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 – either in multiple settings of a single institution or in other collaborating institutions (e.g. with cross-continuum teams), 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
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 Advance Illness – Definitions of words and terms often used in planning for Advance Illness

Task 1: Convening the MOLST Task Force

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

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”

MOLST in Massachusetts Expansion Project Toolkit, March 2012
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.

Before creating any new MOLST policy, it is important to identify and review existing institutional policies or procedures 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.

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**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

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

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**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 as well as a chance to participate in 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.

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**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
## STEP TWO: DEVELOPMENT TOOLS

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<td>Sample Training &amp; Outreach Log (from MOLST Demonstration)</td>
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<td>2-11</td>
<td>Checklist for Clinician Signers of MOLST</td>
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</table>
TASK 1: CONVENE INSTITUTIONAL TASK FORCE (Clinical Champions)

- 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 Task Force members or others as appropriate with clearly defined accountability (e.g. who will do what by when)
- Maintain communication among and participation of key representatives

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

- Review Sample MOLST Policies
- Identify Existing Institutional Policy Related to MOLST, e.g.
  - Medical Decision Making policy
  - Advance Care planning/Health Care Proxy policy
  - Limitations on life sustaining treatments policy (DNR, DNI policy)
  - Informed Consent Policy
  - Surrogate Decision Maker policy
  - Withdrawal of Treatment policy
  - Goals of Care discussion policy
- Develop Institutional MOLST Policy & Procedure
- Submit for Review Process as Appropriate
- Finalize Policy & Procedure
- Alert Workforce of Policy & 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, 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
TOOL 2-2  Glossary of Terms Related to Planning for Advanced Illness

**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 patient/resident’s 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? *(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 will “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? Other ideas?*
- Should a “champion” be designated per site/floor to oversee the MOLST demonstration? *Who would that be? What would be their role?*
- 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?
# MOLST Implementation Sample Work Plan

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

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>MATERIALS</th>
<th>TASK ASSIGNMENTS</th>
<th>TIMELINE</th>
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<tbody>
<tr>
<td>Task Force Meeting #1: Introduction and Orientation</td>
<td>Sign-in sheet</td>
<td>MOLST overview materials from <a href="http://www.molst-ma.org">www.molst-ma.org</a></td>
<td>Implementation Work plan</td>
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<tr>
<td>□ Overview of MOLST, statewide expansion and expectations for institutional implementation</td>
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<tr>
<td>□ Status of institutional support and site readiness</td>
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<tr>
<td>□ Review MOLST form and related documents</td>
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<tr>
<td>□ Q &amp; A about MOLST and site implementation (Track questions or issues that need answers)</td>
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<tr>
<td>□ Discuss members’ role/responsibilities</td>
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<tr>
<td>□ Discuss proposed timeline for implementation</td>
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<tr>
<td>□ Identify others who should be on the Task Force</td>
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<tr>
<td>□ Schedule 4-5 dates for Task Force meetings</td>
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<tr>
<td>Task Force Meeting #2: Implementation planning</td>
<td>Considerations for Site-Level Implementation</td>
<td>MOLST policy/draft (if available)</td>
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<tr>
<td>□ Plan logistics of how implementation will work (who/what/when/where/how)</td>
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<td>□ Identify possible barriers and challenges</td>
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<td>□ Identify additional necessary steps/activities needed before implementation</td>
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<tr>
<td>□ Draft a timeline for implementation</td>
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<tr>
<td>□ Determine how implementation will be coordinated/supervised/monitored/supported</td>
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<tr>
<td>□ Discuss status of institutional policy/protocol development</td>
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<td>Task Force Meeting #3: Training planning</td>
<td>MOLST training materials</td>
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<tr>
<td>□ Determine who at institution needs training</td>
<td>List/org chart of departments, contacts, etc.</td>
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<tr>
<td>□ Review MOLST training materials</td>
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<tr>
<td>□ Determine types/levels of training needed per audience/participant groups</td>
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<tr>
<td>□ Determine best vehicles/venues for training (for start-up and ongoing venues for sustainability)</td>
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<tr>
<td>□ Identify potential trainers and trainer preparation</td>
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<tr>
<td>□ Determine whether patient/family education and outreach is needed and how to deliver</td>
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<tr>
<td>□ Review consumer education materials</td>
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<td>Task Force Meeting #4: Evaluation</td>
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<tr>
<td>□ Determine evaluation plan and tools</td>
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<tr>
<td>□ Discuss how evaluation activities will be implemented</td>
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<tr>
<td>□ Identify existing evaluation measures/processes (that could potentially incorporate MOLST)</td>
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<td>Task Force Meeting #5: Next Steps</td>
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<tr>
<td>□ Identify outstanding tasks and assign activities</td>
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<td>□ Determine need/tasks for additional Task Force meetings and schedule meetings if needed</td>
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Implement MOLST on agreed-upon go-live date
TOOL 2-5 Recommendations for MOLST Policy Development

- 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 existing MOLST policies as examples. (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)

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1 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)
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 identifiable;
- 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.

A legally recognized health care agent or guardian 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 capacity. 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 clinician 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.

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2 (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)

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

4 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.

5 “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.

6 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.

7 “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 form 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.

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

8 Hospitals should designate by policy the specific staff responsible for this action.
9 Hospitals should designate by policy the specific staff responsible for this action.
10 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.
11 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.”
II. Patient Admitted with a Completed MOLST Form

1. During the initial patient assessment, document the existence of the MOLST form\textsuperscript{12}, 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 MOLST\textsuperscript{13}.

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 appropriate\textsuperscript{14}. 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 chart\textsuperscript{15}. 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 transfer\textsuperscript{16}.

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.

\textsuperscript{12} Hospitals should designate by policy the specific staff responsible for this action.
\textsuperscript{13} Hospital should designate by policy the specific staff responsible for this action.
\textsuperscript{14} 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.
\textsuperscript{15} Hospitals should designate by policy the specific staff responsible for this action.
\textsuperscript{16} Hospitals should designate by policy the specific staff responsible for this action.
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.

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 transfer.

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.

17 Hospitals should designate by policy the specific staff responsible for this action.
**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;
- 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.

A legally recognized health care agent or guardian 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. 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 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.

*Additional sample policies can be found at [www.ohsu.edu/polst/resources/policy.htm](http://www.ohsu.edu/polst/resources/policy.htm) and at [www.compassionandsupport.org/index.php/for_professionals/molst_training_center/implementation_resources](http://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 at: [www.molst-ma.org](http://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.

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

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(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.

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(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.
<table>
<thead>
<tr>
<th>TOOL 2-8</th>
<th>MOLST Training Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESOURCE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>MOLST Overview for Health Professionals</td>
<td>PowerPoint presentation</td>
</tr>
<tr>
<td>SAMPLE MOLST form</td>
<td>Official form</td>
</tr>
<tr>
<td>Process for when a patient has a MOLST form</td>
<td>What to do when a patient arrives with/has a MOLST form</td>
</tr>
<tr>
<td>Differences between MOLST and a Health Care Proxy Form</td>
<td>Table illustrating important differences between these forms</td>
</tr>
<tr>
<td>Glossary of End of Life Terms</td>
<td>Definitions of words and terms related to End-of-Life Planning and Care</td>
</tr>
<tr>
<td>MOLST video</td>
<td>13 minute overview</td>
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<tr>
<td>Frequently Asked Questions about MOLST (FAQ)</td>
<td>1-2 page document with responses to the most frequently asked questions about MOLST by audience</td>
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<tr>
<td>Other related training websites</td>
<td>Additional training resources about end of life care and palliative care</td>
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## TOOL 2-9  MOLST Training Plan Template

<table>
<thead>
<tr>
<th>Site, Unit or Department</th>
<th>Site, Unit or Department Contact name, phone, email</th>
<th>Participants (how many, disciplines, roles, etc.)</th>
<th>Trainer(s) name, phone, email</th>
<th>Training location, venue or address</th>
<th>Training materials and handouts</th>
<th>Method for inviting participants</th>
<th>Training date(s) and time(s)</th>
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<td>Faculty Fellows Residents Students</td>
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<td>Patient &amp; Family Advisory Council</td>
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### Sample Training and Outreach Log

*From 2010 MOLST Demonstration*

#### ACUTE CARE SITES

<table>
<thead>
<tr>
<th>Date</th>
<th>Trainer(s)/Presenter(s)</th>
<th>Duration</th>
<th>Location</th>
<th>Participants</th>
<th>Estimated # Participants</th>
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<tbody>
<tr>
<td>2/3</td>
<td>CM</td>
<td>1 hour</td>
<td>Hospital A</td>
<td>Schwarz Rounds for Medical Residents (physicians) and nurses</td>
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<tr>
<td>2/16</td>
<td>MV</td>
<td></td>
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<tr>
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<td>Care Coordinators, SW, pastoral staff, patient care services</td>
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<td>3/18</td>
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<td>Open Nurse Practitioner meeting – NPs, maybe PAs, some lawyers</td>
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<td>3/24</td>
<td>MV</td>
<td>Noon</td>
<td>Hospital B</td>
<td>Hospital medicine</td>
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<td>3/29</td>
<td>MV, CM</td>
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<td>Hospital B</td>
<td>Geriatrics – doctors and NPs – “nursing home” docs</td>
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<td>3/30</td>
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<td>4/1</td>
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<td>4/2</td>
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<tr>
<td>4/27</td>
<td>MV</td>
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<td>General Medicine – primary care doctors and NPs, Hospitalists</td>
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<td></td>
<td>MV</td>
<td></td>
<td>Hospital B</td>
<td>Surgery (several groups)</td>
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<tr>
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<td>CM, DC</td>
<td>1.5 hour</td>
<td>Hospital B</td>
<td>Medical interpreters</td>
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#### EMTs and First Responders

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<tr>
<th>Date</th>
<th>Trainer(s)/Presenter(s)</th>
<th>Duration</th>
<th>Site or group</th>
<th>Participants</th>
<th>Estimated # Participants</th>
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<tr>
<td>2/5</td>
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<td>CMEMS Region 2</td>
<td>EMTs and EMT trainers</td>
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<td>JA</td>
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<td>City 2 fire department</td>
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<td>4/20</td>
<td>JA</td>
<td>1 hour</td>
<td>City 3 fire department</td>
<td>EMTs and First Responders</td>
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</table>

* Training and Outreach was also conducted via staff meetings and individual meetings at multiple local Nursing Homes, Hospice, and Home Health institutions.
**Checklist for Clinician Signers of MOLST**

**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 complete 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 complete 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), and 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).