/sites/molst-ma.org/files/TOOL%20%202-11%20Checklist%20for%20clinician%20signers_0.pdf

¹ Consider whether there may be others from partner institutions with whom you should meet.

² Tailor content for each meeting per participant’s disciplines, training, expertise, areas of interest, roles and responsibilities within the institution, and time allotted for the meeting.



Leadership

- Medicine: CMO or representative
- Nursing: CNO or representative
- Quality: CQO or representative
- Patient Experience: CXO or representative
- Information Technology: CIO or representative

Medical and Nursing Staff representation

- Specialists
- Emergency Medicine
- Critical Care
- Palliative Care
- Hospitalists
- Dialysis
- Pediatrics
- Geriatrics
- Psychiatry
- Primary Care

Other Staff representation

- Care Coordination/Case Management
- Social worker/Psychologist
- Child Life Specialist
- Chaplaincy/Pastoral Care
- Health information management
- Risk Management
- Ethicist/Ethics Committee
- Patient Experience staff
- Legal services

Patients and Families representation

- Patient & Family Representatives
- Patient & Family Council Members



Step Two: DEVELOPMENT

Step Two: *Development* – Overview

MOLST Development activities within an institution may require between 3-6 months or longer for completion. If MOLST is being implemented in multiple locations, also consider whether and how to carry out the key Development tasks in each locale and plan accordingly.

Key tasks for Development include:

- 1) Convening the MOLST Task Force
- 2) Developing MOLST policy and procedures *specific to your institution*
- 3) Developing an institutional training plan



[Tool 2–1 Development Task Checklist](#) - Outline of recommended activities for Development

[Tool 2-2 Glossary of Terms Related to Planning for Advanced Illness](#) - Definitions of words and terms often used in planning for care of Advanced Illnesses

Task 1: Convening the MOLST Task Force

The role of the MOLST Task Force is to provide input, leadership and legwork for implementing MOLST within the institution. After forming the Task Force (see *Step One: Preparation*), the Clinical Champion should keep the Task Force engaged in a series of well-planned meetings and activities, to develop and execute a site-level MOLST implementation work plan.

It is important to note that Task Force members may be able to contribute in significant ways to MOLST *Development* by taking on leadership for specific tasks, for example, developing MOLST policy, delivering MOLST training sessions, etc.



[Tool 2–3 Considerations for MOLST Implementation](#)

[Tool 2-4 MOLST Implementation Sample Work Plan](#)

Task 2: Developing MOLST Policy and Procedures

Adequate time must be invested in the preparatory work of developing MOLST policies, procedures and approval processes. - From “Lessons Learned, MOLST Demonstration Program Recommendations for Statewide Expansion, Pilot Results 2011”

The task of developing MOLST policy and procedures is guided by the Clinical Champion and MOLST Task Force. It is carried out: 1) in the context of the institution’s usual policy development processes, and 2) in collaboration with other institutional personnel that are responsible for policy development.

Every clinical care institution must develop a MOLST policy of its own.

While many sample MOLST/POLST policies exist as resources³ and can be a good starting point, other institutions’ policies will not be exactly appropriate for your institution. **Especially policies from other states must be referred to with caution**, since their laws and regulatory climate may be very different from Massachusetts.

Before writing new MOLST policy, identify and review policies or procedures that already exist within your institution that are salient to MOLST, e.g. guidance about medical decision-making; health care proxy; advance care planning; limitations on treatment/DNR/DNI; informed consent; surrogate decision-makers; withdrawal of treatment; goals of care discussions, etc.

It may be possible or necessary to incorporate MOLST into current policies and procedures *in addition to or instead of* creating a new MOLST policy.



- Tool 2-5 Recommendations for MOLST Policy Development
- Tool 2-6 Sample MOLST Policy for Acute Care Hospitals
- Tool 2-7 Sample MOLST Policy for Skilled Nursing Facilities
- Tool 2-7A Sample MOLST Policy for Home Health Care or Hospice

Task 3: Developing the MOLST Education and Training Plan

Ensuring that health care professionals understand the purpose and the use of MOLST is essential to implementation. Numerous questions arose in the course of MOLST training, not only about the use of the form but also about medical decision-making and communicating with patients about end-of-life issues. Successful implementation therefore requires not only disseminating information but also providing opportunities for trainees to ask questions...and dialogue about their concerns. - “Lessons Learned, MOLST Demonstration Program Recommendations for Statewide Expansion, Pilot Results 2011”

Training is necessary – not only for the physicians, nurse practitioners and physician assistants who will sign MOLST forms, but also for any other personnel, clinical and non-clinical, who provide care and support to patients with advanced illnesses and their families, and/or administrative support for documenting and facilitating the transfer of MOLST forms.



- Tool 2-8 MOLST Training Resources
- Tool 2-9 MOLST Training Plan Template
- Tool 2-10 Sample Training & Outreach Log
- Tool 2-11 Checklist for Clinician Signers of MOLST

³ Those provided in this tool kit and others online at: www.ohsu.edu/polst/resources/policy.htm and at www.compassionandsupport.org/index.php/for_professionals/molst_training_center/implementation_resources).

STEP TWO: *DEVELOPMENT* TOOLS



2-1	Development Task Checklist
2-2	Glossary of Terms Related to Planning for Advanced Illness
2-3	Considerations for MOLST Implementation
2-4	MOLST Implementation Sample Work Plan
2-5	Recommendations for MOLST Policy Development
2-6	<i>Sample</i> MOLST Policy for Acute Care Hospitals
2-7	<i>Sample</i> MOLST Policy for Skilled Nursing Facilities
2-7A	<i>Sample</i> MOLST Policy for Home Health Care or Hospice
2-8	MOLST Training Resources
2-9	MOLST Training Plan Template
2-10	Sample Training & Outreach Log
2-11	Checklist for Clinician Signers of MOLST

**TASK 1: CONVENE INSTITUTIONAL TASK FORCE (Clinical Champion)**

- Schedule and facilitate regular working meetings
- Review and discuss *Considerations for MOLST Implementation*
- Develop an implementation work plan with tasks and timelines
- Delegate tasks to members/others as appropriate, with clearly defined accountability and timelines
- Maintain communication among, and participation of Task Force members

TASK 2: DEVELOP INSTITUTIONAL POLICY & PROCEDURE (Clinical Champion and/or Designee)

- Review Sample MOLST Policies (use caution if referring to policies from other states)
- Identify existing institutional policies related to MOLST, e.g.
 - Medical Decision Making
 - Advance Care planning/Health Care Proxy
 - Limitations on life sustaining treatments (DNR, DNI)
 - Informed Consent
 - Surrogate Decision Maker
 - Withdrawal of Treatment
 - Goals of Care discussion
 - Honoring prescriptions/orders from out of state
- Develop your own institutional MOLST Policy and Procedures
- Submit for your institution's review process as appropriate
- Finalize Policy and Procedures
- Alert workforce of Policy and Procedure

TASK 3: DEVELOP INSTITUTIONAL EDUCATION & TRAINING PLAN (Clinical Champion and/or Designee)

- Identify key audiences, e.g.
 - Clinician Form signers: Physicians, Nurse Practitioners, Physician Assistants
 - Other clinical care providers: Nurse, Therapists, Dialysis, etc.
 - Emergency Medical Services
 - Other non-clinical patient care providers
- Identify trainer(s) and train the trainers if appropriate
- Implement education and training activities
- Manage training logistics
- Track training hours and participants
- Establish plan for ongoing training of new personnel



Advance care planning (ACP) is an ongoing process of discussing and clarifying the current state of a person's goals, values and preferences for future medical care. The discussion often, but not always, leads to the signing of documents known as advance directives. A health care proxy is the only advance directive authorized by Massachusetts statute.

Advance directive (AD) is a general term referring to a written document for future medical care in the event that a person loses capacity to make health care decisions (i.e. becomes "incapacitated."). It sometimes results from the process known as advance care planning. A health care proxy or a living will is considered to be an advance directive.

Artificial hydration and nutrition (AHN) is a medical treatment that supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and/or fluids through a tube placed directly into the digestive tract (enteral); or through a tube directly into a vein (parenteral).

Cardio-pulmonary resuscitation (CPR) is a set of medical procedures that attempt to restart the heartbeat and breathing of a person who has no heartbeat and has stopped breathing. Such procedures may include pressing on the chest to mimic the heart's functions and cause blood to circulate; insertion of an airway into the mouth and throat, or insertion of a tube into the windpipe; artificial ventilation such as mouth-to-mouth or other mechanically assisted breathing; the use of drugs to stimulate the heart; and/or electric shock (defibrillation) to stimulate the heart. CPR can be life-saving in certain cases for otherwise healthy people but is much less effective when a person has a serious chronic illness.

Comfort Care/Do Not Resuscitate Verification protocol (CC/DNR) is followed by emergency medical service (EMS) personnel when encountering an authorized CC/DNR Verification Form outside of a hospital setting. The CC/DNR protocol directs that a patient in respiratory or cardiac distress be made as comfortable as possible, but that no resuscitative measures be attempted.

Decision-making capacity refers to the ability to make and communicate meaningful decisions based upon an understanding of the relevant information about options and consideration of the risks, benefits, and consequences of the decision. The ability to understand other unrelated concepts is not relevant. Capacity can vary according to the task: it may be possible for an individual to appoint a health care agent, for example, yet not make a decision about a medical procedure. Capacity should be assessed routinely, and it is not the same as competence, which is a legal determination made in court. In Massachusetts the determination of a patient's lack of capacity must be made by a physician in writing before a health care proxy can be put into effect.

Dialysis is the process of filtering the blood through a machine via two small tubes inserted into the body in order to remove waste products from the body in the way that the kidneys normally do. Dialysis can be done temporarily in order to allow the kidneys time to heal or it can be done on a longer term basis in order to prolong life.

Do Not Hospitalize orders (DNH) are medical orders signed by a physician that instruct health care providers not to transfer a patient from a setting such as a nursing facility (or one's home) to the hospital unless needed for comfort.

Do Not Intubate orders (DNI) are medical orders signed by a physician that instruct health care providers not to attempt intubation or artificial ventilation in the event of respiratory distress.

Do Not Resuscitate orders (DNR) are medical orders signed by a physician that instruct health care providers not to attempt cardio-pulmonary resuscitation (CPR) in the event of cardiac and respiratory arrest.

Durable Power of Attorney for Health Care is a term used in some states for a health care proxy. (See definition below.)

Guardian is a court-appointed individual granted authority to make certain decisions regarding the rights of a person with a clinically diagnosed condition that results in an inability to meet essential requirements for physical health, safety or self-care. In

Massachusetts not every guardian has authority to make health care decisions. If a health care proxy is in effect, a healthcare decision of the agent takes precedence over that of the guardian (absent an order of the court to the contrary). Further, guardians who do have authority to make health care decisions may be subject to limitations on their authority to make decisions regarding life-sustaining treatments.

Health care agent is a trusted person, officially appointed, who speaks on behalf of a person 18 years of age or older who is unable to make or communicate health care decisions. In Massachusetts this person is appointed in advance via a health care proxy. The agent is called upon only if the doctor determines in writing that a patient lacks capacity to make health care decisions. Unless otherwise limited by the person, the agent has all the rights that the patient has with regard to medical decision-making, including the rights to refuse treatment, to agree to treatment, or to have treatment withdrawn. Decisions should first be made based on the patient's stated wishes, if known; or if unknown, an interpretation of what the patient would have wanted; or finally, an assessment of the patient's best interest.

Health care proxy (HCP) is a document in which a person appoints a health care agent to make future medical decisions in the event that the person becomes incapacitated. This may be an outcome of the advance care planning process and is expressly authorized in Massachusetts by statute (MGL 201D).

Hospice is a philosophy of holistic end of life care and a program model for delivering comprehensive palliative care to persons who are in the final stages of terminal illness and their loved ones in the home or a home-like setting. Hospice provides palliative care in the last months of life. It involves a team-oriented approach that is tailored to the specific physical, psycho-social and spiritual needs of the person and includes support to the family during the dying process. Hospice also provides bereavement support after death occurs.

Life-sustaining treatment refers to medical procedures such as cardio-pulmonary resuscitation, artificial hydration and nutrition, and other medical treatments intended to prolong life by supporting an essential function of the body in order to keep a person alive when the body is not able to function on its own.

Living will (LW) is a document in which a person specifies future medical treatments in the event of incapacity, usually at end of life or if one becomes permanently unconscious, in a persistent vegetative state or "beyond reasonable hope of recovery." Since there is no statute in Massachusetts that expressly authorizes living wills they are not considered to have legal authority. They may, however, be used as evidence of a person's wishes.

Medical (or Physician's) Orders for Life-Sustaining Treatment (MOLST /POLST) is a document intended for seriously ill patients that stipulates wishes for life-sustaining treatment based on the patient's current condition. A MOLST form becomes effective immediately upon signing and is not dependent upon a person's loss of capacity. It does not take the place of a health care proxy. Consideration of MOLST may be an outcome of the advance care planning process.

Palliative care is a comprehensive approach to treating serious illness that focuses on the physical, psycho-social and spiritual needs of the patient. The goal of palliative care is to prevent and relieve suffering and to support the best quality of life for patients and their families through such interventions as managing pain and other uncomfortable symptoms, assisting with difficult decision-making, and providing support, regardless of whether or not a patient chooses to continue curative, aggressive medical treatment.



PATIENT ARRIVES WITH A MOLST FORM

- Who will receive the MOLST form? Who usually admits a new patient/resident?
- Where will the MOLST form be kept? Where will copies be kept?
- How will patients' MOLST be reviewed and written into orders by clinicians? Within what timeframe?
- What if a life-sustaining treatment decision is needed before the MOLST has been written into institutional orders?
- How will the MOLST instructions be relayed among care staff? (E.g. treatment preferences, calling 9-1-1, etc.) (*Within the institution? Across care settings?*)
- When a patient/resident transfers to another locale/level of care, who will be responsible for sending the MOLST with them?
- Who can "champion" the MOLST process at sites/departments/units/on floors?
- How will conflicts be managed if family members or others disagree with a patient/resident's MOLST (*When the patient/resident has capacity? When the patient/resident doesn't have capacity?*)
- What barriers might prevent personnel from honoring a patient/resident's MOLST instructions? How can these be prevented?

NEW MOLST ORDERS

- Should patients/residents/caregivers/family members be generally informed about MOLST? If so, how?
- What will "trigger" clinicians to discuss MOLST with patients/residents/families/caregivers?
- To whom do patients/residents usually express preferences about life-sustaining treatment? *Family, nurses, clinicians?*
- How/where are such discussions documented? Should MOLST discussions be documented the same place?
- If the patient/resident expresses that *they want treatment*, how will this trigger a MOLST form? (*Preferences to receive treatment that is routinely given do not usually result in medical orders, but should now be documented on a MOLST form*).
- When will the actual MOLST form be filled out? Immediately upon discussion, or at discharge or transfer?
- Where will blank MOLST forms be kept? How/will original forms get printed on "hot pink" colored paper? Where will related educational materials be accessible? For health professionals? For patients/residents/family members/others?
- If MOLST is discussed, but the patient/resident decides not to use MOLST, how will this be documented?
- If a MOLST form is completed, where will it be kept? Copies? Who else will get copies (e.g. PCP?)
- How will the MOLST be periodically re-discussed with the patient/resident/health care agent? By whom?
- Will periodic reviews be built into the patient/resident's regular care?
- If patients/residents are transferred to a different care setting, how will the MOLST be sent with them?
- How will MOLST instructions be communicated among the healthcare team? (*Within the institution? Across care settings?*)

STAFF TRAINING

- Who needs MOLST training? Which staff? Which departments? Which disciplines?
- How will staff be motivated to attend? *Will training be required? Will staff be compensated? Will CEUs/CMEs be attached?*
- Should a "champion" be designated per site/floor? *Who would that be? What would be their role?*
- Who should deliver MOLST training? Internally? Externally? Computer-based? Other ideas?
- What other essential, site-specific information should be included with the training?
- How will new employees be trained? Can this be built into existing new-hire training?
- If staff has questions about MOLST, where (or to whom) will they look for information or consult?

TOOL 2-4

MOLST Implementation Sample Work Plan



Meeting Participants: Clinical Champion(s), Task Force members, key stakeholders or advisors or special invitees

ACTIVITIES	MATERIALS	TASK ASSIGNMENTS	TIMELINE
<p>Task Force Meeting #1: Introduction and Orientation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Overview of MOLST, statewide expansion and expectations for institutional implementation <input type="checkbox"/> Status of institutional support and site readiness <input type="checkbox"/> Review MOLST form and related documents <input type="checkbox"/> Q & A about MOLST and site implementation (Track questions or issues that need answers) <input type="checkbox"/> Discuss members' role/responsibilities <input type="checkbox"/> Discuss proposed timeline for implementation <input type="checkbox"/> Identify others who should be on the Task Force <input type="checkbox"/> Schedule 4-5 dates for Task Force meetings 	<p>Sign-in sheet</p> <p>MOLST overview materials from www.molst-ma.org</p> <p>Implementation Work plan</p>		
<p>Task Force Meeting #2: Implementation planning</p> <ul style="list-style-type: none"> <input type="checkbox"/> Plan logistics of how implementation will work (who/what/when/where/how) <input type="checkbox"/> Identify possible barriers and challenges <input type="checkbox"/> Identify additional necessary steps/activities needed before implementation <input type="checkbox"/> Draft a timeline for implementation <input type="checkbox"/> Determine how implementation will be coordinated/supervised/monitored/supported <input type="checkbox"/> Discuss status of institutional policy/protocol development 	<p>Considerations for Site-Level Implementation</p> <p>MOLST policy/draft (if available)</p>		
<p>Task Force Meeting #3: Training planning</p> <ul style="list-style-type: none"> <input type="checkbox"/> Determine who at institution needs training <input type="checkbox"/> Review MOLST training materials <input type="checkbox"/> Determine types/levels of training needed per audience/participant groups <input type="checkbox"/> Determine best vehicles/venues for training (for start-up and ongoing venues for sustainability) <input type="checkbox"/> Identify potential trainers and trainer preparation <input type="checkbox"/> Determine whether patient/family education and outreach is needed and how to deliver <input type="checkbox"/> Review consumer education materials 	<p>MOLST training materials</p> <p>List/org chart of departments, contacts, etc.</p> <p>Institutional meeting dates/schedules (e.g. rounds, committees, department mtgs.</p>		
<p>Task Force Meeting #4: Evaluation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Determine evaluation plan and tools <input type="checkbox"/> Discuss how evaluation activities will be implemented <input type="checkbox"/> Identify existing evaluation measures/processes (that could potentially incorporate MOLST) 			
<p>Task Force Meeting #5: Next Steps</p> <ul style="list-style-type: none"> <input type="checkbox"/> Identify outstanding tasks and assign activities <input type="checkbox"/> Determine need/tasks for additional Task Force meetings and schedule meetings if needed 			
<p>Implement MOLST on agreed-upon go-live date</p>			



Every institution implementing the MOLST process and form must develop MOLST policy of its own.

While many sample MOLST/POLST policies exist as resources and can be a good starting point (some are provided in this tool kit); other institutions' policies will not be exactly appropriate for your institution.

Especially policy samples from other states must be referred to with caution, since their laws and regulatory climate may be very different from Massachusetts.

- Establish MOLST policy in accordance with existing institutional policy-development procedures
- Engage support from and/or delegate MOLST policy development to personnel that is already familiar with policy development within the institution
- Engage and involve administrative leadership and committees in MOLST policy development
- Engage appropriate medical staff leadership and committees in MOLST policy development (medical staff bylaws or rules and regulation should be reviewed and revised if necessary)
- Refer to specific and related policies on matters such as determination of decision making capacity and of a legally recognized health care decision maker (health care proxy); advance care planning; limitations on treatment/DNR/DNI; informed consent; withdrawal of treatment; goals of care discussions, etc.
- Identify and update existing related policies to accommodate MOLST
- Determine how key personnel will be informed and trained about the new MOLST policy
- Refer to other sample MOLST policies as a starting point. (See Tools 2-6 and 2-7; find other sample policies at www.ohsu.edu/polst/resources/policy.htm and at www.compassionandsupport.org/index.php/for_professionals/molst_training_center/implementation_resources)

⁴ Adapted from *Model Policies for General Acute Care Hospitals and Skilled Nursing Facilities*, California Coalition for Compassion (www.capolst.org/pdf/professionals/POLST_PolicyCoverMemo.pdf)

TOOL 2-6 *Sample* MOLST Policy for Acute Care Hospitals⁵



Caution: This policy is provided as *a sample only* and should not be used exactly as it appears here for any institution's MOLST policy. Every Massachusetts clinical care institution is expected to create a unique MOLST policy that is appropriate for their institution, health care system and state.

PURPOSE

The purpose of this policy is to define a process for general acute care hospitals to follow when a patient presents with a MOLST form. This policy also outlines procedures regarding the completion of a MOLST form by a clinician and patient, and necessary steps for re-discussing or revising a MOLST form.

PREAMBLE

The Medical Orders for Life-Sustaining Treatment (MOLST) form should be executed as one possible outcome of the health care planning process and broader advance care planning conversations. The MOLST form is a medical order form that converts an individual's preferences regarding life-sustaining treatment into Medical Orders. It is designed as a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining treatments across health care settings. It is designed to be a portable, valid and immediately actionable medical order that is consistent with the patient's preferences and current medical condition, which shall be honored across treatment settings.

The MOLST form:

- Is a standardized form that is clearly identifiable⁶;
- Is used voluntarily and can be revised or revoked at any time;
- Is recognized as a valid medical order;
- Is recognized and honored across treatment settings;
- Is an expansion of the Massachusetts Comfort Care/Do Not Resuscitate verification protocol, although MOLST is more comprehensive in that it addresses preferences to receive or not receive other life-sustaining treatment in addition to resuscitation; and,
- Should be made available for suitable patients who wish to execute a MOLST form while they are in the general acute care hospital.

A clinician is not required to initiate the MOLST process and form, but is encouraged to treat a patient in accordance with his or her MOLST form instructions. As outlined in the following procedures, the clinician will review the MOLST and incorporate the content of the MOLST into the patient's care and treatment plan. This does not apply if the MOLST requires medically ineffective health care or health care contrary to generally accepted health care standards.⁷

A legally recognized health care agent or guardian⁸ may execute, revise or revoke the MOLST form for a patient to the extent permitted by Massachusetts law. This policy does not address the criteria or process for determining or appointing a legally recognized health care agent, nor does it address the criteria or process for determining decision-making capacity⁹. Legal counsel should be consulted with questions about a health care agent's or guardian's authority.

While a health care provider such as a nurse or social worker may explain a MOLST form to the patient and/or the patient's legally recognized health care decision maker, an attending clinician¹⁰ is responsible for discussing the efficacy or appropriateness of the treatment options with the patient, or if the patient lacks decision-making capacity the patient's legally recognized health care agent.

⁵ (Additional sample policies can be found at www.ohsu.edu/polst/resources/policy.htm and at

www.compassionandsupport.org/index.php/for_professionals/molst_training_center/implementation_resources)

⁶ The official MOLST form for Massachusetts can be seen at: www.molst-ma.org. A photocopy of the form is also valid.

⁷ A clinician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or the individual's legally recognized health care agent, issue a new order consistent with the most current information available about the individual's health status and goals of care.

⁸ "Legally recognized health care agent" is the person's designated healthcare agent as assigned by a Massachusetts health care proxy form. A guardian can sign to the extent permitted by Massachusetts law. Consult legal counsel with questions about a guardian's authority.

⁹ Hospitals should refer to Commonwealth law and/or their own legal department regarding determination of decision-making capacity, and of a legally recognized health care agent.

¹⁰ "Clinician" means a licensed physician, nurse practitioner or physician assistant.

Once the MOLST form is completed, it must be signed by the patient, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, AND the attending clinician.

The MOLST form is intended for the voluntary use of patients approaching the end of life due to a serious medical condition, including but not limited to: chronic progressive disease (including dementia); life-threatening illness or injury; medical frailty; or any patient whose doctor would consider discussing DNR status with them or who would not be surprised if the patient died during the next year. Completion of a MOLST form should reflect a prior process of careful shared decision-making by the patient, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, in consultation with the clinician about the patient's current medical condition, prognoses, values and goals of care.

GENERAL ACUTE CARE HOSPITAL SAMPLE PROCEDURES

I. Patient in Emergency Department with a Completed MOLST Form

1. During the initial patient assessment, document the existence of the MOLST form¹¹ and confirm with the patient, if possible, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, that the MOLST form in hand has not been voided or superseded by a subsequent MOLST form.
2. A nurse or designated staff member will communicate to the emergency department clinician caring for the patient the existence of the MOLST.¹²
3. MOLST orders will be honored by health care providers as a valid medical order until the emergency department clinician reviews the MOLST form and incorporates the content of the MOLST into the care and treatment plan of the patient, as appropriate.¹³ The clinician should document his/her review of the MOLST in the medical record.
4. If the emergency department clinician, upon review of the MOLST and evaluation of the patient, determines that a new order is indicated, he/she shall review the proposed changes with the patient and/or legally recognized health care agent, and issue a new order consistent with the most current information available about the patient's health status, medical condition, treatment preferences and goals of care. The clinician should document the reasons for any deviation from the MOLST in the medical record.
5. Discussions with the patient and/or the patient's legally recognized health care agent regarding the MOLST and related treatment decisions should be documented in the medical record.
6. Copy the MOLST form for the medical record and/or scan into the electronic medical record.
7. Place appropriate hospital patient information label (e.g. addressograph) on the copy of the MOLST form where indicated (in the upper right corner of the front page of the form) and write "COPY" on the form and the date copied.
8. Place the current original MOLST form in the appropriate and prominent section of the patient's medical record.¹⁴ The date and time the order is placed in the medical record must be documented.
9. If the patient is discharged from the Emergency Department, *return the current original MOLST form to the patient* and document such action.
10. If the patient is admitted to an inpatient unit, send the *current original MOLST* with the patient to the inpatient unit.

II. Patient Admitted with a Completed MOLST Form

¹¹ Hospitals should designate by policy the specific staff responsible for this action.

¹² Hospitals should designate by policy the specific staff responsible for this action.

¹³ A clinician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or the individual's legally recognized health care agent, issue a new order consistent with the most current information available about the individual's health status and goals of care.

¹⁴ Hospitals may choose an alternative process that differs in the basic principle of whether the original MOLST should be included in the medical record or treated as "personal property" and secured by another mechanism. For example, "Place the copy of the MOLST form in the front of the patient's chart and keep original with the patient's other personal property."

1. During the initial patient assessment, document the existence of the MOLST form¹⁵, and confirm with the patient, if possible, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, that the MOLST form in hand has not been voided or superseded by a subsequent MOLST form.
2. A nurse, social worker or other designated staff member will communicate to the admitting clinician caring for the patient the existence of the MOLST¹⁶.
3. MOLST orders will be followed by health care providers as a valid medical order until the admitting clinician reviews the MOLST form and incorporates the content of the MOLST into the care and treatment plan of the patient, as appropriate¹⁷. The clinician should document his/her review of the MOLST in the medical record.
4. If the admitting clinician, upon review of the MOLST and evaluation of the patient, determines that a new order is indicated, he/she shall review the proposed changes with the patient and/or legally recognized health care agent, and issue a new order consistent with the most current information available about the patient's health status, medical condition, treatment preferences and goals of care. The clinician should document the reasons for any deviation from the MOLST in the medical record.
5. Discussions with the patient and/or the patient's legally recognized health care agent regarding the MOLST and related treatment decisions should be documented in the medical record.
6. Copy the MOLST form for the medical record and/or scan into the electronic medical record.
7. Place appropriate hospital patient information label (e.g. addressograph) on the copy of the MOLST form in the "Office Use Only" box and write "COPY" on the form and the date copied.
8. Place the current original MOLST form in the appropriate and prominent section of the patient's chart¹⁸. The date and time the order is placed in the medical record must be documented.
9. Because the current original MOLST is the patient's personal property, ensure its return to the patient, or legally recognized health care agent, upon discharge or transfer¹⁹.
10. At discharge, send the most current original MOLST with patient during any transfers to another health care facility or to home. Document in the medical record that the MOLST was sent with the patient at the time of discharge.

III. Completing a MOLST Form with the Patient

1. If the patient, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, wishes to complete a MOLST form, the patient's clinician should be contacted. The clinician should discuss the patient's medical condition, prognosis and treatment options with the patient or the legally recognized health care agent. The discussion should include information or statements the patient has made regarding his/her values and goals for end of life care and treatments. The benefits, burdens, efficacy and appropriateness of treatment and medical interventions should be discussed by the clinician with the patient and/or the patient's legally recognized health care agent.
2. A health care provider such as a nurse or social worker can explain the MOLST form to the patient and/or the patient's legally recognized health care agent, however, the clinician is responsible for discussing treatment options with the patient or the patient's legally recognized health care agent and for co-signing the MOLST form with the patient or the legally recognized health care agent.
3. The above-described discussions should be documented in the medical record, and dated and timed.
4. The MOLST form is to be completed based on the patient's expressed treatment preferences and current medical condition. If the patient lacks decision-making capacity and the MOLST form is completed with the patient's legally recognized health care agent, it must be consistent with the known desires of and in the best interest of the patient.

¹⁵ Hospitals should designate by policy the specific staff responsible for this action.

¹⁶ Hospital should designate by policy the specific staff responsible for this action.

¹⁷ A clinician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or the individual's legally recognized health care agent, issue a new order consistent with the most current information available about the individual's health status and goals of care.

¹⁸ Hospitals should designate by policy the specific staff responsible for this action.

¹⁹ Hospitals should designate by policy the specific staff responsible for this action.

5. In order to be valid, the MOLST must be signed by a clinician and by the patient, or if the patient lacks decision-making capacity the legally recognized health care agent.
6. Follow the instructions above for copying the MOLST form and putting it in the medical record.
7. Because the current original MOLST is the patient's personal property, ensure its return to the patient, or legally recognized health care agent, upon discharge or transfer²⁰.
8. If patient will not be transferred or discharged for a period of time, place the completed current original MOLST in the appropriate and prominent section of the chart. Indicate that the patient has a MOLST on the Discharge Summary Form/Discharge Checklist. The current original MOLST will be sent with patient at time of discharge.

IV. Reviewing/Revising a MOLST Form

1. Discussions about revising or revoking the MOLST should be documented in the medical record, and dated and timed. This documentation should include the essence of the conversation and the parties involved in the discussion.
2. At any time the attending clinician and patient, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, together, may review or revise the MOLST consistent with the patient's most recently expressed wishes. In the case of a patient who lacks decision-making capacity, the attending clinician and the patient's legally recognized health care agent may revise the MOLST, as long as it is consistent with the known desires of and in the best interest of the patient.
3. During the acute care admission, care conferences and/or discharge planning, the attending clinician should review the MOLST when there is change in the patient's health status, medical condition or when the patient's treatment preferences change.
4. If the current MOLST is no longer valid due to a patient changing his/her treatment preferences, or if a change in the patient's health status or medical condition warrant a change in the MOLST, the MOLST can be voided. To void MOLST, write "VOID" in large letters on both sides of the form. Sign and date this line.
5. If a new MOLST is completed, a copy of the original MOLST marked "VOID" (that is signed and dated) should be kept in the medical record directly behind the current MOLST.

V. Conflict Resolution

If the MOLST conflicts with the patient's previously-expressed health care instructions, then, to the extent of the conflict, the most recent expression of the patient's wishes govern.

If there are any conflicts or ethical concerns about the MOLST orders, appropriate hospital resources – e.g., ethics committees, care conference, legal, risk management or other administrative and medical staff resources – may be utilized to address the conflict.

During conflict resolution, consideration should always be given to: a) the attending clinician's assessment of the patient's current health status and the medical indications for care or treatment; b) the determination by the clinician as to whether the care or treatment specified by MOLST is medically ineffective, non-beneficial, or contrary to generally accepted health care standards; and c) the patient's most recently expressed preferences for treatment and the patient's treatment goals.

²⁰ Hospitals should designate by policy the specific staff responsible for this action.

TOOL 2-7 *Sample* MOLST Policy for Skilled Nursing Facilities*



Caution: This policy is provided as *a sample only* and should not be used exactly as it appears here for any institution's MOLST policy. Every Massachusetts clinical care institution is expected to create a unique MOLST policy that is appropriate for their institution, health care system and state.

PURPOSE

The purpose of this policy is to define a process for skilled nursing facilities to follow when a resident is admitted with a Medical Orders for Life Sustaining Treatment (MOLST). This policy also outlines procedures regarding the completion of a MOLST form by a resident and the steps necessary when reviewing or revising a MOLST form.

PREAMBLE

The Medical Orders for Life-Sustaining Treatment (MOLST) form should be executed as part of the health care planning process and preliminary advance care planning conversations. The MOLST form is a medical order form that converts an individual's wishes regarding life-sustaining treatment into Medical Orders. It is designed to be a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining and resuscitative measures. It is designed to be a portable, valid and immediately actionable medical order consistent with the individual's wishes and current medical condition, which shall be honored across treatment settings.

The MOLST form:

- Is a standardized form that is clearly identifiable⁽¹⁾
- Is used voluntarily and can be revised or revoked by an individual with decision-making capacity at any time;
- Is legally sufficient and recognized as a medical order;
- Is recognized and honored across treatment settings;
- Is an expansion of the Massachusetts Comfort Care/Do Not Resuscitate verification protocol, although MOLST is more comprehensive in that it addresses preferences to accept or refuse other life-sustaining treatment in addition to resuscitative measures; and
- Should be made available for residents who wish to execute a MOLST form while in the nursing facility.

A health care provider is not required to initiate the completion of a MOLST form, but is required to treat an individual in accordance with a MOLST form. This does not apply if the MOLST requires medically ineffective health care or health care contrary to generally accepted health care standards.⁽²⁾

A legally recognized health care agent or guardian ⁽³⁾ may execute, revise or revoke the MOLST form for a resident only if the resident lacks decision-making capacity. This policy does not address the criteria or process for determining or appointing a legally recognized health care agent, nor does it address the criteria or process for determining decision-making capacity.⁽⁴⁾ Legal counsel should be consulted with questions about a health care agent's or guardian's authority.

* (Additional sample policies can be found at www.ohsu.edu/polst/resources/policy.htm and at www.compassionandsupport.org/index.php/for_professionals/molst_training_center/implementation_resources)

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- (1) The official MOLST form for Massachusetts can be seen e at: www.molst-ma.org. A photocopy of the form is also valid.
 - (2) A clinician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or individual's legally recognized health care agent, issue a new order consistent with current information available about the individual's health status and goals of care.
 - (3) Legally recognized health care agent is the person's agent as designated by the Massachusetts healthcare proxy form or by another legal definition. A guardian can sign or revoke a patient's MOLST form to the extent permitted by Massachusetts law. Consult legal counsel with questions about a guardian's authority.
 - (4) Skilled nursing facilities should refer to MA law regarding determination of capacity and of a legally recognized health care agent or guardian. While a health care provider ⁽⁵⁾ such as a nurse or social worker can explain the MOLST form to the resident and or the resident's legally recognized health care agent, a clinician is responsible for discussing the efficacy or appropriateness of the treatment options with the resident, or if the resident lacks decision-making capacity, the resident's health care agent.

Once the MOLST form is completed, it must be signed by the resident, or if the resident lacks decision-making capacity the resident's legally recognized health care agent, AND the attending clinician.

MOLST is most suitable for voluntary use by residents approaching the end of life due to a serious medical condition, including but not limited to: chronic progressive disease (including dementia); life-threatening injury or illness; medical frailty; or any resident whose doctor would discuss DNR status with the resident or would not be surprised if the resident were to die during the next year.

Completion of a MOLST form should reflect a prior process of careful decision-making by the resident, or if the resident lacks decision-making capacity the resident's legally recognized health care agent, in consultation with the clinician about the resident's medical condition, prognoses, values and goals of care.

SKILLED NURSING FACILITY SAMPLE PROCEDURES

I. Resident Admitted with a Completed MOLST Form

1. The admitting nurse will note the existence of the MOLST form on the admission assessment and review the form for completeness (e.g. signed by resident or legally recognized healthcare agent, and by a clinician) and confirm with the resident, if possible, or the resident's legally recognized health care agent, that the MOLST form in hand had not been revoked or superseded by a subsequent MOLST form. A completed, fully executed MOLST is a valid medical order, and is immediately actionable.
2. Once reviewed, the MOLST should be copied, and the current original form placed in the front of the resident's chart, along with the resident's advance directive if he/she has one. As the resident moves from one health care setting to another, the original MOLST should always accompany the resident.
3. Add the MOLST form to the resident's inventory to ensure that when the resident is discharged or transferred, the current original MOLST will be sent with the resident.
4. The order to "Follow MOLST instructions" will be added to the resident's admitting orders for clinician review. It is the attending clinician's responsibility to review this order with respect to the resident's wishes and goals of care, within 72 hours of admission whenever possible. The clinician will complete the review process by signing an order in the chart stating, "Follow MOLST instructions." Thereafter, the orders will be renewed and reassessed on a periodic basis and as warranted by a change in the resident's health status, medical condition or preferences.
5. The MOLST will be honored during the initial comprehensive assessment period (14 days) even if the attending clinician has not yet formally reviewed the form. If "Do Not Attempt Resuscitation" is indicated on the MOLST, follow the facility procedure for communication and documentation of DNR/DNAR.
6. MOLST may replace the "Comfort Care/Do Not Resuscitate" verification protocol, if consistent with facility policy.
7. If the MOLST conflicts with the resident's previously-expressed health care instructions, then, to the extent of the conflict, the most recent expression of the resident's wishes governs. (*See "Conflict Resolution" for additional guidance.*)
8. A qualified health care provider(7), preferably a registered nurse or social worker, may conduct an initial review of the MOLST with the resident, or if the resident lacks decision-making capacity the legally recognized health care agent, within the first required 14-day assessment period as part of the comprehensive assessment and care planning process.
9. If the resident, or when the resident lacks decision-making capacity the legally recognized health care agent, expresses concern about the MOLST form, or if there has been a change in the resident's condition or wishes, then the attending clinician or medical director will be notified as soon as possible to discuss the potential changes with the resident, or if the resident lacks decision-making capacity the legally recognized agent.
10. The initial review and discussion about continuing, revising or revoking the MOLST should be documented in the medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.

(5) "Clinician" means a licensed physician, nurse practitioner or physician assistant.

(6) Note: Individual skilled nursing facilities may adapt the model procedures in accordance with their existing structures and related policies.

(7) "Qualified" means that they have had training in the purpose and use of the MOLST form, and on the facility's policy regarding implementing or reviewing the MOLST, including how to respond to questions from the resident and/or the resident's legally recognized health care agent regarding the specific interventions described on the MOLST. And see 6 above regarding "health care provider."

II. Reviewing/Revising the MOLST

1. The MOLST will be reviewed by the facility interdisciplinary team during the quarterly care planning conference, anytime there is a significant change (8) in the resident's condition, and at any time that the resident, or if the resident lacks decision-making capacity the legally designated health care agent, requests it.
2. At any time, a resident with decision-making capacity can revoke the MOLST form or change his/her mind about his/her treatment preferences either verbally or in writing, or after consultation with the resident's clinician, by completing a new MOLST form. The new MOLST form must be signed by the clinician and the resident and the revoked MOLST must be voided.
3. If a resident decides to revoke MOLST, the resident's clinician should be notified and changes to the medical orders should be obtained as soon as possible to ensure that the resident's wishes are accurately reflected in the plan of care.(9)
4. If the resident lacks decision-making capacity and the legally recognized health care agent wants to consider revising or revoking the MOLST form, he/she must consult the resident's clinician before any change is made to the resident's MOLST form (10). The legally recognized health care agent, together with the clinician, may revise the MOLST as long as it is consistent with the known desires of and in the best interest of the resident.
5. All discussions about revising or revoking the MOLST should be documented in the resident's medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.
6. To void MOLST, draw a line through the both sides of the form and write "VOID" in large letters. The original MOLST marked "VOID" should be signed and dated. Advise the resident and/or his or her family members or health care agent to destroy all photocopies of outdated MOLST forms.

III. Initiating a MOLST

1. If a resident (or if the resident lacks decision-making capacity, the legally recognized health care agent) wishes to complete a MOLST form during the resident's stay, provide a MOLST form for the clinician and the resident or the resident's legally designated health care agent to discuss, fill out and sign. Notify the resident's clinician or the medical director that the resident, or the legally designated health care agent (if the resident lacks decision-making capacity), wishes to discuss the treatment options on the MOLST.
2. The clinician should discuss the benefits, burdens, efficacy and appropriateness of treatment and medical interventions with the resident, or if the resident lacks decision-making capacity the resident's the legally recognized health care agent. A health care provider such as a nurse or social worker can explain the MOLST form to the resident and/or the resident's legally recognized health care agent; however, the clinician is responsible for discussing treatment options with the resident and/or the resident's legally recognized health care agent.
3. Follow facility procedures for issues brought to clinician's attention to ensure follow-up on a resident's request for MOLST.
4. Make a copy of the completed MOLST form. Mark it as "COPY" with the date the copy was made. File the copy in the appropriate section of the medical record. The current original MOLST form is considered the resident's property and will be transferred with the resident upon discharge, so the copy is the only record that will remain with the facility.
5. Add the MOLST form to the resident's inventory to ensure that the current original form is sent with the resident upon transfer or discharge from the facility.
6. Place the current original MOLST form at the front of the resident's physical chart.

(8) "Significant change" as defined by the facility's Resident Assessment Instrument

(9) Legally recognized health care agent is the person's agent as designated by the Massachusetts healthcare proxy form or by another legal definition. A guardian can sign or revoke a patient's MOLST form to the extent permitted by Massachusetts law. Consult legal counsel with questions about a guardian's authority.

(10) The legally recognized health care agent of an individual without capacity shall consult the clinician who is, at that time, the individual's treating clinician prior to making a request to modify that individual's MOLST form.

IV. MOLST and the Medical Record (11)

1. The most current MOLST in its original format should be the first page of the medical record.
2. If the resident is transferred or discharged from the facility, the current original MOLST must accompany the resident.
3. A fully executed, dated copy of the MOLST, marked "COPY," should be retained in the medical record in the appropriate section of the medical record.
4. All voided versions of the MOLST, clearly marked "VOID," will be retained in the medical record.
5. Whenever the MOLST is reviewed, revised, and/or revoked, this will be documented in the medical record by the clinician and/or the health care provider(s) involved.
6. For facilities with electronic health records, the MOLST should be scanned in and placed in the appropriate section of the health care record per facility policy.

V. Conflict Resolution

If the MOLST conflicts with the resident's other health care instructions, then, to the extent of the conflict, the most recent expression of the resident's wishes govern. If there are any conflicts or ethical concerns about the MOLST orders, appropriate facility resources – e.g., ethics committees, care conferences, legal, risk management or other administrative and medical staff resources – may be utilized to address the conflict.

During conflict resolution, consideration should always be given to: a) the attending clinician's assessment of the resident's current health status and the medical indications for care or treatment; b) the determination by the clinician as to whether the care or treatment specified by MOLST is medically ineffective, non-beneficial, or contrary to generally accepted health care standards; and c) the resident's most recently expressed preferences for treatment and the resident's treatment goals.

(11) Facilities should decide the most appropriate filing system for MOLST depending on their specific medical records system and modify this model policy accordingly. The main considerations are: 1) that the most current MOLST be available in a location of prominence in order to increase awareness of its existence and promote compliance, and 2) that the current original MOLST must travel with the resident, so obtaining and filing of a copy is critical.



SAMPLE/DRAFT MOLST POLICY and PROCEDURE

Home Health Care or Hospice Agencies

CAUTION: This sample policy should *not* be accepted as MOLST policy by any institution exactly as it appears here. Every Massachusetts clinical care institution must establish a MOLST policy that is appropriate within the context of its own setting and health care system.

PURPOSE

The purpose of this policy is to define a process for home health or hospice providers to follow when a patient is enrolled in home health or hospice with a Medical Orders for Life Sustaining Treatment (MOLST) form.

This policy also outlines procedures regarding steps for the home health or hospice providers to follow to involve *a clinician* to: discuss life-sustaining treatments with a patient; fill out and sign a MOLST form for the patient; or review or revise a patient's existing MOLST form.

PREAMBLE

The Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) form is a standardized medical order form signed by a clinician (physician, nurse practitioner, physician assistant) that is available for use with patients with advanced illness. The choice to use the MOLST form must be made voluntarily by suitable patients. The signed MOLST form documents the patient's decisions about life-sustaining treatments by converting them into standardized, actionable medical orders. The form is designed as a statewide mechanism for a patient to communicate his or her decisions about a range of life-sustaining measures. It is designed to be a portable, authoritative and immediately actionable medical order that is consistent with the individual's preferences and current medical condition, and which can be honored across health care settings.

The Massachusetts MOLST form:

- Is a standardized form originally created on hot pink-colored paper and clearly recognizable;
- Is considered a valid medical order;
- Can be honored across health care settings;
- Expands upon the MA Department of Public Health (DPH) Comfort Care/DNR (CC/DNR) Order Verification Protocol that was the original Massachusetts "out-of-hospital" DNR verification program. CC/DNR Verification has been in place to allow Emergency Medical Services (EMS) personnel to honor a previously completed DNR in an out-of-hospital setting. In contrast to the CC/DNR form, the MOLST form is an actual medical order and can attempt or not attempt resuscitation as well as other life-sustaining treatments;
- Should be made available to any patient with advanced illness or medical frailty, regardless of age, diagnosis, or disability, who wishes to document their decisions about life-sustaining treatments.
- Is intended to remain in the possession of the patient and be transferred or transported with the patient across all health care settings.
- Is revised or revoked at any time by a patient with decision-making capacity, or by the legally designated health care agent for a patient who has been declared to lack capacity to make medical decisions.

A patient cannot be required to utilize a MOLST form. However, a health care provider is expected to treat an individual in accordance with a valid MOLST form, if one exists. This does not apply if the MOLST requires medically ineffective health care or health care contrary to generally accepted health care standards.

A legally authorized health care agent may execute, revise or revoke the MOLST form for a patient only if the patient lacks decision-making capacity and the HCP has been invoked. A guardian may be able to execute, revise or revoke the MOLST form for the patient, depending on the facts and circumstances, to the extent of MA law. Consult legal counsel with questions about a guardian's authority. Spouses, other next of kin or other close family friends of the patient (sometimes referred to as an informal or default surrogate) are not authorized to sign a patient's MOLST form.

This policy, however, does not address the criteria or process for determining or appointing a legally recognized health care decision maker, nor does it address the criteria or process for determining decision-making capacity. **See policy # regarding capacity determination and policy # regarding decision makers.**

While a home health care provider such as a home health or hospice nurse or home health or hospice social worker can explain the MOLST form to a patient and/or to the patient's legally recognized health care decision maker or family members, the patient's physician/nurse practitioner/physician's assistant or the hospice physician/nurse practitioner is responsible for discussing any concerns or questions on the efficacy or appropriateness of the treatment options with the patient, or if the patient lacks decision-making capacity, with the patient's legally recognized health care decision-maker.

Once the MOLST form is filled out to reflect the patient's goals of care and decisions as discussed with the physician/nurse practitioner/physician's assistant, it must be signed by the patient's physician/nurse practitioner/physician's assistant or the hospice physician or nurse practitioner AND by the patient; If the patient lacks decision making capacity, the patient's legally authorized health care decision maker can sign for the patient. Signature by the patient or their legally authorized health care decision maker, and by the signing clinician confirms that the form accurately reflects the discussion held between the patient (or their legally recognized health care decision-maker) and the signing clinician and the decisions reached by the patient or their decision maker.

The MOLST form is intended to be suitable for persons who have a serious advancing illness or injury, or who are medically frail or elderly with a life expectancy of one year of life or less. The MOLST form should be executed as one possible outcome of a comprehensive advance care planning process, and should reflect a process of careful decision making by the patient, or if the patient lacks decision making capacity, by the patient's legally authorized health care decision-maker, in consultation with the patient's clinical team concerning the patient's current medical condition and known treatment preferences.

HOME HEALTH CARE and HOSPICE PROCEDURES

I. Patient Admitted with a Signed MOLST Form

1. The admitting nurse will note the existence of the MOLST form on the admission assessment and review the form for validity (e.g. signed by patient or legally recognized healthcare decision-maker, and by a clinician) and confirm with the patient, if possible, or the patient's legally recognized health care decision-maker, that the MOLST form in hand has not been revoked or superseded by a subsequent MOLST form. A valid MOLST form is a valid medical order and is immediately actionable.
2. Once reviewed, the MOLST form should be scanned or copied, with a copy provided to the hospice. ***(Insert suggested method for scanning/copying the MOLST form of a patient being visited at home).***
3. The current original MOLST form should be returned to the patient and should go with the patient as the patient moves from one health care setting to another.
4. If a patient resides at home, the original MOLST form (preferably printed on hot pink-colored paper) should be prominently displayed in an easily accessible and visible location, with consideration of respect for privacy balanced with the clinical team's need for easy access to the form.
5. MOLST may co-exist with the DPH CC/DNR Verification Protocol form, and both are considered valid. If there is any discrepancy between the two forms, the most recently dated document should be used to determine resuscitation status. If the MOLST form is changed or updated, previous copies should be "VOIDED" per instructions on the MOLST form and replaced by a newly executed MOLST form reflecting the patient's most recent decisions about life sustaining treatments.
6. A qualified health care provider, preferably a physician, registered nurse or social worker, will conduct an initial review of the MOLST form with the patient, or if the patient lacks decision-making capacity, with the patient's legally authorized health care agent, within the first required assessment period as part of the comprehensive assessment and care planning process defined by agency policy and home care or hospice regulations.
7. If the patient, or when the patient lacks decision-making capacity, the legally recognized health care agent, expresses concern about the MOLST form, or if there has been a significant change in the patient's condition or decisions, then the patient's physician/nurse practitioner/physician's assistant or hospice physician or nurse practitioner will be notified as soon as possible to discuss the potential changes with the patient, or if the patient lacks decision-making capacity, with the legally authorized health care agent.
8. The initial review and any discussion about continuing, revising or revoking the MOLST should be documented in the medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed. If new decisions are made about life-sustaining treatments, the outdated MOLST form should be "VOIDED" per instructions on the MOLST form, after a new MOLST form is executed, and orders consistent with home care or hospice regulations should be entered into the plan of care.

II. Reviewing/Revising Existing MOLST forms

1. The presence and content of the MOLST form will be reviewed by the hospice or home care interdisciplinary team during the initial Interdisciplinary Team Meeting or any patient Plan of Care review after admission to hospice or home care and at any time that the patient, or if the patient lacks decision-making capacity, the legally authorized health care agent, requests it.
2. At any time, a patient with decision-making capacity can revoke the MOLST form or change his/her mind about his/her treatment decisions by expressing a verbal desire to revise or revoke the MOLST form. If a patient with decision making capacity, expresses a desire to receive previously documented refusal of life sustaining treatments, the health care provider discussing that desire with the patient will notify the signing clinician, or another physician/nurse practitioner/physician's assistant involved in the patient's care patient of the patient's decisions.
3. If a new MOLST form is executed after discussion between the patient and the physician/nurse practitioner/physician's assistant or hospice physician or nurse practitioner, the outdated MOLST form should be "VOIDED" per instructions on the MOLST form. The new MOLST orders should be updated in the home health care or hospice medical record and the patient care interdisciplinary team should be notified of the changes.
4. At any time, a patient may decide to revoke the MOLST form without executing another MOLST form. The revoked MOLST form should be "VOIDED" per instructions on the MOLST form and the patient's physician/nurse practitioner/physician's assistant or hospice physician or nurse practitioner should be notified so that appropriate changes to the MOLST orders should be obtained as soon as possible to ensure that the patient's decisions are accurately reflected in the home care or hospice plan of care.
5. If the patient lacks decision-making capacity and the legally authorized health care agent wants to consider revising or revoking the MOLST form, he/she may notify the health care provider who will consult with the patient's physician/nurse practitioner/physician's assistant or hospice physician/nurse practitioner to arrange a discussion to update the MOLST. The legally authorized health care agent, may revise the MOLST form, and would be encouraged to honor the previously expressed decisions of the patient.
6. All discussions about revising or revoking the MOLST should be documented in the patient's home care or hospice medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.
7. To void MOLST, draw a line through the entire Section A through D and write, "VOID" in large letters. If the original MOLST form is voided and no new MOLST form is completed, no limitations on treatment are documented and full treatment may be provided to the patient.

III. Facilitating Patient-Clinician Discussions about Treatment Decisions/MOLST

1. If a patient, or if the patient lacks decision-making capacity the legally authorized health care agent, wishes to utilize DNR orders or a MOLST form while a patient is receiving services from the home health care or hospice agency, notify the clinician responsible for the plan of care of the patient's request.
2. A qualified health care provider such as a home health or hospice nurse or home health or hospice social worker may introduce the concept of the MOLST form to the patient and/or the patient's legally authorized health care agent. However, the physician/nurse practitioner/physician's assistant and the patient or the patient's legally authorized health care agent must discuss the decisions about life-sustaining treatments, and sign the MOLST form to accurately reflect their discussions.

Generally, the signing clinician (physician/nurse practitioner/physician's assistant) should discuss the benefits, burdens, efficacy and appropriateness of treatment and medical interventions, or any areas of concern with the patient, or if the patient lacks decision-making capacity, with the patient's legally authorized health care agent.

The MOLST form must be signed by the physician/nurse practitioner/physician's assistant and the patient, or if the patient lacks decision-making capacity, the patient's legally authorized health care agent, who confirm by their signatures that the MOLST form reflects the discussion that they had with each other and the patient's decisions related to life sustaining treatments.

3. Enter the MOLST information into the home care or hospice medical record and obtain an order for DNR, if needed from the physician responsible for the home care plan of care.
4. The current original (pink) MOLST form is considered the property of the patient, and must remain with the patient across all treatment settings. The MOLST form or MOLST instructions should be entered into the relevant medical records sections related to Advance Care Planning, Medical Decision Making, or Medical orders.

IV. MOLST and the Home Health and Hospice Medical Record

1. The most current MOLST form in its original format will always be kept with the patient. Copies are considered valid and actionable medical orders.
2. If possible, a copy of the MOLST form should be placed in the home care or hospice medical record.
3. If the patient has a Health Care Proxy form, a copy should be placed in the home health care or hospice medical record as well.
4. If the patient is transferred, admitted to a facility, or discharged from home health care or hospice, the current original MOLST must remain with the patient.
5. A fully executed, dated copy of the MOLST form should be retained in the traditional paper medical record in the advance directive or legal section of the home health or hospice medical record, if possible.
6. All voided versions of the MOLST form, clearly marked "VOID," should be retained in the medical record if available.
8. Whenever the MOLST form is reviewed, revised, and/or revoked, this will be documented in the medical record by the physician/nurse practitioner/physician's assistant. All discussions about revising or revoking the MOLST should be documented in the patient's home care or hospice medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.
7. If possible, for home health and hospice agencies with electronic health records, the MOLST should be scanned in and placed in the appropriate section of the health care record per facility/agency policy.

V. Conflict Resolution

In the event of a conflict between the MOLST form decisions and the family or caregivers present in the home when EMS is called, the EMS protocol will recommend initiating treatment and transporting the patient to the emergency department for further discussion and intervention by a physician/nurse practitioner/physician's assistant. While all efforts will be made to honor a patient's valid MOLST form decisions about life sustaining treatments, conflicts are better resolved in a setting where full support, including palliative care and ethics consultation, legal and risk management services may be available, and not in the home or hospice setting.

During conflict resolution, consideration should always be given to: a) the assessment by the patient's physician/nurse practitioner/physician's assistant or hospice physician or nurse practitioner of the patient's current health status and the medical indications for care or treatment; b) the determination by the clinician as to whether the care or treatment specified by MOLST is medically ineffective, non-beneficial, or contrary to generally accepted health care standards; and c) the patient's most recently expressed decisions about treatment and the patient's treatment goals.

TOOL 2-8

MOLST Training Resources



RESOURCE	DESCRIPTION	TARGET AUDIENCE(S)	WHERE TO FIND IT
MOLST Overview for Health Professionals	PowerPoint presentation	Health Professionals	www.molst-ma.org/Health Professionals/Training
MOLST Implementation Overview	PowerPoint presentation	Health Professionals	www.molst-ma.org/Health Professionals/Training
MOLST form	Official form	General	www.molst-ma.org/Home Page
Process when a patient has a MOLST form	What to do when a patient arrives with/has a MOLST form	Health professionals; emergency responders	www.molst-ma.org/Health Professionals
Differences between MOLST and a Health Care Proxy Form	Table illustrating important differences between these forms	General	www.molst-ma.org/Patients & Families
Glossary of End of Life Terms	Definitions of words and terms related to End-of-Life Planning and Care	General	www.molst-ma.org/Health Professionals
MOLST video	13 minute overview	General	www.molst-ma.org/Home page / DVD available from MOLST Program Office (Call 508-856-5890)
Frequently Asked Questions about MOLST (FAQ)	1-2 page document with responses to the most frequently asked questions about MOLST by audience	Health Professionals EMTs/First Responders Assisted Living Residences Lawyers Patients & Families	www.molst-ma.org/About MOLST/Frequently Asked Questions or MOLST homepage
Other related training websites	Additional training resources about end of life care and palliative care	Health Professionals	www.molst-ma.org/Health Professionals/Training

TOOL 2-9

MOLST Training Plan Template



Site, Unit or Department <i>E.g.</i>	Site, Unit or Department Contact name, phone, email	Participants (how many, disciplines, roles, etc.)	Trainer(s) name, phone, email	Training location, venue or address	Training materials, handouts	Method to invite participants	Training date(s) and time(s)
<i>Clinical: Faculty, Fellows, Residents, Students</i>							
<i>Key staff by department</i>							
<i>Emergency medicine</i>							
<i>Nursing: Educators, Leaders, Advanced Practice, Staff/Floor</i>							
<i>Care Coordination</i>							
<i>Social Work</i>							
<i>Admissions</i>							
<i>Discharge</i>							
<i>Pastoral Care</i>							
<i>Medical Interpreters</i>							
<i>Medical Records</i>							
<i>Patient Care</i>							
<i>Legal/lawyers</i>							
<i>Patient & Family Advisory Council</i>							
<i>Others...</i>							



ACUTE CARE SITES

<i>Date</i>	<i>Trainer(s)/ Presenter(s)</i>	<i>Duration</i>	<i>Location</i>	<i>Participants</i>	<i>Estimated # Participants</i>
2/3	CM	1 hour	Hospital A	Schwarz Rounds for Medical Residents (physicians) and nurses	50
2/16	MV		Hospital B	Care Coordinators, SW, pastoral staff, patient care services	14
2/17	MV		Hospital B	Care Coordinators, SW, pastoral staff, patient care services	16
2/19	MV, JA	30 min	Hospital B	Nurse Educators	24
2/24	MV	1 hour	Hospital B	Hospitalists	20
3/8	MV	10 min	Hospital B	Cardiology - mostly doctors	25
3/8	MV	20 min	Hospital B	G.I.	20
3/10	MV	10 min	Hospital B	Critical Care – mixed group	40
3/11	MV	15 min	Hospital B	Hem/Oncology	30
3/16	MV, JA	40 min	Hospital B	Pastoral care – “covering” clergy, not regular hospital staff	20
3/17	MV	30 min	Hospital B	Pulmonary – mostly doctors	40
3/18	MV	45 min	Hospital B	Open Nurse Practitioner meeting – NPs, maybe PAs, some lawyers	65
3/24	MV	Noon	Hospital B	Hospital medicine	20
3/29	MV, CM	15 min	Hospital B	Geriatrics – doctors and NPs – “nursing home” docs	20
3/30	MV, JA	1 hour	Hospital B	Barre Family Health Center	15
4/1	MV	30 min	Hospital B	Renal – doctors, NPs mostly	15
4/2	MV	15 min	Hospital B	Rheumatology – doctors, NPs mostly	15
4/16	MV	20 min	Hospital B	Infectious disease – doctors, NPs mostly	25
4/27	MV	30 min	Hospital B	General Medicine – primary care doctors and NPs, Hospitalists	25
	MV		Hospital B	Surgery (several groups)	
4/15	CM, DC	1.5 hour	Hospital B	Medical interpreters	

EMTs and First Responders

<i>Date</i>	<i>Trainer(s)/ Presenter(s)</i>	<i>Duration</i>	<i>Site or group</i>	<i>Participants</i>	<i>Estimated # Participants</i>
2/5	JA, MR	1 hour	CMEMS Region 2	EMTs and EMT trainers	50
3/6	JA	1 hour	City 1 fire department	EMTs and First Responders	20
4/12	JA	1 hour	City 2 fire department	EMTs and First Responders	18
4/20	JA	1 hour	City 3 fire department	EMTs and First Responders	12

²¹ From 2010 MOLST Demonstration; Training and Outreach was also conducted via staff meetings and individual meetings at multiple local Nursing Homes, Hospice, and Home Health institutions.



Who is responsible for filling out MOLST forms with patients?

All clinicians in any setting should talk about advance care planning with patients and document patients' treatment preferences as appropriate—regardless of specialty or length of relationship with the patient.

Such discussions may result in filling out a MOLST form, if medically indicated and desired by the patient.

1) BEFORE talking about MOLST:

- Talk to all patients, healthy or sick, aged 18 and older about the importance of signing a health care proxy
- When medically indicated, initiate advance care planning conversations with the patient*
- Determine if a patient may be suitable for MOLST based on his or her current medical status and prognosis

2) To INTRODUCE the option of using MOLST:

- Engage in discussions with the patient and his or her loved ones and/or representatives about the patient's health condition, prognosis, values and goals of care
- Discuss the burdens and benefits of CPR, ventilation, hospitalization and other life-sustaining treatments; explain the potential outcome of each treatment based on the patient's current medical condition
- Explore the patient's expectations and hopes for treatment – especially what the patient would consider to be a successful or acceptable outcome of treatment, and discuss the patient's treatment preferences
- Clarify that MOLST is a voluntary way to express preferences about life-sustaining treatments
- Explain that all patients are made as comfortable as possible as they are nearing the end of life

3) FILLING OUT the MOLST form with a patient:

On Page 1

- Fill in Sections A, B, and C to reflect the patient's preferences
- Instruct the patient, health care agent, or authorized representative* to fill in Section D completely
- Fill in Section E yourself (*Both Sections D and E must be fully compete and legible for Page 1 to be valid*).
- Fill in optional information as instructed at the bottom of Page 1, if appropriate for the patient

On Page 2

- For Section F, explain the uses, benefits and burdens of each treatment and mark the patient's* treatment preferences (or mark "Undecided" or "Did not discuss")
- Talk with the patient* about what "other treatment preferences" to include if appropriate (e.g. use of blood products, antibiotics, hospice care)
- Instruct the patient, health care agent, or authorized representative* to fill in Section G completely
- Fill in Section H yourself (*Both Sections G and H must be fully compete and legible for Page 2 to be valid*).
- Explain that the MOLST form should be: 1) kept with the patient; 2) put where it is easy to find (e.g. on the refrigerator, door, at bedside); 3) taken with the patient (e.g. in a purse or wallet) outside the home
- Discuss decision-making about calling 911 in an emergency, based on the patient's MOLST preferences
- Copy the MOLST form for the patient's record and discuss who else needs a copy (e.g. health care agent)
- Re-discuss the contents of the MOLST form with the patient* whenever there is a significant change in the patient's health status, treatment preferences or goals of care, health care setting, or level of care
- Void the MOLST form and fill in a new MOLST with updated instructions if one is desired by the patient*

* A health care agent can act on a patient's behalf if the patient lacks capacity per a clinician's written verification. If the patient has no appointed health care agent, a guardian or parent/guardian of a minor may be able to utilize MOLST on the patient's behalf, to the extent permitted by MA law (*consult legal counsel with questions about a guardian's authority*).



Step Three: LAUNCH

Step Three: Launch

Once MOLST Preparation and Development are well underway in the institution – even if some of those tasks are continuing or ongoing, it is time to plan for the MOLST Launch.

The Launch date is the date that MOLST forms will go into use with patients.

This may be the same date that the institution's MOLST Policy and Procedures goes into effect, or some time afterwards if more preparations are needed.

Key tasks for the MOLST *Launch* include to:

- 1) Identify baseline data elements
- 2) Prepare to launch
- 3) Launch MOLST



[Tool 3–1 *Launch* Task Checklist](#) - Outline of all recommended activities for *Launch*

Task 1: Identify Baseline Data Elements

Prior to launch, institutions should identify what baseline data elements could be collected for later comparison to measure the impact of MOLST.²² These may include programmatic measures (staff uptake of MOLST use, application of MOLST data to the institution's quality measures or reporting, etc.), as well as patient-level measures (changes in utilization of health care proxy forms, limitations of treatment orders, frequency of advance care planning discussions, etc.). Some data may be already collected within the institution, whereas others may require putting new processes in place to collect.



[Tool 3–2 Examples of Baseline Data](#)– Elements to consider measuring at baseline

²² Please note that specific suggestions and tools for incorporating evaluation measures to assess outcomes of MOLST use and to inform continuous quality improvement are the topics of *Step Four – Evaluation* and *Step Five – Sustainability*.

Task 2: Prepare to Launch

Prior to the Launch date, certain preparatory activities and notifications are recommended to promote a smooth MOLST implementation – not only for personnel and patients inside the institution, but also for the professionals, organizations and individuals that are part of the institution’s broader community.



- Tool 3–3 [Get the Massachusetts MOLST Form](#) – where and how to download the form
- Tool 3–4 [Questions to Consider before Launch](#) – for thinking about timeline, communication, etc.
- Tool 3–5 [Sample Notification of MOLST Launch](#) – to inform other community stakeholders
- Tool 3–6 [Patient and Family Education Materials](#) – resources and where to find them

Task 3: Launch MOLST

When MOLST launches, it is important to respond in a timely manner to any questions or concerns about MOLST use, and to continue making MOLST training and information available to staff.

If questions or issues emerge about which you are uncertain, please remember to utilize the many resources on the MOLST website at www.molst-ma.org.

In addition to troubleshooting implementation within the institution, there may be other small ways MOLST Champions can promote and encourage the uptake and appropriate use of MOLST.



- Tool 3–7 [Small Ways to Help MOLST Work](#) – Ideas and tips from the MOLST demonstration program

STEP THREE: *LAUNCH* TOOLS



3-1	Launch Checklist
3-2	Examples of Baseline Data
3-3	Get the Massachusetts MOLST Form
3-4	Questions to Consider Before Launch
3-5	Sample Notification of MOLST Launch
3-6	Patient and Family Education Resources
3-7	Small Ways to Help MOLST Work

**TASK 1: IDENTIFY BASELINE DATA ELEMENTS**

- Review tool 3-2 *Examples of Baseline Data*
- Determine what data elements the institution already collects that may pertain to MOLST
- Consider other types of data that would be important and/or possible to collect
- Put mechanisms in place to collect baseline data to the extent possible

TASK 2: Prepare for Launch (the date MOLST forms will go into use with patients)

- Inform MOLST Program Office of the Launch date and order blank MOLST forms
- Identify locale(s) for the Launch
- Communicate Launch plan throughout the institution
- Communicate Launch date and information to other stakeholders and institutions
- Confirm that key staff are trained about MOLST
- Alert personnel about who to contact in case of MOLST questions or concerns
- Make MOLST blank forms readily available for use
- Prepare and make patient and family education materials readily available for use

Task 3: MOLST Launch

- Respond in a timely manner to questions, concerns or issues that arise about MOLST use
- Communicate with the MOLST Program Office as needed with questions or concerns
- Encourage and support MOLST uptake and use
- Acknowledge and celebrate the accomplishment Launching MOLST with the MOLST Task Force
- If MOLST is being launched in stages, continue preparation activities in other sites



Baseline data is basic information gathered before a program begins. It is used later to provide a comparison for assessing program impact.

Before launching MOLST use with patients, institutions may want to identify potential baseline data elements and begin putting mechanisms and/or resources in place to collect data elements that might be expected to change with the introduction of the MOLST process and form use within the institution, community and state.

The following examples are data elements that were collected during the 2010 MOLST Demonstration program by participating implementation sites. These may be useful for institutions considering types of data that would be useful to track before, during and after MOLST implementation.

MOLST Implementation

- Number and types of staff trained about MOLST
- MOLST uptake per specific departments/units/services, etc.
- Number of MOLST forms ordered/used
- Percentages of MOLST forms signed by provider type (e.g. physicians; nurse practitioners; physician assistants)

Patient Data

- Total patients on the particular (hospital) service or in the particular program being reviewed
- Number of patient charts reviewed
- Ages of the patients
- Number of patients suitable for MOLST due to certain diagnoses and/or current health status
- Number of patients with health care proxies
- Number of patients with CC/DNR verification forms
- Number of patients with limitation of treatment while inpatient (e.g. DNR, DNI)
- Number of patient who discussed MOLST (or any limitations of treatment) with clinician
- Number of patients whose family members discussed MOLST with clinician
- Average number of discussions per patient before signing MOLST
- Number of patients who signed a MOLST form
- Number of MOLST forms signed by the patient
- Number of MOLST forms signed by the health care agent
- Number of patients that had CC/DNR forms and then signed MOLST
- Number of MOLST forms invalid and reasons why
- Number of patients with MOLST at discharge
- Number of MOLST forms voided



The MOLST form is available to individual clinicians and to Clinical Champions/clinical care institutions implementing use of the MOLST process and form.

MOLST forms should be ordered by institutions when the launch date is set. This is usually around the same date that the institutional MOLST policy goes into effect, and when training of personnel is nearing completion.

Instructions:

- 1) Download the *Massachusetts MOLST form* at: <http://www.molst-ma.org/order-molst-form>.
- 2) Be sure to access the correct form. Other MOLST forms may be available on line or already in circulation, including the 2010 MOLST Demonstration form and forms from other states (e.g. NY) that are pulsar pink and similar to the MA form.
- 3) Do not alter the MOLST form in any way before printing it.
- 4) Print original Massachusetts MOLST forms on bright or fluorescent pink paper for maximum visibility. Astrobrights® Pulsar Pink* is the color highly recommended for original MOLST forms. In Massachusetts, EMTs are trained to look for the bright pink MOLST form before initiating life-sustaining treatment with patients.

Astrobrights® Pulsar Pink paper can be purchased from office suppliers, including:

Staples - Item #491620 Wausau™ Astrobrights® Colored Paper, 8 1/2" x 11", 24 Lb, Pulsar Pink, in stores or at <http://www.staples.com>, and

Office Depot – Item #420919 Astrobrights® Bright Color Paper, 8 1/2 x 11, 24 Lb, FSC Certified Pulsar Pink, in stores or at <http://www.officedepot.com>.

- 5) Print the MOLST form as a double-sided, single sheet form.
- 6) Provide an electronic version of the downloaded MOLST form to your institution's forms department or to personnel responsible for copying/providing forms in your institution.
- 7) Determine the locations within the institution where supplies of the MOLST form should be stocked – to maximize availability when they are needed (e.g. discharge, different floors/units, emergency departments, critical care, etc.) and distribute blank forms accordingly.
- 8) Establish a plan for how supplies will be re-stocked as needed; large institutions may want to establish a "MOLST contact" in each location to be responsible for keeping forms available.



Timeline

- Will MOLST be launched institution-wide or staggered (e.g. in select pilot locations)?
- Which departments, sites, services or units could serve as good pilot locations?
- If implementation will be staggered, what is the timeline for launching MOLST in other locations?
- What is a target date for institution-wide implementation?

Staff Readiness

- Have all key personnel received MOLST training about MOLST?
- Are all key personnel aware of MOLST policy and procedures – especially as they relate to documentation?
- How/where will MOLST information or training resources be made available to staff if needed?
- Where will blank MOLST forms, health care proxy forms, patient education materials be kept?
- Should a “MOLST contact person” be designated per floor, unit, department, etc.? Who could the contact person be (e.g. floor nurse, care coordinator, etc.)? What additional preparation or support will the person need?
- If staff has questions about MOLST, where will they find information or assistance?

Communication

- How will the Launch date be communicated within the institution?
- What internal venues can be used to alert staff about the MOLST launch (e.g. meetings, posters, screen savers, bulletin boards, newsletters, Email notifications)?
- How will information about MOLST be relayed to patients and families?
- How will the Launch date be communicated outside of the institution?
- What other agencies, organizations, health providers, etc. should be alerted about the Launch?
- What community agencies, organizations, health providers are likely to come into contact with MOLST forms as our patients move from one care setting to another?
- What external venues can be used for communicating information about MOLST and the Launch date (e.g. media, professional newsletters, meetings, Email lists, conferences, etc.)?



ALERT – MOLST to LAUNCH at (INSTITUTION NAME) on (DATE)

Letterhead

Date

Salutation

We are writing to inform you that our institution will begin utilizing Medical Orders for Life-Sustaining Treatment (MOLST) with suitable patients/residents, effective **(launch date)**.

You are receiving this information because you or your organization may interact with our patients/residents who have recently completed a Massachusetts MOLST form—*valid medical orders* containing instructions about life-sustaining treatments to be honored by health professionals across care settings.

The use of MOLST in Massachusetts is authorized by the Massachusetts Department of Public Health and supported by the Boards of Registration in Medicine, Nursing, and Physicians Assistants as “an appropriate way to meet the standard of care for communicating patient’s treatment preferences at the end of life.”

Enclosed with this packet is a:

- MDPH Circular Letter DHCQ 12-3-560;
- Sample Massachusetts MOLST form;

To prepare for honoring patients’ MOLST forms, you may wish to:

- Review the Massachusetts MOLST website www.molst-ma.org, which contains detailed information and resources, such as training tools, a variety of consumer information and other materials
- Appoint a “MOLST champion” in your own organization to prepare for receiving and honoring patients’ or clients’ MOLST forms
- Participate in MOLST implementation training (information available at www.molst-ma.org)

Successful outcomes for patients with MOLST forms will require cooperation among all persons involved in providing their care and a commitment to understanding the process and intent of Medical Orders for Life-Sustaining Treatment. We encourage you to learn more by visiting www.molst-ma.org.

Sincerely,

(Signer or signers)

TOOL 3-6	Patient and Family Education Resources 	
MOLST Website	Overview of the MOLST process and form and access to educational materials	http://www.molst-ma.org/patients-families
MOLST Brochure	Hard copy tri-fold brochure with introductory information	http://www.molst-ma.org/consumers/brochure
FAQ - Patients and Families	Answers to “Frequently Asked Questions” from patients and their families	http://www.molst-ma.org/consumers/faq
MOLST video	13 minute video with stories and comments about MOLST and end-of-life experiences from patients, family members, health providers, clergy and others	www.molst-ma.org Or call 508-856-5890 for a DVD copy
Sample MOLST form	The two-page Massachusetts MOLST form marked SAMPLE and not for actual use	http://www.molst-ma.org/forms
Massachusetts Health Care Proxy form	Advance Directive form to be used by all adults in Massachusetts (18 years old and older), whether healthy or sick, to designate a health care agent	http://www.molst-ma.org/forms/the-massachusetts-health-care-proxy-form
About the MOLST form	Explains the contents of the MOLST form and what patients and families should discuss with a <i>physician, nurse practitioner or physician assistant</i> before using MOLST	http://www.molst-ma.org/consumers/the-form-explained
Difference between MOLST and a Health Care Proxy form	Both forms may be used as a part of advance care planning, but they are used at different times for different reasons	http://www.molst-ma.org/patients-families
Glossary of Terms	Definitions of words often used during advance care planning discussions	http://www.molst-ma.org/resources/glossary-of-terms
Better Ending Website	A web site that helps individuals plan in advance for serious illness before a medical emergency occurs	http://www.betterending.org/
MA End of Life Care Commission website	End of life services Resource Guide	http://www.endoflifecommission.org/end_pages/guide.htm
Hospice and Palliative Care Federation of Massachusetts	A guide to hospice and palliative care in MA for patients, family members and friends	http://hospicefed.org/
The Conversation Project	The Conversation Project - This project (and website) is "dedicated to helping people talk about their wishes for end-of-life care" and includes a Starter Kit to help individuals have "the conversation."	http://theconversationproject.org/



Ideas from the MOLST Demonstration Program:

- ❖ Provide an ample supply of blank MOLST forms and other roll-out materials to floors, units, departments, or sites where MOLST is being implemented.
- ❖ Provide a supply of Astrobrights® Pulsar Pink-colored paper onto which MOLST forms may be printed or copied (especially to personnel that prepare forms and to discharge personnel).
- ❖ Supply appropriate personnel (e.g. admissions staff, floor nurses, others) with hot-pink post-it notes to “tag” the charts of patients or residents that have current DNR orders or Comfort Care/DNR forms – to remind clinicians to discuss MOLST with those individuals.
- ❖ Provide discharge personnel with hot-pink colored envelopes – or envelopes with hot-pink colored labels – for inserting MOLST forms and sending with the patients or resident (EMTs recommend placing these hot pink-colored envelope on the refrigerator at home).
- ❖ Provide hot pink colored folders/transparent sleeves labeled “Property of (patient name and contact phone number or phone number of SNF, etc.)” – for sending MOLST forms with patients/residents to outside health care appointments, emergency room visits, etc.
- ❖ “Tag” the charts or discharge plans of patients who have MOLST – to remind personnel to send the MOLST form with the patient at discharge.
- ❖ Conduct periodic chart reviews of discharged patients/residents to check for original MOLST forms that may have been left in the charts; if any are found, return them to the patient/resident if possible.
- ❖ Make rounds of floors, units, departments, or sites that are utilizing MOLST to 1) replenish MOLST forms and materials and 2) interact with staff that may have questions.
- ❖ *Please add (and share with the MOLST team) your own ideas for helping MOLST work!*