

April 2012

## Frequently Asked Questions (FAQs)

### **What is MOLST (Medical Orders for Life-Sustaining Treatment)?**

Honoring patient preferences is a critical element in providing quality end-of-life care. Medical Orders for Life-Sustaining Treatment (MOLST) is a program designed to improve the quality of care patients receive at the end of life by translating patient goals for care and preferences into medical orders. MOLST is based on communication between the patient, his or her health care agent or other designated surrogate decision-maker, and health care professionals that ensures shared, informed medical decision-making.

### **What is the DOH-5003 MOLST form?**

To help physicians and other health care providers discuss and convey a patient's wishes regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment, the Department of Health has approved a physician order form DOH-5003 MOLST, which can be used statewide by health care practitioners and facilities.

The MOLST form is a bright pink medical order form signed by a New York State licensed physician or a border state physician that tells others the patient's medical orders for life-sustaining treatment. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders, and changes them.

The MOLST serves as a single document that contains a patient's goals and preferences regarding:

- Resuscitation instructions when the patient has no pulse and/or is not breathing
- Instructions for intubation and mechanical ventilation when the patient has a pulse and the patient is breathing
- Treatment guidelines
- Future hospitalization and transfer
- Artificially administered fluids and nutrition
- Antibiotics
- Other instructions about treatments not listed

Under State law, the MOLST form is the only authorized form in New York State for documenting both nonhospital Do Not Resuscitate (DNR) and Do Not Intubate (DNI) orders. In addition, the form is beneficial to patients and providers as it provides specific medical orders and is recognized and used in a variety of health care settings.

**Can the DOH-5003 MOLST form be changed if the patient or doctor does not like the form?**

**No.** NYSDOH updated the form in June of 2010 to make it more user-friendly and to align the form with the Family Health Care Decisions Act (FHCDA) and other provisions of Chapter 8 of the Laws of 2010 that went into effect June 1, 2010.

However, additional guidelines for withhold/withdrawing treatment not addressed elsewhere on the form can be included in Section E under “Other Instruction,” including, for example, decisions about dialysis, implantable defibrillators, and the duration of time-limited trials.

**What is the difference between a Health Care Proxy or Living Will and the MOLST form?**

A health care proxy and a living will are traditional advance directives for adults 18 years of age and older. These documents are completed when a patient has capacity to do so and only apply when medical decision-making capacity is lost.

To complement the use of traditional advance directives and facilitate the communication of medical orders impacting end-of-life care for patients with advanced chronic or serious illness, the Medical Orders for Life-Sustaining Treatment (MOLST) program was created. The MOLST contains specific and actionable medical orders that transition with the patient across health care settings. Health care proxies and living wills typically contain more general instructions, and cannot be followed by EMS providers in an emergency.

In contrast to a health care proxy, the MOLST applies as soon as a patient consents to the orders in it and a physician signs it. It is not conditional on a physician’s determination that a patient has lost medical decision-making capacity. The MOLST program is based on the belief that patients have the right to make their own health care decisions, including decisions about life-sustaining treatment, to describe these wishes to health care providers and to receive comfort care while wishes are being honored.

**Has the DOH-5003 MOLST form been approved for use for adult patients and minor patients?**

The Department of Health has approved a physician order form DOH-5003 MOLST for use with adult patients and minor patients. MOLST can be used statewide by health care practitioners and facilities.

NYSDOH has created separate instructions for completing the MOLST form with adult and minor patients respectively. The “General Instructions” and “Legal Requirements Checklists for Adult Patients” are intended to assist health care professionals in completing the MOLST form with adult patients and/or their authorized health care decision-makers and can be found at

[http://www.health.ny.gov/professionals/patients/patient\\_rights/molst/](http://www.health.ny.gov/professionals/patients/patient_rights/molst/).

NYSDOH has also created a “Legal Requirements Checklist for Minor Patients” with instructions to assist health care professionals in completing the MOLST form with minor patients and their parents or other legal guardians with authority to make health care decisions on his or her behalf. The checklist for minor patients can be found at:

[http://www.health.ny.gov/professionals/patients/patient\\_rights/molst/docs/checklist\\_minor.pdf](http://www.health.ny.gov/professionals/patients/patient_rights/molst/docs/checklist_minor.pdf).

**Has the DOH-5003 MOLST been approved for use for persons with developmental disabilities or persons with mental illness?**

The DOH-5003 MOLST form has been approved by the Office of Mental Health (OMH) and the Office for People with Developmental Disabilities (OPWDD) for use as a nonhospital DNR/DNI form for persons with developmental disabilities or persons with mental illness, including persons who are incapable of making their own health care decisions or who have a guardian of the person appointed pursuant to Article 81 of the Mental Hygiene Law or Article 17-A of the Surrogate's Court Procedure Act.

The DOH-5003 MOLST must be completed with the OPWDD approved checklist, and the checklist MUST be attached to the MOLST form, when the form is used for a person with a developmental disability who is incapable of making his/her own health care decisions or who has a guardian of the person appointed pursuant to Article 81 of the Mental Hygiene Law or Article 17-A of the Surrogate's Court Procedure Act. The OPWDD checklist can be found at:  
[http://www.opwdd.ny.gov/opwdd\\_resources/information\\_for\\_clinicians/MOLST? .](http://www.opwdd.ny.gov/opwdd_resources/information_for_clinicians/MOLST?)

**How is a MOLST form completed for a person with developmental disabilities who lacks medical decision-making capacity or has a guardian of the person appointed pursuant to Article 81 of the Mental Hygiene Law or Article 17-A of the Surrogate's Court Procedure Act?**

Effective January 21, 2011, the Office for People with Developmental Disabilities (OPWDD) has approved the use of the MOLST form [http://www.nyhealth.gov/professionals/patients/patient\\_rights/molst/](http://www.nyhealth.gov/professionals/patients/patient_rights/molst/) for the individuals served in the OPWDD system. However, the MOLST form must be accompanied by the [MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities](#).

This means that the MOLST form may only be completed after the Surrogate's Court Procedure Act § 1750-b process has been completed for an individual. Use of the Checklist ensures that the appropriate statutory standards have been met prior to use of the MOLST process. Please note that use of the MOLST form is optional.

The most significant change resulting from approval of the MOLST form by the OPWDD is with respect to non-hospital Do Not Resuscitate (DNR) orders. Previously, such DNR orders were required to be on the DOH-3474 form <http://www.nyhealth.gov/forms/doh-3474.pdf>. Now a non-hospital DNR order can be written on either the DOH-3474 form or the MOLST form (DOH-5003).

The advantage of the MOLST form is that it is transferable to other settings across care transitions. Accordingly, a DNR issued on a MOLST form is effective in hospitals, nursing homes and community settings.

**What type of adult patient should have a MOLST form?**

MOLST is generally for patients with serious health conditions. Physicians should consider consulting with the patient about completing a MOLST form if the patient:

- Wants to avoid or receive life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

Patients with serious health conditions typically include those who have advanced chronic progressive illness and/or frailty (significant weakness and extreme difficulty with

personal care activities) and those who might die or lose medical decision-making capacity in the next year. MOLST also may be appropriate for a patient with advanced age wishing to further define his or her preferences for care.

These patients may:

- Want *all* appropriate treatment, including cardiopulmonary resuscitation (CPR).
- Want to avoid *all* life-sustaining treatment.
- Choose to *limit* life-sustaining treatment.
- Want to avoid any attempt to initiate cardiopulmonary resuscitation (CPR) and prefer to Allow Natural Death (DNR order)
- Want to avoid placement of a tube down the throat into the windpipe connected to a breathing machine (intubation) and request a “Do Not Intubate Order” (DNI order).

### **How is a MOLST form completed for an adult patient?**

The MOLST form must be completed based on the patient’s current medical condition, values, wishes, and informed consent by the patient or his/her authorized decision-maker.

Completion of the MOLST begins with a conversation or a series of conversations between the patient, the health care agent or the surrogate, and a qualified, trained health care professional that defines the patient’s goals for care, reviews possible treatment options on the entire MOLST form, and ensures shared, informed medical decision-making. The conversation should be documented in the medical record. The MOLST orders cannot be issued without the consent of the patient or other medical decision-maker, with the exception of patients covered by Checklist #4 (for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy or a Public Health Law surrogate).

Although the conversation(s) about goals and treatment options may be initiated by any qualified and trained health care professional, a licensed physician must always, at a minimum: (i) confer with the patient and/or the patient’s health care agent or surrogate about the patient’s diagnosis, prognosis, goals for care, treatment preferences, and consent by the appropriate decision-maker, and (ii) sign the orders derived from that discussion. If the physician is licensed in a border state, the physician must insert the abbreviation for the state in which he/she is licensed, along with the license number.

### **How much of the form should be completed for an adult patient?**

Completion of both the first and second pages of the MOLST form is strongly encouraged. However, the patient or decision-maker (i.e., a health care agent or surrogate) may not be physically or emotionally prepared to reach a decision concerning every treatment option on the form in a single meeting.

Completion of only page 1 of the MOLST form (concerning CPR/DNR) is permissible, and page 2 (Section E) may be completed at a later time.

If a patient or decision-maker can reach a decision on one or more treatment options, but not others, on page 2, the physician should cross out the portion of the form with the treatment option(s) for which there is no decision and write “Decision Deferred” next to those treatment option(s). If the patient or decision-maker reaches a decision

concerning that treatment option(s) at a later time, a new form must be completed and signed by a physician, indicating all of the patient's or decision-maker's decisions.

The Department has developed Legal Requirements Checklists to assist providers in completing the forms with patients and/or their authorized medical decision-makers in various settings. The checklists are available at:

[http://www.health.ny.gov/professionals/patients/patient\\_rights/molst/](http://www.health.ny.gov/professionals/patients/patient_rights/molst/).

**Who can complete a MOLST form with the adult patient or health care agent?**

Completion of the MOLST begins with a conversation or a series of conversations between the patient, the health care agent or the surrogate, and a qualified, trained health care professional that defines the patient's goals for care, reviews possible treatment options on the entire MOLST form, and ensures shared, informed medical decision-making. The conversation should be documented in the medical record.

Although the conversation(s) about goals and treatment options may be initiated by any qualified and trained health care professional, a licensed physician must always, at a minimum: (i) confer with the patient and/or the patient's health care agent or surrogate about the patient's diagnosis, prognosis, goals for care, treatment preferences, and consent by the appropriate decision-maker, and (ii) sign the orders derived from that discussion. If the physician is licensed in a border state, the physician must insert the abbreviation for the state in which he/she is licensed, along with the license number.

Conversations between the health care professional and patient should be shared with the health care agent and family to ensure the health care agent and family are aware of the patient's wishes and to avoid future conflict.

**May a physician licensed in another state complete and sign a MOLST?**

Physicians licensed in a border state may sign a MOLST form. The physician must insert the abbreviation for the state in which he/she is licensed, along with the license number.

**Who provides consent for MOLST orders for adult patients?**

The patient or other medical decision-maker (a health care agent or Public Health Law surrogate, if the patient does not have the ability to make medical decisions about life-sustaining treatment) must consent to the MOLST orders, with the exception of patients covered by Checklist #4 (for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy or a Public Health Law surrogate).

**Is verbal consent permitted for MOLST orders?**

**Yes.** Verbal consent is permissible for MOLST orders.

**Are the legal requirements under New York State Public Health Law the same for all medical decision-makers for life-sustaining treatment for adult patients?**

Decision-making standards, procedures and statutory witness requirements for decisions to withhold or withdraw life-sustaining treatment, including DNR, vary depending on who makes the decision and where the decision is made. Accordingly, the New York State Department of Health developed different checklists for different types of decision-makers and settings. The checklists are available at:

[http://www.health.ny.gov/professionals/patients/patient\\_rights/molst/](http://www.health.ny.gov/professionals/patients/patient_rights/molst/).

## **How can providers adhere strictly to all legal requirements for completing the MOLST form for adult patients?**

In addition to the MOLST form itself, the Department has developed legal requirements checklists. The DOH checklists are NOT intended for use with patients with developmental disabilities who lack medical decision-making capacity, or patients with mental illness in a mental hygiene facility.

The checklists are intended to assist providers in satisfying the complex legal requirements associated with decisions concerning life-sustaining treatment for all other patients. They are guidance documents, and the use of these checklists is not mandatory. However, providers that do not use the checklists must use an alternative method for assuring that they adhere strictly to all legal requirements for completing the form, including requirements related to securing informed consent to the medical orders from the proper person, making the clinical judgments necessary to support orders withholding or withdrawing life sustaining treatment and, where applicable, securing ethics committee approval and witnesses to the consent.

Decision-making standards, procedures and statutory witness requirements for decisions to withhold or withdraw life-sustaining treatment, including DNR, vary depending on who makes the decision and where the decision is made. Accordingly, the New York State Department of Health developed different checklists for different types of decision-makers and settings.

There are 5 different checklists for adult patients:

**Checklist #1** - Adult patients with medical decision-making capacity (any setting)

**Checklist #2** - Adult patients without medical decision-making capacity who have a health care proxy (any setting)

**Checklist #3** - Adult hospital, hospice, or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (surrogate selected from the surrogate list)

**Checklist #4** - Adult hospital, hospice, or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the list is available

**Checklist #5** - Adult patients without medical decision-making capacity who do not have a health care proxy, and the MOLST form is being completed in the community

For further information on MOLST General Instructions and Glossary, please review [http://www.health.state.ny.us/professionals/patients/patient\\_rights/molst/docs/general\\_instructions.pdf](http://www.health.state.ny.us/professionals/patients/patient_rights/molst/docs/general_instructions.pdf).

The Office for People with Developmental Disabilities has developed its own checklist for individuals with developmental disabilities who lack medical decision-making capacity.

For information about the OPWDD checklist, please review [http://www.opwdd.ny.gov/opwdd\\_resources/information\\_for\\_clinicians/MOLST?](http://www.opwdd.ny.gov/opwdd_resources/information_for_clinicians/MOLST?).

**What are the legal requirements for a patient's prior decision to withhold or withdraw life-sustaining treatment to be effective in a hospital, nursing home or hospice setting, if he or she later loses the capacity to make medical decisions?**

In order for a patient's prior decision to withhold or withdraw life-sustaining treatment to be effective in a hospital, nursing home or hospice after he or she loses capacity to make medical decisions, the prior decision must have been made:

- Orally in a hospital, nursing home, or hospice, in the presence of two witnesses, 18 years of age or older, at least one who is a health or social services practitioner affiliated with the hospital, nursing home, or hospice; or
- In writing.

**What are the legal requirements for a health care agent completing a MOLST under FHCDA on behalf an adult patient without medical decision-making capacity who has a health care proxy in any setting?**

A health care agent may make medical decisions on behalf of a patient, after two physicians concur that the patient lacks medical decision-making capacity. Health care agents are generally authorized to make decisions as if they were the patient. However, sometimes the patient's health care proxy limits the authority of the health care agent.

Health care agents are required to make decisions according to the patient's wishes, including the patient's religious and moral beliefs. If the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, the health care agent may make decisions according to the patient's best interests, except a decision to withhold or withdraw artificial nutrition or hydration. Health care agents are authorized to make a decision to withhold or withdraw artificial nutrition or hydration only if they know the patient's wishes regarding the administration of artificial nutrition and hydration.

For further information on legal requirements for adult patients without medical decision-making capacity who have a health care proxy in any setting, please review [http://www.health.state.ny.us/professionals/patients/patient\\_rights/molst/docs/checklist\\_2.pdf](http://www.health.state.ny.us/professionals/patients/patient_rights/molst/docs/checklist_2.pdf).

**What are the legal requirements for a surrogate completing a MOLST under FHCDA for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is a Public Health Law Surrogate (a surrogate selected from the surrogate list)?**

Under the Family Health Care Decisions Act, a surrogate selected from the surrogate list can make any kind of medical decision in a hospital or nursing home, after a legally valid determination is made that the patient lacks capacity. For decisions to withhold or withdraw life-sustaining treatment, specific clinical criteria must be satisfied.

Special requirements exist for declining artificial nutrition and hydration in a hospital over the attending physician's objection and for decisions other than DNR in a nursing home, if the physician has determined the patient has an irreversible or incurable condition. In these situations, the facility's ethics review committee must agree. This nursing home requirement does not apply to a decision to withhold or withdraw life-sustaining treatment if death is expected within 6 months with or without treatment, or the patient is permanently unconscious.

For further information on legal requirements for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and the decision-maker is Public Health Law Surrogate (a surrogate selected from the surrogate list), please review [http://www.health.state.ny.us/professionals/patients/patient\\_rights/molst/docs/checklist\\_3.pdf](http://www.health.state.ny.us/professionals/patients/patient_rights/molst/docs/checklist_3.pdf).

**How does the provider identify and notify the appropriate Public Health Law surrogate under FHCDA?**

The attending physician identifies and notifies a person from the class highest in priority who is reasonably available, willing, and competent to serve as a surrogate decision-maker. Such person may designate any other person on the list to be surrogate, provided no one in a class higher in priority than the person designated objects.

In order of highest priority, the appropriate Public Health Law surrogate under FHCDA is:

- Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
- Patient's spouse, if not legally separated from the patient, or the domestic partner
- Patient's son or daughter, age 18 or older
- Patient's parent
- Patient's brother or sister, age 18 or older
- Patient's actively involved close friend, age 18 or older

This is the Public Health Law Surrogate List. There is a different Surrogate List for Persons with Developmental Disabilities who lack capacity to make medical decisions; this list is found on the [OPWDD Checklist](#). For further information, view the [OPWDD Memorandum dated January 21, 2011](#).

**Is the "surrogate" a court appointed position?**

Please refer to the [New York State Bar Association Family Health Care Decisions Act Information Center Frequently Asked Questions](#).

**The highest priority is "A guardian authorized to decide about health care" pursuant to MHL Article 81. Does that include a guardian appointed prior to the date the FHCDA became effective?**

Please refer to the [New York State Bar Association Family Health Care Decisions Act Information Center Frequently Asked Questions](#).

**When the highest category is an adult son or daughter, and there is more than one such person, are they all surrogates? If not, then who chooses the surrogate, and on what basis?**

Please refer to the [New York State Bar Association Family Health Care Decisions Act Information Center Frequently Asked Questions](#).

**What if someone lower down on the surrogate list objects to the decision of the surrogate, how would the hospital respond? For example, would the hospital withdraw treatment from a patient despite objections by the adult child because a domestic partner is higher in priority than the adult child?**

Please refer to the [New York State Bar Association Family Health Care Decisions Act Information Center Frequently Asked Questions](#).

**Would the following persons be considered a brother or sister for purposes of the FHCDA surrogate list: A half-brother or half-sister? A step-brother or step-sister? A brother or sister by adoption? Would a full brother or sister have priority over a half-brother or half-sister?**

Please refer to the [New York State Bar Association Family Health Care Decisions Act Information Center Frequently Asked Questions](#).

**Would the following persons be considered a son or daughter: A step-son or daughter? An adopted son or daughter?**

Please refer to the [New York State Bar Association Family Health Care Decisions Act Information Center Frequently Asked Questions](#).

**What is the role of the designated representative (NYCRR 415.10) in a nursing home? Are the designated representative and surrogate one and the same?**

Please refer to the [New York State Bar Association Family Health Care Decisions Act Information Center Frequently Asked Questions](#).

**What clinical standards apply to a decision made by a surrogate to consent to a DNR order?**

Under FHCDA, the physician and a concurring physician must determine to a reasonable degree of medical certainty that cardiopulmonary resuscitation would be extraordinarily burdensome, and:

- The patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; **or** the patient is permanently unconscious, and/or
- The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under any circumstances; and the patient has an irreversible or incurable condition; and
- The concurring physician's determination is documented in the medical order.

**What are standards for FHCDA surrogates for making decisions recorded on a MOLST form under FHCDA?**

Decisions made by a FHCDA surrogate under FHCDA must be consistent with the patient's wishes, including religious and moral beliefs; or if the patient's wishes are not reasonably known and cannot be ascertained, in accordance with the patient's best interests. This includes consideration of:

- the dignity and uniqueness of every person;
- the possibility and extent of preserving the patient's life;
- the preservation, improvement or restoration of the patient's health or functioning;
- the relief of the patient's suffering; and
- any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

**What special requirements exist under FHCDA for decisions to withhold or withdraw life-sustaining treatment based on the existence of an “irreversible or incurable condition”?**

In hospitals, special requirements exist when withdrawing or withholding artificial nutrition and hydration in a hospital over the attending physician's objection. If the attending physician objects to the order, the ethics review committee (including a physician who is not directly responsible for the patient's care) or an appropriate court must determine that the medical order meets the required standards

In nursing homes, for orders to withhold or withdraw life-sustaining treatment other than DNR orders, the ethics review committee, (including at least one physician who is not directly responsible for the patient's care) or an appropriate court must determine that the orders meet the required standards.

**Who makes decisions and what are the legal requirements for completing a MOLST for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available?**

Under the Family Health Care Decisions Act, life-sustaining treatment may be withheld from a patient in a hospital or nursing home who does not have a health care proxy or a surrogate, only if a court makes the decision or two physicians authorized by the facility concur that the patient would die imminently, even if the patient received the treatment, and that provision of the treatment would violate accepted medical standards.

For further information on legal requirements for adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the surrogate list is available, please review [http://www.health.state.ny.us/professionals/patients/patient\\_rights/molst/docs/checklist\\_4.pdf](http://www.health.state.ny.us/professionals/patients/patient_rights/molst/docs/checklist_4.pdf).

**Who makes decisions and what are the legal requirements for completing a MOLST for adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community?**

In the community, Public Health Law surrogates (surrogates selected from the surrogate list) can consent to a nonhospital DNR order or a nonhospital DNI order, on behalf of patients who lack medical decision-making capacity. If MOLST is being completed in the community for a patient who does not have a health care proxy, the physician may issue other medical orders to withhold life-sustaining treatment – other than DNR and DNI – *only* if there is clear and convincing evidence of the patient's wishes to refuse the treatment.

If the patient is enrolled in a community-based hospice program, decisions regarding the hospice plan of care may be made by a surrogate without clear and convincing evidence, as long as they comply with the applicable patient-centered and clinical standards for decisions by FHCDA surrogates described above.

“Clear and convincing evidence” is evidence that the patient held a firm and settled commitment to the withholding of life-sustaining treatment in the event of circumstances like the patient's current medical condition. The evidence may be in a written living will, and/or previous oral statements indicating the patient's wishes, considering the circumstances under which such statements were made and to whom. In order to decide whether the evidence of the patient's wishes is clear and convincing, consideration should be given to:

- whether the statements were general or specific;
- whether the statements were about specific circumstances (for example, terminal illness, persistent vegetative state) that are similar to the patient's current medical condition;
- the intensity, frequency, consistency, and seriousness of such statements;

- whether the statements tended to show that the patient held a firm and settled commitment to certain treatment decisions under circumstances like those presented;
- whether the strength and durability of the patient's religious and moral beliefs make a more recent change of heart unlikely; and
- whether the statements were made to one person only or to more than one person close to the patient.

For further information on legal requirements for adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community, please review

[http://www.health.state.ny.us/professionals/patients/patient\\_rights/molst/docs/checklist\\_5.pdf](http://www.health.state.ny.us/professionals/patients/patient_rights/molst/docs/checklist_5.pdf).

### **Is documentation in the medical record important and part of the process?**

**Yes.** The conversation should be documented in the medical record. The health care professional should document:

- Conversation with the patient, Health Care Agent, surrogate decision-maker and 'family,' as defined by the patient.
- Patient capacity assessments
- Documentation of 'clear and convincing' evidence, as required
- Documentation of legal requirements, based on who made the decision and where the decision is made. These are outlined in the NYSDOH Legal Requirements Checklist for Adult Patients and Minor Patients and the OPWDD MOLST Checklist for Individuals with Developmental Disabilities who lack medical decision-making capacity.

### **What is 'clear and convincing' evidence?**

For decisions on behalf of a patient who lacks capacity, in the community, other than DNR and/or DNI, "clear and convincing" evidence is needed.

"Clear and convincing evidence" is evidence that the patient held a firm and settled commitment to the withholding of life-sustaining treatment in the event of circumstances like the patient's current medical condition. The evidence may be in a written living will, and/or previous oral statements indicating the patient's wishes, considering the circumstances under which such statements were made and to whom. In order to decide whether the evidence of the patient's wishes is clear and convincing, consideration should be given to:

- whether the statements were general or specific;
- whether the statements were about specific circumstances (for example, terminal illness, persistent vegetative state) that are similar to the patient's current medical condition;
- the intensity, frequency, consistency, and seriousness of such statements;
- whether the statements tended to show that the patient held a firm and settled commitment to certain treatment decisions under circumstances like those presented;
- whether the strength and durability of the patient's religious and moral beliefs make a more recent change of heart unlikely; and
- whether the statements were made to one person only or to more than one person close to the patient.

### **What does a physician do if there is a disagreement about the ‘clear and convincing evidence’?**

If there is a disagreement among family members, there are often reasons for conflict unrelated to the underlying medical condition. Attention must be focused on identifying the source of conflict and then proceeding with a plan for conflict resolution. An Ethics or Palliative Care Consult may help.

### **What is capacity?**

Family Health Care Decisions Act (FHCDA) defines "decision-making capacity" as the ability to understand and appreciate the nature and consequences of proposed health care, including the benefits and risks of and alternatives to proposed health care, and to reach an informed decision.

### **Who determines capacity?**

The attending physician determines capacity. The Health Care Proxy Law currently requires that a second physician provide the concurring determination. The FHCDA also requires a concurring determination of incapacity, but allows a concurring determination to be made by a health or social services practitioner.

If the attending physician has determined that the lack of medical decision-making capacity is due to mental illness, one of the two physicians who determined that the patient lacks medical decision-making capacity must be a qualified psychiatrist.

If the attending physician has determined the individual's lack of capacity to make health care decisions is due to developmental disabilities, either the attending physician or the concurring physician or licensed psychologist must: (a) be employed by a developmental disabilities services office (DDSO); or (b) have been employed for at least 2 years in a facility or program operated, licensed or authorized by OPWDD; or (c) have been approved by the commissioner of OPWDD as either possessing specialized training or have 3 years experience in providing services to individuals with developmental disabilities.

### **Can the physicians make a determination of capacity, without personally examining the patient, e.g., over the phone?**

Unlike the prior DNR Law, the FHCDA no longer contains a "personal examination" requirement. As a result, the physician must comply with the applicable professional standard of care. In most instances, that would require a personal examination, but in limited circumstances it might not, such as when the patient lacks capacity as a result of being unconscious or late stage dementia.

### **Do I need a psychiatric consultation in all cases to determine decision-making capacity?**

**No.** The attending physician may determine capacity, but must seek consultation with a qualified psychiatrist if the patient has a mental illness or if there is a question regarding the capacity determination. Any qualified physician can determine capacity.

### **When do I need a psychiatric consultation?**

If there is reason to believe the individual *lacks capacity* due to mental illness, one of the two physicians who determined that the patient lacks medical decision-making capacity must be a qualified psychiatrist. The determination by the qualified psychiatrist is documented in the medical record.

“Qualified psychiatrist” means a physician licensed to practice medicine in New York State, who is a diplomate or eligible to be certified by the American Board of Psychiatry and Neurology or who is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board.

Mental illness does not refer to dementia; it includes, but is not limited to conditions such as schizophrenia or acute psychotic episode.

### **Who determines capacity for individuals with developmental disabilities?**

If the individual *lacks capacity* because of a developmental disability, the concurring opinion must be provided by a physician or psychologist with special experience or training in the field of developmental disabilities. The physician or psychologist must: (a) be employed by a developmental disabilities services office (DDSO); or (b) have been employed for at least 2 years in a facility or program operated, licensed or authorized by OPWDD; or (c) have been approved by the commissioner of OPWDD as either possessing specialized training or have 3 years experience in providing services to individuals with developmental disabilities.

### **What do you do with a completed MOLST form?**

*MOLST forms are designed to travel with the individual between care settings.*

#### **In a Facility**

The form should be kept in the front of the individual's medical chart when the individual is in a facility.

#### **At Home**

When the individual is at home, the MOLST form should be kept on the refrigerator, by the phone in the kitchen, or by the individual's bedside. In case of emergency, EMS personnel are trained to look for the MOLST form in these locations.

#### **Care Transitions**

A photocopy of the MOLST form should be made when the individual is transferred from one healthcare setting to another (e.g., being admitted from a nursing home to a hospital). The photocopy of the form should be kept in the medical chart at the original location at the time of care transition. The original form should accompany the individual and be placed in the individual's medical chart at the new care setting.

MOLST forms and all advance directives known to have been completed and documentation of any *oral advance directive* should be kept together and transferred with patient at discharge.

### **When must the MOLST be reviewed?**

The physician must review the MOLST form from time to time as the law requires, and also:

- If the patient moves from one location to another to receive care; or
- If the patient has a major change in health status (for better or worse); or
- If the patient or other decision-maker changes his or her mind about treatment.

DNR/Allow Natural Death orders: Public Health Law requires the physician to review non-hospital DNR orders and record the review at least every 90 Days. In hospitals and

nursing homes, MOLST orders must be reviewed regularly in accordance with facility policies.

Life-Sustaining Treatment orders: The patient's medical condition, prognosis, values, wishes and goals for his/her care may change over time. The physician should review these orders at the same time as DNR/Allow Natural Death orders are reviewed and the review is recorded.

### **How should MOLST orders be reviewed and renewed?**

Review all medical orders in Sections A through E of the MOLST form.

Document the outcome of the review in Section F

- If there is no change in the patient's health status, medical decision-making capacity or preferences, sign, date and check the "No Change" box.
- If there is a substantial change in patient's health status, medical decision-making capacity, goals for care or preferences that results in a change in MOLST orders, write "VOID" in large letters on pages 1 and 2, and complete a new form, in accordance with NYS Public Health Law decision-making standards and procedures. Check the box marked "FORM VOIDED, new form completed". (RETAIN the voided MOLST form in chart, medical record, or electronic registry as required by law.)
- If this form is voided and no new form is completed, full treatment and resuscitation will be provided, unless a different decision is made by the patient, surrogate or health care agent. Write "VOID" in large letters on pages 1 and 2 and check box marked "FORM VOIDED, no new form." (RETAIN voided MOLST form in chart, medical record, or electronic registry as required by law.)

### **Can MOLST orders be changed by a patient?**

A patient with capacity to make medical decisions regarding life-sustaining treatment may revoke his or her consent to MOLST orders and may ask his/her physician to change them. If the patient lacks capacity to make health care decisions and there is a change in the goals for care based on a major change in health status, the Health Care Agent or Surrogate may also revoke consent and may request a change in the MOLST. The patient, Health Care Agent or Surrogate must be consulted about any changes recommended by the patient's health care provider. No change can be made without the informed consent of the patient or appropriate decision-maker.

### **Are MOLST orders legal and valid as patients move across care settings?**

MOLST orders completed in accordance with New York law remain valid when the patient transitions from one health care setting to another. Non-hospital DNR orders, including those on a MOLST form, must be reviewed by a physician at least every 90 days. In addition, all MOLST orders must be reviewed consistent with facility policy and when the patient transitions between care settings, when there is a major change in health status, and when the patient or other health care decision-maker changes his/her mind about treatment.

### **Why is the MOLST form bright pink?**

Printing the form on bright "pulsar" pink, heavy stock paper is strongly encouraged. When EMS personnel respond to an emergency call in the community, they are trained to check whether the patient has a pink MOLST form before initiating life-sustaining treatment. They might not notice a MOLST form on plain white paper. However, white

MOLST forms and photocopies, faxes, or electronic representations of the original, signed MOLST are legal and valid.

**How can the pinkness of the MOLST form be maintained?**

When the patient is transferred between care settings, a copy of the form should be made on Pulsar Pink paper. The original MOLST form should accompany the patient and be placed in the chart in the new care setting or placed on the refrigerator at home.

**Is a white copy of the original, signed MOLST form legal and valid?**

**Yes.** White MOLST forms and photocopies, faxes, or electronic representations of the original, signed MOLST are legal and valid.

**Is a photocopy of the original, signed MOLST form legal and valid?**

**Yes.** White MOLST forms and photocopies, faxes, or electronic representations of the original, signed MOLST are legal and valid.

**Is a facsimile (fax) of the original, signed MOLST form legal and valid?**

**Yes.** White MOLST forms and photocopies, faxes, or electronic representations of the original, signed MOLST are legal and valid.

**Is an electronic representation of the original, signed MOLST form legal and valid?**

**Yes.** White MOLST forms and photocopies, faxes, or electronic representations of the original, signed MOLST are legal and valid.

**Is a stamped signature on the original, signed MOLST form legal and valid?**

**No.** A stamped signature is not permitted.

**How should a MOLST form be used in a facility with electronic health records?**

Scan the MOLST into the computer at the time of admission and discharge. Review the MOLST at the time of discharge or transition of care and retain an electronic copy. The original pink MOLST form should be given to the patient at the time of discharge. A copy should be retained in the electronic medical record, a copy should go to the primary care physician's office and a copy should go to home care agency if the patient has home care.

**Is an electronic version of MOLST (eMOLST) available?**

As a result of a New York State Department of Health HEAL 5 (Health Care Efficiency and Affordability) grant, a secure web-based application will render an electronic version of the current paper-based New York State Department of Health-5003 MOLST Form that is available to providers through the Rochester Regional Health Information Organization (RHIO). Integration with the Rochester RHIO will attach signed eMOLST forms to the XDS.b registry.

In keeping with New York State's vision for open-system solutions, the eMOLST application is being developed following open architectural principles for the benefit of the community and other RHIOs across the state. The long range goal is to develop a New York State MOLST Registry, through working with all RHIO's statewide. A mobile application is available to support many eMOLST functions.

The eMOLST application documents the clinical process, including goals for care discussion, as well as the legal requirements. The eMOLST application upgrades the workflow around completing the information required for a legal medical order with

automated user feedback for quality review and notification of missing information and training tools for users. A DOH-5003 MOLST form and a MOLST Chart Documentation Form for adult or minor patients or OPWDD checklist for individuals with developmental disabilities who lack medical decision-making capacity are created.

By moving the MOLST form to a readily accessible electronic format, health care providers, including EMS, will have access to MOLST forms at all sites of care including hospitals, nursing homes and the community. This approach will allow for EMS to view in the event of an emergency and will allow for other systems to view at the time of need, as the document is shared across the care continuum.

**Does the MOLST form replace traditional Advance Directives?**

**No.** A properly completed MOLST form contains legal and valid medical orders. It is not intended to replace traditional advance directives like the health care proxy and living will.

**Can the MOLST take the place of current DNR forms in health care facilities?**

**Yes.** In October 2005, New York State Department of Health (NYSDOH) approved the physician order form, the Medical Orders for Life-Sustaining Treatment (MOLST), as a Do Not Resuscitate (DNR) form that can be used in any setting.

On January 11, 2006 NYSDOH sent a letter introducing the MOLST to all health care facilities throughout the New York State.

NYSDOH updated the MOLST form June of 2010 to make it more user-friendly and to align the form with the Family Health Care Decisions Act (FHCDA) and other provisions of Chapter 8 of the Laws of 2010 that went into effect June 1, 2010.

**Where can I get MOLST forms?**

MOLST forms can be downloaded from the NYSDOH web site at [http://www.health.state.ny.us/professionals/patients/patient\\_rights/molst/](http://www.health.state.ny.us/professionals/patients/patient_rights/molst/) or [www.CompassionAndSupport.org](http://www.CompassionAndSupport.org).

The MOLST form should be printed on bright "pulsar" pink, heavy stock paper. Hard copies of the card stock pink form (with all four pages printed landscape/double-sided on a single 11" X 17" sheet folded in the middle) can be ordered using a form that can be downloaded from <http://www.compassionandsupport.org/>.

**Where can I get more information about MOLST?**

For more information about the MOLST Program, view the Department of Health's website at [http://www.nyhealth.gov/professionals/patients/patient\\_rights/molst/](http://www.nyhealth.gov/professionals/patients/patient_rights/molst/) and the Compassion and Support website, Professionals section on MOLST and the MOLST Training Center at [www.CompassionAndSupport.org](http://www.CompassionAndSupport.org).