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Implementing the MOLST (medical order for life-sustaining treatments): Challenges faced by nursing home staff

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ABSTRACT

This study examined how the Medical Order for Life-sustaining Treatment (MOLST) is implemented in two nursing homes in Massachusetts; one had primarily long-term care residents and high hospice utilization, the other had low hospice utilization and a high proportion of post-acute care residents. Qualitative in-person interviews with 21 staff members who had a role implementing the MOLST explored their experiences using the form in their daily work routines. Staff at both nursing homes described benefits of the MOLST such as providing guidance for staff and family. Yet, they also gave detailed accounts of challenges they face in implementing the form. They reported problems with the form itself such as confusing language and conflicting categories as well as a set of procedural challenges that undermined the timely completion of the form. The nursing home with more post-acute care residents faced more challenges with transferability of the MOLST to and from hospitals.

Introduction

The topic of end-of-life (EOL) care planning has received a surge of attention in recent years.[1] One approach to EOL care planning is the Medical Order for Life-Sustaining Treatment (MOLST) or Physician's Order for Life-Sustaining Treatment (POLST), designed to ensure that care preferences are appropriately implemented in actual care when a person is facing a serious advancing illness. Preceding the MOLST, POLST is the original term, and the National POLST Paradigm Task Force (www.polst.org) tracks POLST/MOLST initiatives across the US. But some states such as New York and Massachusetts have selected the more general term "medical order."

In either version, it constitutes a standardized medical order form for use by clinicians caring for patients with serious advancing illnesses. It is specifically meant for patients nearing end of life; it is not designed as an advance directive for people without limited life expectancies. The purpose of the MOLST is to communicate life-sustaining treatment preferences of patients with advanced illnesses across care settings, so that those practices may be honored at the appropriate time and location. The completed form must be signed by the patient (or healthcare proxy) and the patient's clinician (physician, nurse practitioner, or physician assistant). Protocol also requires that the form be completed and signed only after an in-depth conversation between patient and clinician signer.

The MOLST/POLST has been implemented to varying degrees in a number of states.[2] Its systematic use has been shown to be associated with a significant decrease in hospitalization of nursing home patients in Oregon, West Virginia, and Wisconsin.[3] Evidence also indicates that POLST/MOLST completion has helped to assure that patient preferences were honored.[4–8] In Massachusetts (MA), a statewide MOLST expansion effort was launched in 2010. An initial evaluation of this effort found some evidence of implementation initiatives or intentions to do so, but it also demonstrated that only around a third of agencies had engaged in such efforts.[9] Overall findings showed that the MOLST was inconsistently implemented by agencies across MA. Also, the evaluation reflected mainly the perspectives of agency leadership, and to a lesser degree the experiences of the clinical staff who were involved in the implementation. Furthermore, the study's design only allowed very limited insights about MOLST adoption or implementation challenges.

Even though studies have found positive attitudes towards the POLST/MOLST among healthcare staff,[10,11] researchers and policy makers to date still have little insight into how the implementation of the MOLST works "on the ground" as part of daily routines in healthcare settings.[2,12] While findings suggest that staff knowl-

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edge regarding the POLST/MOLST is important for successful implementation,[13] questions remain. Larger studies examining completeness and consistency of POLSTs for specific states, such as Oregon and West Virginia, have found good results.[14] However, these types of studies do not shed light on instances where MOLST/POLST completion fall short, nor do they identify factors that contribute to quality of completion. One smaller data collection targeting this issue has suggested considerable variation in how healthcare staff interpret the MOLST, and that only few staff members seemed to be aware of all review requirements of the form.[12] Moreover, since daily routines differ across clinical settings, it is important to gain a close-up view into MOLST implementation within specific settings, and to focus on care settings in which a high proportion of patients are near the end of life (e.g., nursing homes) and thus constitute the target population for the MOLST.

The purpose of this study was to take the next step towards addressing this knowledge gap by undertaking an in-depth investigation of MOLST-related interactions and activities in nursing homes, a setting in which the MOLST comes into use often, as a substantial proportion of nursing home residents are or will be in need of EOL care. Specifically, this study sought to better understand how the MOLST is implemented in daily routines of two nursing homes in MA, who is involved in which part of the process, and what staff members experience both in terms of potential benefits and challenges related to the MOLST. It further considered how the culture of the facility around EOL care might influence the MOLST implementation. The context of MA is particularly suitable for this endeavor because it has launched a state-wide MOLST expansion in recent years, and thus is in the midst of large-scale implementation. Insights gained from this study context may be particularly helpful to nursing homes and states implementing the MOLST because it focuses on show how daily work practices shape utilization.

Methods

Sampling

This study examines the benefits and challenges nursing home staff reported when using the MOLST. A purposive sampling method was used to build in similarities and contrasts, by selecting two nursing homes located in Massachusetts and of the same large, for-profit agency with the same agency policies. A key component of this agency policy stated that all residents should have a MOLST completed at the point of admission. It is important to note that the MOLST is legally recognized, but it is not a legal requirement in Massachusetts nursing homes. While the nursing homes were similar in this and many other respects, there were some notable differences. Site 1 was a nursing home with primarily long-term care residents and a high hospice utilization rate (72% of all deaths on hospice), while Site 2 had a low hospice utilization rate (26% of all deaths on hospice) and a high portion of post-acute care residents (nearly twice as many new admissions as Site 1). The rationale for this approach was to build in the element of contrasting care settings with respect to the culture around end-of-life care. Hospice utilization as well as a higher proportion of long-term care residents can be seen as reflective of attitudes toward end-of-life care within a facility. These dimensions of variation allow for meaningful comparisons that shed new light on how the utilization of end-of-life care preferences forms, such as the MOLST, are shaped by organizational factors.

All staff members at both nursing homes who had a role in implementing the MOLST were approached for an interview. The final sample included 21 staff members, 10 at Site 1 and 11 at Site 2. Staff in a wide variety of positions were interviewed, including Director of Nursing (2), Unit Manager (4), Floor Nurse (2), Reimbursement Coordinator (2), Director of Social Services (2), Social Worker (2), Medical Director (2), Administrator (1), Assistant Administrator (1), Nurse Educator (1), Manager of Clinical Operations (1), and CNA (1). Accessing this range of vantage points provided a more holistic picture than considered in previous research of the benefits and challenges nursing home staff face when using the MOLST.

Data collection

Data collection was done via qualitative, in-person interviews that took between 30–60 minutes. The interviewing style was responsive interviewing, meaning that interviews were like extended conversations, and the questions and specific issues discussed varied depending on who was being interviewed and their position in the nursing home.[15] A strength of this method is that the interviewers approach the interview with the understanding that participants in different occupational roles likely have different contexts in their dealings with the MOLST. The goal was to learn from each staff member about their experiences in using the MOLST. They were asked to describe these experiences, including interactions about the MOLST with residents, family members, and colleagues, and to share with us any challenges they perceived in this context. They were also asked about end-of-life care at their facility including hospice utilization. Interviews were conducted by one of the Co-Principal Investigators, who is a trained ethnographer, and an advanced PhD student in Gerontology with extensive training in qualitative interviewing. All interviews were audio-recorded and transcribed; the transcripts were imported into Atlas.ti 8, a qualitative data analysis program.

Coding and analysis

A coding system was developed with an analytical theme-identification approach often used in qualitative data analysis.[16,17] The two Co-Principal Investigators and two Graduate Research Assistants (PhD students in Gerontology) engaged in a coding process that involved independent review of initially two transcripts at a time (later 3–4), followed by team meetings in which the interviews were discussed, codes were suggested, and coding guidelines defined. In-depth discussions ensured that consensus was reached on coding procedures. This full review process was continued for all transcripts even after an initial coding system was established, which ensured that coding of each transcript was only finalized after thorough team review and agreement on coding decisions.

To exhaustively represent the narrative data, fourteen main coding categories were developed and a varying number of subcategories within them. The present paper focuses on the four main coding categories MOLST Benefits, Problems with the MOLST Form (MA MOLST), Procedural Challenges, and Hospitals and the MOLST. The other categories not found herein captured narrative data on related but separate issues that will be utilized in future research. After all transcript were coded, the team engaged in a process of reviewing quotes for all categories and subcategories, systemically comparing codes and related quotes from the two sites, as well as looking for links between categories and subcategories within and across sites.

Steps to enhance trustworthiness

Several strategies were employed to address potential validity threats throughout the data review process. These included team members engaging in an active search for discrepant information and negative cases, and using systematic comparison, by comparing the perspectives of different staff members, at different sites,