MASSACHUSETTS COALITION FOR
SERIOUS ILLNESS CARE

# MOLST to POLST Stakeholder Session

March 17, 2023

## MOLST to POLST Stakeholder Session

# Thanks for joining!

- Lots of people with us today.
- Please mute yourselves when not talking (we might mute you if there's background noise)
- We want to hear from you! Feel free to write questions or ideas in chat throughout the session
- We will be recording the session

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# MOLST to POLST Stakeholder Session

## Who's in the room?

**Tell us who you are in the chat!**

- Which stakeholder group and/or organization are you representing?
- What is your role?

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# MOLST to POLST Stakeholder Session

## Agenda

- **PART I: MOLST to POLST Transition Updates**
  - MOLST to POLST Advisory Group
  - Why update to POLST?
  - POLST Program mission and principles/goals
  - Questions and discussion about MOLST to POLST transition
- **PART II: Meet & Greet or (re-meet & re-greet) the POLST Form**
  - Advance care planning, serious illness communication, and POLST
  - Meet the POLST form
  - Q&A

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# Welcome!

maseriouscare.org/molst-to-polst

About Us | What We Do | Membership | News | Partner with Us

## MOLST to POLST Advisory Group

- **Co-Chairs:** Ellen DiPaola, Esquire
  Erik Fromme, MD, MCR, FAAHPM
- **Project Director:** Jane Kavanagh
- Updates on the MOLST to POLST transition and opportunities to engage and provide input can be found on the Advisory Group website: **https://www.maseriouscare.org/molst-to-polst**

**Advisory Group includes representatives from:**
Ariadne Labs,
Honoring Choices Massachusetts,
Massachusetts Coalition for Serious Illness Care,
The Massachusetts Health & Hospital Association,
The Hospice and Palliative Care Federation of Massachusetts, Massachusetts Medical Society,
UMass Memorial Health Care,
State Emergency Medical Services,
Center for Public Representation,
Mass General Brigham,
Massachusetts Senior Care Association.

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# Why update to POLST?

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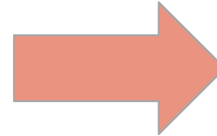
# Why do we need to update our program?

- In our paper-based system, MOLST orders often do not follow a patient across different health care settings.
- The MOLST order form often includes conflicting or incompatible choices.
- MOLST orders are often completed without a high-quality conversation about what truly matters to patients and their families.



A **patient's documented treatment choices** can be **hard to locate** in a critical moment or **ignored** due to concerns about validity .

source

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# Why switch to the national POLST form

- Based on best practices learned from research and mature programs around the country
- Designed to simplify and better facilitate the translation of a patient's care preferences into medical orders
- Align with national standards and benefits from reciprocity with other states using the National form and National POLST.
- The form has been adopted by Maine and New Hampshire and is being considered by Connecticut and Rhode Island.

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

**National POLST Form: A Portable Medical Order**

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

**Patient Information.** **Having a POLST form is always voluntary.**

**This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form**

Patient First Name: ______
Middle Name/Initial: ______ Preferred name: ______
Last Name: ______ Suffix (Jr, Sr, etc): ______
DOB (mm/dd/yyyy): __/__/____ State where form was completed: ______
Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-__ __ __ __

**A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.**

Pick 1
☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)
☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

**B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.**

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1
☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.
☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.
☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

**C. Additional Orders or Instructions.** These orders are in addition to those above (e.g., blood products, dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

**D. Medically Assisted Nutrition** (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1
☐ Provide feeding through new or existing surgically-placed tubes
☐ No artificial means of nutrition desired
☐ Trial period for artificial nutrition but no surgically-placed tubes
☐ Not discussed or no decision made (provide standard of care)

**E. SIGNATURE: Patient or Patient Representative** (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

X (required)

If other than patient, print full name: ______ **Authority:** ______

**The most recently completed valid POLST form supersedes all previously completed POLST forms.**

**F. SIGNATURE: Health Care Provider** (eSigned documents are valid) **Verbal orders are acceptable with follow up signature.**

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

X (required) **Date** (mm/dd/yyyy): Required __/__/____ **Phone #:** ( )

Printed Full Name: ______ **License/Cert. #:**

Supervising physician signature: ☐ **N/A** **License #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

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# Why electronic POLST and e-registry

The transition to electronic completion of the POLST and a centralized electronic registry will support:

- Accurately completed POLST forms (no more conflicting or incompatible choices)
- A trusted, single source of truth
- Enhanced visibility and transferability across providers and different care settings
- Robust data for reporting and policy making
- An opportunity to re-center conversations

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# POLST Program mission

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# POLST Program mission

The POLST (Portable Orders for Life Sustaining Treatment) Program's mission is to help persons living with serious illness and advancing frailty engage in care planning conversations with their clinicians and care teams to ensure that their treatment preferences are understood and honored.

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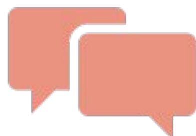
## These goals and principles will guide us in achieving our mission

Establish POLST Program as integral part of care planning continuum across MA



Support effective care planning conversations for people with serious illness and advancing frailty

Ensure clear, reliable documentation

Improve integration across care settings

Align with national standards and best practices

Continually improve

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# MOLST to POLST transition updates

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# MOLST to POLST transition updates

**March 2021** MA began work of updating paper-based MOLST Program to the POLST Program

**Spring- Fall 2021**

The Executive Office of Health and Human Services (EOHHS) and Executive Office of Elder Affairs (EOEA) engaged Auribus Consulting to assess MOLST process and develop blueprint of a POLST Program. **The Auribus team met with over 100 stakeholders across MA.**

**November 2022**

Governor Baker signed Bill H.5374 "An Act Relating to Economic Growth and Relief for the Commonwealth," including language **authorizing EOEA to lead and administer update to a POLST Program.**

**January 2023**

EOHHS, on behalf of EOEA, Department of Public Health, and the Mass HIway **issued a Request for Responses to procure a vendor to implement, maintain, and support the Massachusetts ePOLST registry** with a deadline of March 14, 2023.

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## POLST Program co-development and early testing

- EOEA team has been engaging with Cooley Dickinson Hospital, Lowell General Hospital, and Fairview Hospital for co-development and early testing of POLST program components and workflows
  - These sites were chosen because of relative proximity to state borders
  - Each site will be working with at least one skilled nursing facility, EMS provider, home health agency, outpatient affiliate

- EOEA will share more information about this co-development and early test phase soon

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# POLST Program Timeline

- **March 14, 2023 -**RFR bidder responses due
- **Spring 2023**
  - Anticipated selection of vendor for e-registry **(May)**
  - EOEA statewide announcement regarding Test phase and how those outside the test sites should honor POLST
  - Slide deck and talking points "Just in case you see a POLST" will be available on mass.gov
- **Spring-Fall 2023** - co-development and early testing phase with Lowell General Hospital, Cooley Dickinson Hospital, and Fairview Hospital
- **Summer 2023 -** Anticipated e-registry contract execution
- **Fall 2023 - Spring 2024 -** Promulgation of regulations governing POLST implementation
- **Spring/Summer 2024**: Anticipated registry implementation statewide
  - 18 month period with MOLST and POLST both active
  - MOLST sunset date will be announced

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# Discussion:

- What are your questions?
- What are you most worried about?
- What do you need us to make sure the state knows?

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# Meet & Greet with the POLST form

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## Which of the following is/are true of POLST?

A. POLST is not for every seriously ill patient
B. Must be voluntary in all aspects
C. Is only as good as the conversation to fill it out
D. Is useful only if family members and clinicians will honor it
E. All of the above

Name a health care proxy

Talk to your family; complete an advance directive

**Serious illness conversation with clinician**

Complete a POLST w. clinician

End-of-life talk

HEALTHY-----ILL-----END OF LIFE

HEALTH TRAJECTORY

ONGOING CONVERSATIONS AND DOCUMENTATION

Izumi S and Fromme EK, Journal of Palliative Medicine. March 2017, 20(3): 220-221.

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**MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT**

**(MOLST) www.molst-ma.org**

Patient's Name ______________________

Date of Birth ______________________

Medical Record Number if applicable: ______________

**INSTRUCTIONS:** *Every patient should receive full attention to comfort.*

- → This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the signing clinician.
- → Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
- → If any section is not completed, there is no limitation on the treatment indicated in that section.
- → The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

| | |
|---|---|
| **A** Mark one circle → | **CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest**<br>O Do Not Resuscitate O Attempt Resuscitation |
| **B** Mark one circle → | **VENTILATION: for a patient in respiratory distress**<br>O Do Not Intubate and Ventilate O Intubate and Ventilate |
| Mark one circle → | O Do Not Use Non-invasive Ventilation (e.g. CPAP) O Use Non-invasive Ventilation (e.g. CPAP) |
| **C** Mark one circle → | **TRANSFER TO HOSPITAL**<br>O Do Not Transfer to Hospital (*unless needed for comfort*) O Transfer to Hospital |
| PATIENT or patient's representative signature<br>**D**<br>*Required*<br>Mark one circle and fill in every line for valid Page 1. | **Mark one circle below to indicate who is signing Section D:**<br>o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor<br>Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. ***A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.***<br>✗ Signature of Patient (or Person Representing the Patient) — Date of Signature<br>Legible Printed Name of Signer — Telephone Number of Signer |
| CLINICIAN signature<br>**E**<br>*Required*<br>Fill in every line for valid Page 1. | Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.<br>✗ Signature of Physician, Nurse Practitioner, or Physician Assistant — Date and Time of Signature<br>Legible Printed Name of Signer — Telephone Number of Signer |
| Optional<br>Expiration date (if any) and other information | **This form does not expire unless expressly stated.** *Expiration date (if any) of this form:* ________<br>Health Care Agent Printed Name ________ Telephone Number ________<br>Primary Care Provider Printed Name ________ Telephone Number ________ |

**SEND THIS FORM WITH THE PATIENT AT ALL TIMES.**
HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.



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HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

## National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

**Patient Information.** **Having a POLST form is always voluntary.**

**This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form**

Patient First Name: ______________________

Middle Name/Initial: ________ Preferred name: ________

Last Name: ________ Suffix (Jr, Sr, etc): ________

DOB (mm/dd/yyyy): ___/___/___ State where form was completed: ________

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-____

**A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.**

Pick 1

- ☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)
- ☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

**B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.**

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

- ☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.
- ☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.
- ☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

**C. Additional Orders or Instructions.** These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

**D. Medically Assisted Nutrition** (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

- ☐ Provide feeding through new or existing surgically-placed tubes
- ☐ No artificial means of nutrition desired
- ☐ Trial period for artificial nutrition but no surgically-placed tubes
- ☐ Not discussed or no decision made (provide standard of care)

**E. SIGNATURE: Patient or Patient Representative** (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✗ (required)

**The most recently completed valid POLST form supersedes all previously completed POLST forms.**

If other than patient, print full name: ________ **Authority:** ________

**F. SIGNATURE: Health Care Provider** (eSigned documents are valid) **Verbal orders are acceptable with follow up signature.**

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge.
[Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✗ (required) **Date** (mm/dd/yyyy): Required ___/___/___ **Phone #:** ( )

Printed Full Name: ________ **License/Cert. #:** ________

Supervising physician signature: ☐ N/A **License #:** ________

# Patient Information

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

## National POLST Form: A Portable Medical Order

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| **Patient Information.** | **Having a POLST form is always voluntary.** |
|---|---|
| This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form | Patient First Name: ____________________<br>Middle Name/Initial: ____________ Preferred name: ____________<br>Last Name: ____________________ Suffix (Jr, Sr, etc): ________<br>DOB (mm/dd/yyyy): ____/____/______ State where form was completed: ____________<br>Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___ |

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# Cardiopulmonary Resuscitation Orders

| A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing. | | |
|---|---|---|
| Pick 1 | ☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B) | ☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B) |

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# Initial Treatment Orders

| B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing. | Intubate? | Transport? |
|---|---|---|
| Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes. | | |
| **Pick 1** ☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care. | Y | Y |
| ☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location. | N | Y |
| ☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting. | N | ? |

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# Additional Orders and Medically Assisted Nutrition

**C. Additional Orders or Instructions.** These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

**D. Medically Assisted Nutrition** (Offer food by mouth if desired by patient, safe and tolerated)

| Pick 1 | | |
|---|---|---|
| | ☐ Provide feeding through new or existing surgically-placed tubes | ☐ No artificial means of nutrition desired |
| | ☐ Trial period for artificial nutrition but no surgically-placed tubes | ☐ Not discussed or no decision made (provide standard of care) |

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# Signatures

| E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid) | | | |
|---|---|---|---|
| I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest. | | | |
| X (required) | | | The most recently completed valid POLST form supersedes all previously completed POLST forms. |
| If other than patient, print full name: | | Authority: | |
| **F. SIGNATURE: Health Care Provider (eSigned documents are valid)** | | | **Verbal orders are acceptable with follow up signature.** |
| I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order] | | | |
| X (required) | | **Date** (mm/dd/yyyy): Required / / | **Phone #:** ( ) |
| Printed Full Name: | | | **License/Cert. #:** |
| Supervising physician signature: | ☐ N/A | | **License #:** |

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

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# Comments and Questions About the New Form

## Positives

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## Negatives

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## Why not make changes to the National Form to make it better?

- The form has already been through an extensive 'improvement' process through national POLST that included more than 30 state representatives
- What makes it better for one stakeholder often makes it worse for another
- While by no means perfect, the form is quite close to versions that have worked well in multiple states for many years.
- The closer the form is to neighboring states, the more likely MA forms will be honored there
- QED: the MOLST 2 POLST Advisory Group has agreed we should adopt the National Form as is

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# What comes next?

- Check out the POLST form on the Advisory Group site- send any questions, concerns your or your colleagues have to us
- Visit the Advisory Group webpage for updates throughout the transition and more virtual sessions like this one. **http://maseriouscare.org/molst-to-polst**
- Share your ideas by filling out this form.
- If you would like to be more involved in the process, contact jane.kavanagh@gmail.com

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