



Nationally Recognized for Patient-Centered Care



**ProHealth Physicians Testimony
John Lynch, MPH
Regarding Senate Bill 413, An Act Concerning the Department of Public Health's
Recommendations Regarding Medical Orders for Life-Sustaining Treatment**

**Public Health Committee
March 14, 2014**

Senator Gerratana, Representative Johnson, and members of the Public Health Committee, on behalf of the ProHealth Physicians, its 351 primary care providers, and its over 350,000 patients, thank you for the opportunity to testify today.

My name is John Lynch, MPH. I am the Vice President for Research at ProHealth.

I am here today SUPPORT passage of Senate Bill 413.

We applaud the Department of Public Health and the Governor's Office for bringing forward this legislation that will provide our patients an opportunity to discuss their desires for Life Sustaining Treatment with their primary care provider well in advance of the crises of a life threatening situation, and have their desires be part of their ongoing medical record. In this Patient Centered Medical Home environment, more and more of our patients are expressing a desire to avoid spending their final days hooked up to all kinds of medical equipment in a critical care unit. They would rather spend their final days in their home, surrounded by family and friends, in a warm and comforting environment.

The MOLST would be a portable document (both paper and digital) that would accompany medical records and allow the patient to choose medical treatments they want to receive, and medical treatments they do not want. These documents will provide healthcare providers directions during serious illness and allows healthcare providers to know and honor wishes for end-of-life care. These documents will transform the patient's treatment plan into actionable medical orders to be followed regardless of a patient's health care setting.

I would recommend one minor change to the proposal. Limiting the pilot to one year is extremely short. It will take time for the Department of Public Health to develop regulations and for pilots to be selected and gear up. If the results of the pilot work as well as we expect, we wouldn't want to deny the opportunity to our patients while waiting for the next legislative session to approve full deployment. Please provide a sufficient time for the pilot and opportunity for the legislature to reconvene and pass follow-up legislation.

We are willing to work with the Department of Public Health to develop mechanisms to make the MOLST documents workable and flow smoothly with our electronic health records.

We have attached to this testimony a model MOLST document that's used in Massachusetts to provide members of the committee with the best idea of what these proposals could look like if implemented.

Thank you for your time and attention and hope you can support SB413.

**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 | CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest | |
| Mark one circle → | <input type="radio"/> Do Not Resuscitate | <input type="radio"/> Attempt Resuscitation |
| B | VENTILATION: for a patient in respiratory distress | |
| Mark one circle → | <input type="radio"/> Do Not Intubate and Ventilate | <input type="radio"/> Intubate and Ventilate |
| Mark one circle → | <input type="radio"/> Do Not Use Non-invasive Ventilation (e.g. CPAP) | <input type="radio"/> Use Non-invasive Ventilation (e.g. CPAP) |
| C | TRANSFER TO HOSPITAL | |
| Mark one circle → | <input type="radio"/> Do Not Transfer to Hospital (<i>unless needed for comfort</i>) | <input type="radio"/> Transfer to Hospital |
| PATIENT or patient's representative signature D <i>Required</i> Mark one circle and fill in every line for valid Page 1. | Mark one circle below to indicate who is signing Section D: <input type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor 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. <i>*A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i> <input checked="" type="radio"/> _____ Signature of Patient (or Person Representing the Patient) Date of Signature _____ _____ Legible Printed Name of Signer Telephone Number of Signer _____ | |
| CLINICIAN signature E <i>Required</i> 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. <input checked="" type="radio"/> _____ Signature of Physician, Nurse Practitioner, or Physician Assistant Date and Time of Signature _____ _____ Legible Printed Name of Signer Telephone Number of Signer _____ | |
| Optional Expiration date (if any) and other information | This form does not expire unless expressly stated. <i>Expiration date (if any) of this form:</i> _____ Health Care Agent Printed Name _____ Telephone Number _____ 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.

Patient's Name: _____ Patient's DOB _____ Medical Record # if applicable _____

| | | | | |
|--|---|---|--|--|
| F | Statement of Patient Preferences for Other Medically-Indicated Treatments | | | |
| | INTUBATION AND VENTILATION | | | |
| | Mark one circle → | <input type="radio"/> Refer to Section B on Page 1 | <input type="radio"/> Use intubation and ventilation as marked in Section B, but short term only | <input type="radio"/> Undecided <input type="radio"/> Did not discuss |
| | NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP) | | | |
| | Mark one circle → | <input type="radio"/> Refer to Section B on Page 1 | <input type="radio"/> Use non-invasive ventilation as marked in Section B, but short term only | <input type="radio"/> Undecided <input type="radio"/> Did not discuss |
| | DIALYSIS | | | |
| Mark one circle → | <input type="radio"/> No dialysis | <input type="radio"/> Use dialysis <input type="radio"/> Use dialysis, but short term only | <input type="radio"/> Undecided <input type="radio"/> Did not discuss | |
| ARTIFICIAL NUTRITION | | | | |
| Mark one circle → | <input type="radio"/> No artificial nutrition | <input type="radio"/> Use artificial nutrition <input type="radio"/> Use artificial nutrition, but short term only | <input type="radio"/> Undecided <input type="radio"/> Did not discuss | |
| ARTIFICIAL HYDRATION | | | | |
| Mark one circle → | <input type="radio"/> No artificial hydration | <input type="radio"/> Use artificial hydration <input type="radio"/> Use artificial hydration, but short term only | <input type="radio"/> Undecided <input type="radio"/> Did not discuss | |
| Other treatment preferences specific to the patient's medical condition and care _____ | | | | |

| | | | | |
|--|---|---|---------------------------------|---|
| G <i>Required</i> | Mark one circle below to indicate who is signing Section G: | | | |
| | <input type="radio"/> Patient | <input type="radio"/> Health Care Agent | <input type="radio"/> Guardian* | <input type="radio"/> Parent/Guardian* of minor |
| | 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 H 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. <i>*A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i> | | | |
| Mark one circle and fill in every line for valid Page 2. | Signature of Patient (or Person Representing the Patient) | | Date of Signature | |
| | Legible Printed Name of Signer | | Telephone Number of Signer | |

| | | | |
|-----------------------------|---|--|----------------------------|
| H <i>Required</i> | Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G. | | |
| | Signature of Physician, Nurse Practitioner, or Physician Assistant | | Date and Time of Signature |
| | Legible Printed Name of Signer | | Telephone Number of Signer |

Additional Instructions For Health Care Professionals

- Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.
- Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. *If no new form is completed, no limitations on treatment are documented and full treatment may be provided.*
- Re-discuss the patient's goals for care and treatment preferences as clinically appropriate to disease progression, at transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences.
- The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*

IMPORTANT INFORMATION ABOUT MASSACHUSETTS MOLST

The Massachusetts MOLST form is a MA DPH-approved standardized medical order form for use by licensed Massachusetts physicians, nurse practitioners and physician assistants.

While MOLST use expands in Massachusetts, health care providers are encouraged to inform patients that EMTs honor MOLST statewide, but that systems to honor MOLST may still be in development in some Massachusetts health care institutions.

PRINTING THE MASSACHUSETTS MOLST FORM

- Do not alter the MOLST form. EMTs have been trained to recognize and honor the standardized MOLST form. The best way to assure that MOLST orders are followed by emergency medical personnel is to download and reproduce the standardized form found on the MOLST web site.
- Print original Massachusetts MOLST forms on bright or fluorescent pink paper for maximum visibility. Astrobrights® Pulsar Pink* is the color highly recommended for original MOLST forms. EMTs are trained to look for the bright pink MOLST form before initiating life-sustaining treatment with patients.
- Print the MOLST form (pages 1 and 2) as a double-sided form on a single sheet of paper.
- Provide an electronic version of the downloaded MOLST form to your institution's forms department or to personnel responsible for copying/providing forms in your institution.

FOR CLINICIANS: BEFORE USING MOLST

MOLST requires a physician, nurse practitioner, or physician assistant signature to be valid. This signature confirms that the MOLST accurately reflects *the signing clinician's discussion(s) with the patient*. The MOLST form should be filled out and signed only after in-depth conversation between the patient and the clinician signer.

Before using MOLST:

- Access the *Clinician Checklist for Using MOLST with Patients* at: <http://www.molst-ma.org/health-care-professionals/guidance-for-using-molst-forms-with-patients>.
- Listen to *MOLST Overview for Health Professionals* at: <http://www.molst-ma.org/molst-training-line>.
- Access the MOLST website at: <http://www.molst-ma.org> periodically for MOLST form updates.
- For more information about Massachusetts MOLST or the Massachusetts MOLST form, visit <http://www.molst-ma.org>.

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

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

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