



EMS Frequently Asked Questions (FAQ's)

Approved by New York State Department of Health

(Revised December 2008)

What is the Medical Orders for Life-Sustaining Treatment (MOLST) Program?

The Medical Orders for Life-Sustaining Treatment (MOLST) program is designed to improve the quality of care people receive at the end of life. It is based on effective communication of patient wishes, documentation of medical orders on a brightly colored pink form and a promise by health care professionals to honor these wishes.

MOLST translates patient/resident goals and preferences into medical orders. The MOLST program is based on communication between the patient/resident, Health Care Agent or other designated decision-maker and health care professionals that ensures sound and informed medical decision-making.

What are the goals of the MOLST program?

MOLST aims to improve the communication of personal wishes about life-sustaining treatments resulting in higher quality medical care.

The MOLST Program was designed to:

- Document a person's treatment preferences regarding:
 - Cardiopulmonary resuscitation (CPR)
 - Intubation and mechanical ventilation
 - Other life-sustaining treatments
- Coordinate physician orders with the individual's wishes.
- Communicate an individual's wishes regarding care across health care settings.
- Improve Emergency Medical Services (EMS) personnel's ability to treat according to the individual's wishes.
- Reduce repetitive documentation while complying with New York State law and the federal Patient Self-Determination Act.

What is the MOLST form?

The MOLST form is a bright pink medical order form signed by a New York State licensed physician that communicate patient wishes regarding life-sustaining treatment to health care providers. These valid medical orders must be followed by all health care professionals in all sites of care, including the community.

The form includes medical orders and patient preferences regarding:

- CPR (cardiopulmonary resuscitation)
- Intubation and mechanical ventilation
- Artificial hydration and nutrition
- Future hospitalization and transfer
- Antibiotics

When Can EMS honor the MOLST form?

Now! Use of the MOLST form was approved for use throughout the state with passage of the legislation that amends Public Health Law that Governor Paterson signed into law on July 8, 2008. Training of EMS personnel is **essential** for success of the MOLST Program.

Does the MOLST form replace traditional Advance Directives?

No. A properly completed MOLST form contains valid medical orders signed by a licensed New York State physician. It is **not** intended to replace traditional Advance Directives like the Health Care Proxy and Living Will.

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 all adults 18 years of age and older. These documents are completed ahead of time and only apply when 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. In contrast to a Health Care Proxy, the MOLST applies right now and is *not* conditional on losing decision-making capacity. The MOLST program is based on the belief that individuals have the right to make their own health care decisions, including decisions about life-sustaining treatments, to describe these wishes to health care providers and to receive comfort care while wishes are being honored.

Who should have a MOLST form?

Health care professionals should discuss MOLST with their patients who have advanced progressive chronic illness, are terminally ill or are interested in further defining their care wishes if the patients/residents:

- Want *all* appropriate treatments including cardiopulmonary resuscitation (CPR).
- Want to avoid *all* life-sustaining treatments.
- Choose to *limit* life-sustaining treatments.
- Want to avoid cardiopulmonary resuscitation (CPR) by requesting a “Do Not Resuscitate Order” (DNR order).
- Might die within the next year.
- Reside in a long-term care facility.
- Reside in the community and are eligible for long-term care.

What are key points for EMS to know about the MOLST form?

- It is distributed as a **BRIGHT PINK**, cardstock, multi-page form, but it can be photocopied and faxed.
- It has the same legal effect as a NYS non-hospital Do Not Resuscitate (DNR) form and must be honored.
- The NYS non-hospital DNR form is still valid.
- The MOLST form is valid throughout the State. It is no longer a pilot project.
- It provides orders limiting or preventing ALS care (i.e. intubation, IVs).
- It also includes information to be used in other health care settings such as the hospital (i.e. placement of feeding tubes, etc).
- Ask to see the MOLST form.
- Add “D” to the **SAMPLE** acronym
 - **S** - Signs and Symptoms
 - **A** - Allergies
 - **M** - Medication(s)
 - **P** - Pertinent past medical history
 - **L** - Last oral intake
 - **E** - Events leading up to contacting 911
 - **D** - Do you have advance directives (i.e. health care proxy and living will) and medical orders (i.e. non-hospital DNR or MOLST)?

Are EMTs allowed to honor a Do Not Intubate (DNI) order?

Yes. EMTs are now allowed to honor a Do Not Intubate (DNI) order on the MOLST form.

Does the MOLST carry more weight in the field than the Health Care Proxy?

Absolutely. The Health Care Proxy and the MOLST form are different documents used for different purposes based on the patient's condition and circumstances.

That being said, the MOLST contains actionable medical orders for seriously ill patients near the end of life that are followed by EMS personnel in the pre-hospital setting. Medical orders carry more weight in the field as medical orders are precise and can be easily interpreted in an emergency. The MOLST program is based on a proven national model.

If EMS personnel are presented with a MOLST DNR form, they must honor it. If someone presents them with a health care proxy form and claims to be the health care agent, EMS personnel should follow the DNR form. Since the health care proxy form is a legal document, there is no way for the EMS personnel to determine if the health care proxy form is valid or has not been amended or revoked. If a person signs a health care proxy he or she designates another person, called an agent, to make decisions on his or her behalf. The authority of an agent to make decisions begins only after a physician has determined that the patient lacks capacity. Also, a health care agent must consult with qualified professionals to ensure informed decision-making. In an out-of-hospital emergency situation, it would be unusual for a physician to be present to make the capacity decision, an agent to be present, and licensed professionals to be present to provide advice to the agent. Therefore, it is very unlikely that an agent will be authorized to make immediate resuscitation decisions.

Accordingly, in the absence of a written DNR order or bracelet, pre-hospital personnel should follow their normal treatment protocols (i.e. treat and transport) when a proxy is presented or an agent is present for the same reasons noted above. The destination hospital should be notified of the existence of the proxy, and it should be brought with the patient. The agent should be advised of the hospital to which the patient will be taken, and the agent should be advised that emergency department personnel can determine if the proxy is valid, make capacity decisions and provide advice to the agent.

Does the MOLST carry more weight in the field than the Living Will?

Yes. The Living Will and the MOLST form are different documents used for different purposes based on the patient's condition and circumstances.

That being said, a living will is a statement of the patient's desires or intentions regarding treatment or resuscitation. New York State courts have ruled that if a living will provides clear and convincing evidence of the patient's intentions, it may be followed. There is no standard living will form. Pre-hospital EMS personnel have no way to determine whether a living will provides clear and convincing evidence, but rather should follow their normal treatment protocols, notify medical control of its existence and bring it with the patient to the hospital.

The MOLST contains medical orders that are followed by EMS personnel in the pre-hospital setting. Medical orders carry more weight in the field as medical orders are precise while the Living Will is ambiguous and cannot be easily interpreted most of the time, especially in an emergency. The MOLST program is based on a proven national model.

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

Yes. In October 2005, New York State Department of Health (NYS DOH) approved the physician order form, the Medical Orders for Life Sustaining Treatment (MOLST), as the legal equivalent of an inpatient Do Not Resuscitate (DNR) form.

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

Can the MOLST form now be used in lieu of the current New York State Order Not to Resuscitate (also called the New York State Nonhospital DNR form) in the community?

Yes. The MOLST can be used in the community in lieu of the NYS Nonhospital Do Not Resuscitate (DNR) as a result of a successful MOLST Pilot Project.

On July 9, 2008, Gov. David A. Paterson signed into law a bill that helps to ensure a person's end-of-life wishes are followed whether the person is at home, in a nursing home or in any other non-hospital setting. The new law amends NYS public health law and permanently permits use of the MOLST form in the community throughout New York State.

The MOLST can be used in the community in lieu of the NYS Nonhospital Do Not Resuscitate (DNR) In signing the legislation, Gov. Paterson said, "People should be allowed as much say in their end-of-life care as they would have at any other time. This bill will allow many people who are critically ill to make enduring decisions on the care they will receive. These will be difficult decisions for every person to make, but they should have the freedom to make them."

What was the MOLST Pilot Project?

Governor Pataki signed the MOLST bill (PHL § 2977(13)) establishing a pilot of the MOLST program in Monroe and Onondaga Counties on October 11, 2005. This bill allowed for the use of the MOLST form *in lieu of* the New York State Nonhospital Do Not Resuscitate (DNR) form. The Pilot was officially launched on May 1, 2006.

A Chapter Amendment (PHL § 2977(13)) signed by Governor Pataki on July 26, 2006, permitted EMS to honor Do Not Intubate (DNI) instructions prior to full cardiopulmonary arrest only in Monroe and Onondaga Counties during the MOLST Pilot and provides a carve out for persons with mental retardation and developmental disabilities *without capacity*. Individuals with mental retardation and developmental disabilities *with capacity* can complete a MOLST form.

Was the MOLST Pilot Project a success?

Yes. The MOLST Pilot Project conducted in 2005 - 2008 in Monroe and Onondaga counties was a success. There were no untoward consequences and no major issues with MOLST. The positive attributes and benefits outweigh any potential risks. MOLST is well-recognized. Trained professionals know how to read it and understand its intent.

How is Public Health Law changed as a result of a successful MOLST Pilot Project?

EMTs can follow DNR and Do Not Intubate (DNI) orders on the MOLST form. Training of EMS personnel is **essential** for success of the MOLST Program.

Does the existence of a MOLST form mean that the patient has made a decision to forego cardiopulmonary resuscitation (CPR) and has a Do Not Resuscitate (DNR) order?

No. The MOLST form is based on ensuring goal-based discussions that integrate patient preferences and informed medical decision-making. It is not based on limiting medical interventions. The existence of a MOLST form signifies the occurrence of a thoughtful prior conversation and not the presence of a DNR order.

Does a DNR order imply that a patient does not want treatment?

No. Do Not Resuscitate (DNR) does not mean Do Not Treat (DNT). A well-informed patient may recognize the futility of CPR in the presence of advanced or serious illness and may request a DNR order. However, based on their goals for care, the patient may wish to receive further treatment.

Does the MOLST form indicate treatment preferences other than DNR?

Yes. The DNR order applies in situations when the patient has a complete cardiopulmonary arrest and has no pulse and/or respirations.

In addition to the DNR order, the MOLST contains orders for other life-sustaining treatment when the patient still has pulse and/or is breathing. These include orders for intubation and mechanical ventilation, artificial hydration and nutrition, antibiotics, and hospital transfer.

As a result of the NYSDOH approval, the form may be used in health care settings, including hospitals and nursing homes, to convert the patient's end-of-life treatment preferences beyond DNR into medical orders contained on a single form. The MOLST can be used to transfer these orders from one site of care to another.

How much of the form should be completed?

Completion of the entire form is strongly recommended. Any section not completed implies full treatment for that section.

Review of the entire form serves to educate the patient regarding additional choices for life-sustaining treatment.

Is there any reason to complete the MOLST form if the patient chooses full cardiopulmonary resuscitation?

Yes. Reviewing the entire MOLST form with a patient serves to educate the patient regarding additional choices for life-sustaining treatment.

Inconsistencies in goals and preferences may emerge through the discussion that needs to be reconciled. For example, a patient may indicate a desire to never undergo intubation and mechanical ventilation under any circumstance. The patient may not realize that intubation and mechanical ventilation will be required if CPR is successful.

Can a patient choose to have a CPR order and also choose to have an order for DNI?

No. These preferences are inconsistent and reflect a lack of understanding of cardiopulmonary resuscitation (CPR). Choosing CPR implies accepting the entire array of treatments in an emergency situation without limitations.

Since intubation is required after successful cardiopulmonary resuscitation (CPR), the presumption in the case of full cardiopulmonary arrest is that the patient agrees to intubation and mechanical ventilation.

Thus, all patients who prefer DNI should also have a DNR order.

However, the discussion regarding a Do Not Intubate order is in the context of a patient/resident who still has a pulse and/or is breathing. Thus, in this context, a patient who chooses not to be resuscitated may still consent to external defibrillation, Heimlich maneuver, clearing of the airway, etc.

Should all patients who choose DNR also be DNI?

No. DNR applies to patient who experience acute cardiopulmonary arrest, where as DNI applies only to intubation for patients who experience impending pulmonary failure.

Patients may not want CPR and have a DNR order, but may benefit from ventilator support and therefore may not wish to have a DNI order. Rather, they may wish to have a limited trial or long-term intubation and mechanical ventilation.

What is ‘a trial period of intubation and ventilation’?

A time-limited trial of intubation and mechanical ventilation provides the patient a choice of a trial of therapy where the underlying acute impending pulmonary failure is potentially reversible and the patient does not wish long term mechanical ventilation.

The potential need for tracheostomy, preferences for alternate treatments such as BIPAP and CPAP and the provision of symptomatic treatment for dyspnea (oxygen, morphine) should be reviewed.

The patient’s goals for care, response and wishes should be documented in the patient’s chart and clarified on the MOLST form in “Other Instructions”.

Does a ‘trial period’ of intubation raise ethical issues?

Time-limited trials are ethically and legally appropriate. There is no ethical or legal distinction between withholding and withdrawing life-sustaining treatment.

Who provides consent for a Do Not Intubate (DNI) order?

Do Not Intubate (DNI) is not addressed in DNR PH law.

- An individual *with capacity* (the ability to make health care decision) can provide their own consent for DNI in the absence of full arrest.
- If the individual *lacks capacity and has a designated health care agent or proxy*, then the health care agent or proxy can provide consent for DNI in the absence of full arrest. The Agent can make all decisions just as the patient can, including DNI.
- If the individual *lacks capacity and does not have a designated health care agent or proxy*, then a decision for DNI in the absence of full arrest can only be made with "clear and convincing" evidence.

"Clear and convincing" evidence is defined by a living will or repeated oral expression of wishes instead of application of a literal interpretation of an isolated, out-of-context, patient statement made earlier in life.

Furthermore, other than DNR, all other choices for or against medical treatment requires either the direction of the patient with capacity or the Health Care Agent or “clear and convincing” evidence.

What do you do with a completed MOLST form?

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

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

When the individual is transferred between care settings, a copy of the form should be made and kept in the medical chart at the transferring location. The original form should accompany the individual and be placed in the individual’s medical chart at the new care setting.

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.

MOLST, supplemental forms, traditional Advance Directives and documentation of any ‘*clear and convincing evidence*’ should be kept together and transferred with patient at discharge. Otherwise the form may need to be redone.

The seriously ill patient should consider keeping other important information needed in the event of an emergency with the MOLST form in a MOLST LIFE Pack.

Can the MOLST form be changed if the patient or doctor does not like the form?

No. The MOLST form cannot be changed if the patient or doctor does not like the form. The MOLST form is consistent with New York State Law and approved by the New York. It is reviewed annually and revised as needed to conform to New York State Public Health Law.

The current MOLST form revised in August 2008 includes amendment to the Public Health Law in July 2008 as a result of the successful MOLST Pilot Project and suggestions from early adopters of the MOLST Program from across New York State during 2005-2008. The original MOLST forms underwent an extensive review process with the NYSDOH in 2005. The forms revised in October 2005 are consistent with New York State Law and are approved for use by NYSDOH for all health care facilities in New York State.

However, additional guidelines for starting/stopping treatment not addressed elsewhere on the form can be included in Section E under "Other Instructions," for example, decisions about dialysis, implantable defibrillators, and the duration of time-limited trials.

Should the MOLST be reviewed? If so, how often?

Yes. The entire MOLST form should be reviewed and renewed by a physician periodically, as required by New York State and Federal law or regulations, and/or if:

- The patient/resident is transferred from one facility to another.
- There is a substantial change in the person's health status (improvement or deterioration).
- The patient/resident treatment preferences change.

The DNR Order on the MOLST form must be reviewed and renewed by a physician as required by New York State law and regulations:

- Hospital: at least every 7 Days.
- Nursing Home/Skilled Nursing Facility: at least every 60 Days.
- Nonhospital/Community Setting: at least every 90 Days.

If a completed MOLST form is present upon admission or transfer to a health care facility and the patient does not remember the conversation, how should the health care professional proceed?

Assess patient capacity at the time of form completion. Was patient deemed to have decisional capacity at the time of MOLST completion, as evidenced by the fact that the patient completed the form and no supplemental documentation is completed and attached?

Review admission or transfer papers for evidence of documentation of the conversation, such as the MOLST chart documentation form.

If no documentation is present, verify information through a conversation with the physician who completed the MOLST form. The physician license # and phone/pager # is on the MOLST form. Reassess patient capacity at the time of transfer as the patient *may have had capacity* when the MOLST form was completed but *lost capacity* in the interim.

If capacity is intact, the patient's goals for care may have changed. Initiate a goal-based discussion, per the 8-Step Protocol and complete a new MOLST consistent the patient's current preferences.

Is a copy of the MOLST form acceptable and legal?

Yes.

Is a facsimile (fax) of the MOLST form acceptable and legal?

Yes.

Is a stamped signature on the MOLST form acceptable and legal?

No.

Is an electronic representation of the original signed MOLST form acceptable and legal?

Yes.

Why is the MOLST form bright pink?

The MOLST form is bright pink so Health Care Providers can identify it in case of an emergency.

How can the pinkness of the MOLST form be maintained?

When the individual 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 placed in the chart in the new care setting or placed on the refrigerator at home.

How does MOLST work with electronic health records?

Scan MOLST into the computer at time of admission and discharge. Review MOLST at the time of discharge or transition of care and retain an electronic copy. For example, if a patient is discharged to home, the original MOLST form should go with the patient. 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 the health care agency if the patient has home care.

Can midlevel providers (NP, PA) complete the MOLST form and issue DNR and other orders for life sustaining treatments?

While New York State Law allows only a doctor to complete a DNR order, practicality demands that there is a mechanism for conveying this order when the doctor is not on site. The midlevel provider NP/PA may complete MOLST after a discussion with the attending or covering physician and the physician issues a verbal order. The midlevel notes this in the medical record and the MOLST form and the physician signs the order later. Consider using the MOLST chart documentation form.

Verbal orders are acceptable, in accordance with facility or community policy. The orders should be cosigned by an attending physician within a specified brief period of time; for example, within 24 hours in a hospital, and within 1-7 days in a nursing home.

Are verbal orders for DNR given to nurses, nursing supervisors, residents, NP, or PA's acceptable?

Yes. Verbal orders are acceptable, in accordance with facility or community policy. The orders should be cosigned by an attending physician within a specified brief period of time; for example, within 24 hours in a hospital, and within 1-7 days in a nursing home.

Can a physician who has never seen a patient (e.g. a new admission to a skilled nursing facility assigned to a new physician) give a verbal order for DNR to nurses, nursing supervisors, residents, NP, or PA's?

Yes. Verbal orders are acceptable, in accordance with facility or community policy.

Verbal orders are acceptable when followed by a signature of a doctor, in accordance with facility or community policy. The orders should be cosigned by an attending physician within a specified brief period of time; for example, within 24 hours in a hospital, and within 1-7 days in a nursing home.