MOLST Online Survey Feedback

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RESPONDENTS (n=21)

DISCIPLINE
- PC Coordinator
- Ethicist
- Chaplain
- Administrator
- Nurse
- Physician
- Social worker

WORK SETTING
- Hospice/PC
- LTC
- Hospital
Considering MOLST orders completed at your health care facility since July 1, 2013, how common is it for patients who have a MOLST form that puts limitations on life-sustaining treatments ALSO to have a valid advance directive (for example, a living will and/or appointed health care agent)?

- Don't know
- Always
- Often
- Sometimes
- Rarely
- Never

0 2 4 6 8 10 12 14
How common is it at your facility that a MOLST form received upon admission is voided and re-done within the first 48 hours?

- Don't know: 4
- Always: 1
- Often: 3
- Sometimes: 10
- Rarely: 3
- Never: 0
The Maryland MOLST form was created to improve communication about EOL treatment preferences across health care settings. How satisfied are you with its ability to accomplish this goal?
TOP REASONS DISSATISFIED

- Acute care is difficult setting for MOLST discussion
- Lack of time, motivation, & skills in goals of care/EOL discussion
- Contradicts what’s in advance directive
- Mandatory while advance directives are optional
- Trouble keeping up with most recent MOLST
- Distrust MOLST form accuracy
- Not coming with patient from nursing home
- Over-burdens healthy/non-terminal patients
Positive evaluations

- **Compliance with MOLST form**
  - “Most patients now have them on their charts and we are finding that accepted transfers have them.”

- **Improved patient care**
  - “The MOLST form has helped open up dialogue with pts and family about end of life issues. It has increased the awareness of assigning a HCA.”
  - “In general the MOLST form is a big plus in terms of avoiding unwanted and unnecessary medical care.”
Focus on **PROCESS**, not just **FORM**

- “We have been using the MOLST process (it is more than an order form!) since November, 2011.”

- “There is a process, all parties educated on process. Key: Administration holds physicians accountable for completion of MOLST on initial visit to facility.”

- “It is used as our system DNR (DNAR) order form. That was an easy transition and familiarized our folks. We also had intense education of nurses and discharge planners…”
PROBLEMS ENCOUNTERED
Problems in MOLST completion

- Wrong (or no) decision-maker identified
- Not signed
- Conflicting preferences
  - Palliative care on P1, “do everything” on P2
- Not sent with patient when should be
Doesn’t reflect patient’s preferences

“Many patients return from hospital with MOLST forms completed and they have no recollection of any discussion about the form, and often do not agree with the way the form has been filled out.”

“Surrogates overriding what is in the MOLST Options A-1 …”

In many cases, the provider in the hospital is just checking full CPR when the patient is a full code in the hospital, without a discussion with the patient as the assumption is that the patient would want to be a full code.”
Voiding MOLST

- “[MOLST is] changed by another MD at SNF after the palliative care team took much time to review/discuss with family; SNF MD will go in to room and say ‘So you don’t want us to do anything for you’.”

- “We have had patients come from our hospital that had a MOLST done by their PCP and the hospitalist will do another one (frequently exact opposite choice of the previous MOLST). The previous MOLST is not voided and more often than not, the patient states they did not request or agree to a change of MOLST from their original done with their PCP.”

- “Nurses should be able to void MOLST.”
Problems interpreting MOLST

- “... A-2 being misinterpreted by physicians as allowing CPR.”
- A-2 missing
- “Some facilities will not honor the MOLST if done with family members of incapacitated pt's if there is not a previously signed POA as well.”
Problems interpreting MOLST

“For patients whose MOLST orders and their AD do not agree, although the MOLST is the most recent, is this the best way to figure out what the patient's wishes are?" 

“Does a MOLST for No CPR/no intubation apply even to a sudden, acute reversible condition? Can it distinguish between "death prolonging vs. life restoring conditions?"
Difficulty finding most recent MOLST

“...We are having a hard time keeping up with the most recent copy and also having our very enthusiastic hospitalist complete a new one on most patients upon admission without really waiting to see if there is already one in the system.”

“Even in old fashioned paper chart systems, keeping the information updated in every place it appears poses challenges. The most recent MOLST should be the current order. But making sure everyone knows where to find the most recent order may be problematic.”

“...without an official registry, you may be working off of an older MOLST order. Patient DO NOT CARRY THE MOLST WITH THEM....so you are left to create a new MOLST at d/c (but the MOLST at home appears to be active - unable to VOID).”
Not consistent with HCDA

“When MOLST forms are completed in a hospital setting, we find that inadequate consideration is given to several aspects of the Maryland Health Care Decisions Act, for example, who is the authorized decision maker for an incapacitated person, and have appropriate certifications of medical condition or medical ineffectiveness been completed when surrogate decision makers are limiting treatment?”
BARRIERS TO EFFECTIVE IMPLEMENTATION
POOR EOL COMMUNICATION SKILLS

- Lack of focus on goals of care
- Untrained staff completing MOLST

“Having the MOLST signed by an NP or an Attending does not mean that they are the ones taking the time for a full discussion. Residents, who might not be very comfortable with this discussion, are having it, and I don't know how well the conversation goes.”
PERCEIVED LACK OF TIME

“Doctors do not have end of life discussions with their patients. They say it takes too much time. Clearly has improved by requiring [MOLST], but level of conversation is hard to know and the default of full code still is the easiest path.”

“When resident is not capable of decision making, physicians check box for no decision maker/cannot make choice rather than take the time to call family to speak with the authorized decision maker…”

“NP - gives blank MOLST to patient to fill out.... reports being too busy to have discussions …”
LACK OF BUY-IN FROM DOCS

“Too many doctors in the hospital setting see it as a nuisance and do not give the time and information to pt/family that is needed to complete it accurately.”

“Some physicians believe it is not their duty or responsibility to have the necessary discussions with patients or families. ‘That is the job of the social worker, not the physician.’”
PERCEPTIONS OF DIFFERENT SXS

- Cardiology - want to customize options to clinical picture
- ED teams - uncomfortable having MOLST discussion with patient who is “not theirs”
  - discussion should be at provider level
  - discussions upset patients
  - discussions slows ED workflow
- Surgical patients – “doc in OR unwilling to sign MOLST for d/c referral. While the orders should have been considered earlier, reality is that the community referral may be a second thought....and result in a delay due to signature.”
“Uncertainty that physician actually talked with the patient about code status—communication not happening. Suspect that many times form is just filled out for full resuscitation without a discussion—just to get the paperwork done.”
POOR TIMING

- “Effort made to complete on admission … very challenging for residents with middle of the night ICU admissions when this is the first conversation the patient has about advance directives.”
- “The discussion is left until discharge. It is my understanding … that the conversation is rushed, that it is just part of the discharge planning, and is not taken seriously by the staff or by the patient.”
The State needs to develop CRISP sooner than later. It is difficult to access MOLST & Advance Directives from previous admissions. Also, there could be other versions of the MOLST archived at various institutions.”
“… What is success-- and how do we measure it?”

- Quality of goals of care/EOL planning discussion
- Documenting conversation & EOL preferences
- Reducing unwanted life support
- Reducing non-beneficial life support
- Other?
Finding solutions …

- Acute care difficult setting
- Lack of time, motivation & communication skills
- Distrust MOLST form accuracy
- Over-burdens healthy/non-terminal patients
- Contradicts AD; AD not mandatory
- Trouble finding most recent MOLST
- Not sent with patient from NH

- TRAINING
  - Communication
  - EOL/palliative care
  - HCDA
- ADMIN SUPPORT
- AD/MOLST REGISTRY
- ENFORCEMENT