

M.O.L.S.T.

Medical Orders for Life Sustaining Treatment Guidebook

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For New York Residents

Updated September 2006

Table of Contents

Medical Orders for Life-Sustaining Treatment (MOLST) Program	1
MOLST Community Pilot	1
Goals of the MOLST Program	3
Core Elements of the MOLST Program	3
Who Should Complete a MOLST Form	4
Development of the MOLST Program	5
Forms used in the MOLST Program	
○ Medical Orders for Life-Sustaining Treatment (MOLST) Form	6
○ Capacity Determination	7
○ MOLST Supplemental Documentation Form for Adults	7
○ MOLST Supplemental Documentation Form for Minors	8
Completing a MOLST Form	
○ How to Complete a MOLST Form	9
○ 8-Step MOLST Protocol	10
○ When to Review and Renew a MOLST Form	11
○ What to Do With a Completed MOLST Form	11
Appendix 1: MOLST FAQ's	12
Appendix 2: Monroe and Onondaga Counties MOLST Community Implementation Team	24
Appendix 3: MOLST Creation Workgroup	25
Appendix 4: MOLST Information for Patients / Family	26

Medical Orders for Life-Sustaining Treatment (MOLST) Program

MOLST is based on the belief that individuals have the right to make their own health care decisions.

The Medical Orders for Life-Sustaining Treatment (MOLST) Program is designed to improve the quality of care people receive at the end of life by translating patient/resident goals and preferences into medical orders.

MOLST is based on communication between the patient/resident or surrogate (the Health Care Agent or proxy or other legally designated decision-maker) and health care professionals that ensures informed medical decision-making.

The MOLST Program:

1. Assists health care professionals in discussing and developing treatment plans that reflect patient wishes.
2. Results in the completion of the MOLST form.
3. Helps physicians, nurses, health care facilities and emergency personnel honor patient wishes regarding life-sustaining treatments.

MOLST Community Pilot

NOTE: MOLST Community Pilot pertains to Monroe and Onondaga Counties only.

Governor Pataki signed the MOLST bill (**A.8892, S.5785**) establishing a pilot of the MOLST program in Monroe and Onondaga Counties on October 11, 2005. This bill allows 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 (**A.9479, S.6365**), signed by Governor Pataki on July 26, 2006, permits 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. A Chapter Amendment was needed as Do Not Intubate (DNI) is not covered in Nonhospital DNR Law (PHL §2977). As per current New York State Department of Health policy, Do Not Intubate (DNI) orders cannot be honored in the pre-hospital settings and thus is not currently in the scope of practice for EMS.

The MOLST Community Pilot will study whether a completed, signed MOLST form can act as a suitable replacement for the New York Nonhospital Order Not to Resuscitate (also called the Out-of-hospital Do Not Resuscitate (DNR) Order).

During the MOLST Community Pilot:

Emergency Medical Service (EMS) personnel will follow the orders on the MOLST form **for individuals living in Monroe and Onondaga Counties.**

- **Individuals living in Monroe or Onondaga Counties:** A completed, signed MOLST form can replace the New York State Department of Health Nonhospital DNR form. EMS can follow Do Not Intubate (DNI) orders prior to full cardiopulmonary arrest.
- **Individuals living outside of Monroe and Onondaga Counties:** The New York State Department of Health Nonhospital DNR form must be completed in addition to the MOLST. In counties other than Monroe and Onondaga, EMS cannot directly follow Do Not Intubate (DNI) orders prior to full cardiopulmonary arrest. However, as always, EMS can contact Medical Control as is currently within the scope of practice.

All hospitals, long-term care facilities, home care and hospice agencies and community health care professionals in Monroe or Onondaga Counties are encouraged to participate in the MOLST Community pilot. A successful Pilot will help to ensure the MOLST Program moves beyond the pilot phase.

Timeline:

June 2005: The *MOLST Pilot Project Legislation (A.8892, S.5785)* passed.

October 2005: Governor Pataki signed the bill with a carve-out for Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD). Individuals with mental illness and/or developmental disabilities with capacity can complete a MOLST form.

October 2005: The New York State Department of Health (NYSDOH) approved the MOLST form for use *in* institutions throughout New York State as the legal equivalent of an *inpatient Do Not Resuscitate* (DNR) form. The MOLST form can also be used in hospitals and nursing homes to indicate the patient/resident end-of-life preferences.

January 2006: A Chapter Amendment (**A.9479, S.6365**) was introduced. This amendment authorizes EMS in only Monroe and Onondaga Counties to honor Do Not Intubate (DNI) instructions prior to full cardiopulmonary arrest during the MOLST pilot.

May 2006: MOLST pilot study launched in Monroe and Onondaga Counties.

June 2006: The Chapter Amendment (**A.9479, S.6365**) passed.

July 2006: Governor Pataki signed the Chapter Amendment.

June 30, 2008: The MOLST Pilot legislation is set to expire.

The *Monroe and Onondaga Counties MOLST Community Implementation Team* was formed to help introduce and oversee the pilot. Team members include representatives from hospitals, long term care facilities, hospice and home care agencies, EMS personnel, NYSDOH Western Region – Rochester and Syracuse offices, local medical societies, local bar associations and the respective county health departments. ***For a list of the members of the Monroe and Onondaga Counties MOLST Implementation Team, see Appendix 2.***

The team is:

1. Helping to introduce and oversee the pilot in Monroe and Onondaga Counties.
2. Assuring adequate regional training and utilization of the MOLST form and program.
3. Collecting, reviewing and tracking quality data to ensure accurate form completion.
4. Working to establish standardized metrics.
5. Developing a system that ensures that the form and program are appropriately used as the project moves beyond the pilot phase.
6. Assisting in facility implementation throughout state.

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:

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

Core Elements of the MOLST Program

The MOLST Program is based on communication between the patient/resident or surrogate (the Health Care Agent or proxy or legally designated decision-maker) and health care professionals that ensures informed medical decision-making.

Medical orders derived from these conversations should be recorded on the MOLST form.

The MOLST form:

1. Contains actionable medical orders regarding life-sustaining treatments.
2. Is recommended for individuals with an advanced chronic progressive illness or terminal illness or for anyone interested in further defining their end-of-life care wishes.
3. May be used to limit medical interventions or clarify a request for all medically indicated treatments including cardiopulmonary resuscitation (CPR).
4. Provides explicit direction about resuscitation status ("code status") if the patient is pulseless and/or apneic (not breathing).
5. Includes directions about other types of intervention that the patient may or may not want.
For example: Decisions about future hospitalizations, ICU care, antibiotics, artificial nutrition and hydration, intubation and mechanical ventilation.
6. Is a bright pink color that is easily identified in case of emergency.
7. Accompanies the patient as he or she is transferred home or to a new care settings (e.g., long-term care facility or hospital).
8. Should be reviewed and renewed periodically, as required by New York State and Federal law and regulations, and/or if:
 - The individual is transferred from one care setting or care level to another.
 - There is a substantial change in the patient/resident health status (improvement or deterioration).
 - The patient/resident treatment preferences change.

Additionally, the MOLST Program:

1. Includes training of health care professionals about the goals of the program and use of the MOLST form.
2. Features a plan for ongoing monitoring of the program and its implementation.

Who Should Have a Completed 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. Specifically, health care professionals should discuss MOLST with their patients 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.

Health Care Professionals using MOLST need to be aware of the patient’s goals of care and share existing medical evidence with patients to facilitate their decision-making.

For example:

Cardiopulmonary resuscitation (CPR) is intended to prevent sudden, unexpected death and is generally not indicated in cases of:

1. Terminal, irreversible illness where death is expected, or
2. In certain medical situations where CPR is deemed ineffective.

For many people resuscitation is unwanted, unneeded and impossible. Depending on the situation and the person’s preferences, CPR may be inappropriate, futile and undignified.

Statistics to keep in mind when having discussions about CPR:

- Survival rate of CPR on television shows: -----> 66%
- Actual in-hospital rates of survival to discharge for CPR:
 - All hospital patients: -----> 15%
 - Frail elders*: -----> <5%
 - Individuals with advanced chronic illness**: -----> <1%

* An older person with trouble performing activities of daily living because of weakness or fatigue. Frail elders are more vulnerable to acute illness due to low activity level.

** Advanced chronic illnesses such as Alzheimer’s, Parkinson’s or end-stage heart, lung or kidney disease.

Development of the MOLST Program

The *Community-wide End-of-life/Palliative Care Initiative*, a Rochester, New York-based initiative aimed at improving end of life care in New York, created the *Medical Orders for Life-Sustaining Treatment (MOLST) Program*.

Medical Orders for Life-Sustaining Treatment (MOLST) was adapted from an Oregon program called *Physician Orders for Life-Sustaining Treatment (POLST)*. Developed in the early 1990's, POLST communicates medical orders describing an individual's preferences for life-sustaining treatments. POLST was designed for use in all care settings including the hospitals, long-term care facilities and the community.

Examples of life-sustaining treatments:

Cardiopulmonary resuscitation (CPR or "code status") Antibiotics

Intubation and mechanical ventilation

Artificial nutrition and hydration

A decade of research in the state of Oregon has proven that the POLST program more accurately conveys end-of-life preferences that are more likely followed by medical professionals. The POLST program has been a key vehicle in Oregon's successful efforts to increase the effectiveness of advance care planning and decrease unwanted hospitalizations at the end of life. For more information about POLST, please visit www.polst.org

Eager to replicate Oregon's success, other states are now instituting this model. MOLST is a POLST Paradigm. For more information about the POLST Paradigm, please visit www.polst.org

Discussions with the New York State Department of Health (NYSDOH) were initiated in March 2004 regarding the MOLST form and program. Collaborative review of the form with NYSDOH resulted in the first revision of the MOLST form in October 2005. The MOLST is consistent with New York State's laws and regulations NYSDOH has approved this new revised MOLST form for use in health care settings, including hospitals and nursing homes, throughout the state.

Governor Pataki signed the MOLST bill (**A.8892, S.5785**) establishing a pilot of the MOLST program in Monroe and Onondaga Counties on October 11, 2005. This bill allows 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 (**A.9479, S.6365**), signed by Governor Pataki on July 26, 2006, permits EMS to honor Do Not Intubate (DNI) instructions prior to full cardiopulmonary arrest in Monroe and Onondaga Counties during the MOLST Pilot and provides a carve out for persons with mental retardation and developmental disabilities without capacity.

Special thanks to the primary care physicians, emergency room doctors, EMS staff, nurses, pulmonologists, intensivists, palliative care specialists, social workers, lawyers, consumers, long-term care facility staff, hospice workers and home care staff that created MOLST. For a list of members of the MOLST Creation Workgroup, see Appendix 2.

Special thanks to New York State Department of Health (NYSDOH) and the Medical Society of the State of New York (MSSNY) Ethics Committee for their support of the MOLST Pilot legislation and Chapter Amendment, as well as countless community collaborators and professional associations across the state for their support of implementation of the MOLST Program.

Additional thanks to Excellus BlueCross BlueShield for moving MOLST beyond the Rochester community.

Medical Orders for Life-Sustaining Treatment (MOLST) Form

The *Medical Orders for Life-Sustaining Treatment (MOLST)* is a bright pink medical order form signed by a New York State licensed physician that communicates patient wishes regarding life-sustaining treatments to health care providers. The form includes medical orders and patient preferences regarding:

1. CPR (cardiopulmonary resuscitation)
2. Intubation and mechanical ventilation
3. Artificial hydration and nutrition
4. Future hospitalization and transfer
5. Antibiotics

MOLST is based on the individual's current medical condition and wishes. MOLST should be completed only after:

1. The individual has given significant thought to life-sustaining treatments.
2. The health care professional has discussed current medical condition, prognosis and treatment options including life-sustaining treatments with the individual.
3. The individual has communicated his/her personal preferences regarding life-sustaining treatments to the physician.

If the individual desires, a physician uses the MOLST to record orders for Do Not Resuscitate (DNR), Do Not Intubate (DNI), and/or other life-sustaining treatments. The MOLST form centralizes information on these issues, improves record keeping, and transfers appropriate information between health care professionals and between care settings.

The MOLST form is on bright pink paper so health care professionals can identify it in case of an emergency.

MOLST is approved by the New York State Department of Health (NYSDOH) for use as an inpatient DNR in all hospitals and long-term care facilities.

Although, the MOLST form summarizes advance directives, it is **not** intended to replace traditional advance directives such as the Health Care Proxy form and/or Living Will.

Health Care Proxy / Advance Directives	MOLST
- For all adults	- For those who are chronically ill or nearing the end of their lives
- Completed ahead of time	- Applies Right Now
- Applies only when decision-making capacity is lost	- Not conditional on losing decision-making capacity
	- Contains actionable medical orders

The MOLST form was revised in October 2005. To download a sample of the revised MOLST form please visit www.compassionandsupport.org

Capacity Determination

Capacity is the ability to take in information, understand its meaning and make an informed decision using the information. Intact capacity permits functional independence. Capacity requires a cluster of mental skills people use in everyday life and includes memory, logic, the ability to calculate and “flexibility” to turn attention from one task to another.

Medical determination of capacity is often difficult to determine. There is no standard “tool.” Capacity assessment is a complex process and is not simply determined by the Mini-Mental Status Exam (MMSE). Capacity assessment should involve a detailed history from the patient, collateral history from family, focused physical examination, including cognitive, function and mood screens and appropriate testing to exclude reversible conditions.

Capacity requirements vary by task. The capacity to choose a trusted individual as an appropriate Health Care Agent differs from the capacity to agree to a medical procedure or treatment.

From a legal perspective, capacity depends on ability to understand the act or transaction, understand the consequences of taking or not taking action, understand the consequences of making or not making the transaction, understand and weigh choices, and make a decision and commitment to the decision.

MOLST: Supplemental Documentation Form for Adults

The *MOLST: Supplemental Documentation Form for Adults* must be completed by a physician and a concurring physician *only* when an adult patient *lacks capacity* (the ability to make health care decisions) to consent for himself or herself or under exceptional circumstances.

These exceptional circumstances include:

- *Therapeutic Exception* – when an individual with capacity would be harmed by a discussion of Do Not Resuscitate.
- *Medical Futility* – when CPR would be ineffective given the individual’s condition and the individual has no appointed surrogate (the health care agent or proxy).
- When the individual is a resident of a care setting administered by the Office of Mental Health or Office of Mental Retardation and Developmental Disabilities facilities.
- When the individual resides in a correctional facility.

MOLST: Supplemental Documentation Form for Adults satisfies the documentation requirements outlined by the 1988 New York State legislation governing do-not-resuscitate (DNR) orders.

Consent for DNR can be provided by the patient, resident, a duly appointed health care agent or proxy or surrogate decision-maker, in accordance with NYS Public Health law (PHL § 2977).

If the patient/resident *lacks capacity*, the **Health Care Agent makes DNR decisions based on known patient wishes** and is not limited to specific situations. Thus, Step 3 outlined in the “Supplemental” Documentation Form for Adults does *not* apply and does *not* need to be completed.

If the patient *lacks capacity* and does *not* have a designated health care agent or proxy, the surrogate makes DNR decisions under any of the following situations:

- The patient/resident has a terminal condition.
- The patient/resident is permanently unconscious.
- Resuscitation would be medically futile.
- Resuscitation would impose an extraordinary burden on the patient/resident in light of the patient/resident’s medical condition and the expected outcome of resuscitation.

The *MOLST: Supplemental Documentation Form for Adults* is a supplement to the MOLST form and should be kept with the MOLST at all times.

NOTE: After completing the *MOLST: Supplemental Documentation Form for Adults*, please check the corresponding box in Section B of the original MOLST form.

Concurring Physician Certification Requirement for DNR Orders for Individuals Lacking Capacity including Mental Illness, Mental Retardation or Developmental Disability:

In cases of individuals who *lack capacity* including mental illness, mental retardation or developmental disability, the *MOLST: Supplemental Documentation Form for Adults* requires certification and signature of a concurring physician.

If the individual *lacks capacity* because of a mental illness, the concurring physician must be board certified in psychiatry.

Note: Mental illness is defined by conditions such as schizophrenia or acute psychotic episode and *does not* refer to dementia.

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 certification and signature of the concurring physician is documented in Section 1, Step 9 of the *MOLST: Supplemental Documentation Form for Adults*.

Note: Individuals with mental illness, mental retardation or developmental disability *with capacity* may complete a MOLST form. No additional documentation on supplemental forms is needed.

To view and download a printable sample of the *MOLST: Supplemental Documentation Form for Adults*, please visit www.compassionandsupport.org

MOLST: Supplemental Documentation Form for Minors

MOLST: Supplemental Documentation Form for Minors contains the documentation requirements outlined by the 1988 New York State legislation governing do-not-resuscitate (DNR) orders.

If MOLST is completed for patients/residents under 18 years old who are not married and/or are not a parent, the *MOLST: Supplemental Documentation Form for Minors* must be completed as well. Patients/residents under 18 who are married and/or are parents are treated as adults under New York State law. A lawyer should be contacted if there is any uncertainty about the situation.

As per Public Health Law §2967(4)(b), **a parent may give a verbal consent** in the presence of 2 witnesses one of whom must be a physician affiliated with the hospital in which the patient is being treated. The decision must be noted in the patient's medical chart.

The *MOLST: Supplemental Documentation Form for Minors* is a supplement to the MOLST form and should be kept with it at all times.

NOTE: After completing the *MOLST: Supplemental Documentation Form for Minors*, please check the corresponding box in Section B of the original MOLST form.

To view and download a printable sample of the *MOLST: Supplemental Documentation Form for Minors*, please visit www.compassionandsupport.org

How to Complete a MOLST Form

MOLST must be completed by a health care professional, based on patient preferences and medical indications. Health care professionals should be trained, competent and comfortable with having the conversation with the 8-Step MOLST Protocol. 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. Conflict arises when the wrong person is chosen as the Health Care Agent or if there is no antecedent conversation. Document the conversation in the medical record.

1. The MOLST form must be signed by a New York State-licensed physician to be valid. Verbal orders are acceptable with follow-up signature by a physician in accordance with facility/community policy.
2. If the individual has a legal and valid DNR previously completed while the individual had capacity, attach it to the MOLST form.
3. Use of the original form is strongly encouraged. The readily-identifiable pink color makes it easier to find in case of an emergency. Photocopies and faxes of signed MOLST forms are acceptable and legal.
4. Completion of the entire form is strongly recommended. Review of the entire form serves to educate the patient regarding additional choices for life-sustaining treatment. Any section not completed implies full treatment for that section.
5. Consent for DNR must be obtained and documented in Section B of Page 1. Consent can be provided by the patient, resident, a duly appointed Health Care Agent or proxy or surrogate decision-maker, in accordance with NYS Public Health law (PHL § 2977):
 - An individual with capacity (the ability to make health care decisions) can provide their own consent.
 - 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 the individual.
 - If the individual *lacks capacity and does not have a designated Health Care Agent or proxy*, then the surrogate must be selected from the following list [in order of priority with a) as the highest priority and h) as the lowest priority]:
 - a) Designated Health Care Agent
 - b) Court-appointed committee or guardian
 - c) Spouse
 - d) Son or daughter, age 18 or older
 - e) Parent
 - f) Brother or sister, age 18 or older
 - g) Close friend of the person, age 18 or older (affidavit of close friend required)
 - h) No appropriate surrogate decision-maker is available
6. Consent for 'Orders for Life-Sustaining Treatment and Future Hospitalization' should be obtained and documented in Section E of Page 2.
 - An individual *with capacity* (the ability to make health care decisions) can provide their own consent.
 - If the individual *lacks capacity and has a designated Health Care Agent or other designated decision-maker*, then the Health Care Agent or other designated decision-maker can provide consent for the individual.
 - If the individual *lacks capacity and does not have a designated Health Care Agent or other designated decision-maker*, then "clear and convincing evidence" of the individual's preferences is required in the form of an Advance Directive or repeated oral expression. Confirmation of the person's treatment preferences must be obtained and documented in the consent for Section E.

Medical Orders for Life Sustaining Treatment (MOLST)*



8-Step MOLST Protocol

1. Prepare for discussion
 - Review what is known about patient and family goals and values
 - Understand the medical facts about the patient's medical condition and prognosis
 - Review what is known about the patient's capacity to consent
 - Retrieve and review completed Advance Care Directives and prior DNR documents
 - Determine who key family members are, and (if the patient does not have capacity), see if there is an identified "Agent" (Spokesperson) or responsible party
 - Find uninterrupted time for the discussion
2. Begin with what the patient and family knows
 - Determine what the patient and family know regarding condition and prognosis
 - Determine what is known about the patient's views and values in light of the medical condition
3. Provide any new information about the patient's medical condition and values from the medical team's perspective
 - Provide information in small amounts, giving time for response
 - Seek a common understanding; understand areas of agreement and disagreement
 - Make recommendations based on clinical experience in light of patient's condition / values
4. Try to reconcile differences in terms of prognosis, goals, hopes and expectations
 - Negotiate and try to reconcile differences; seek common ground; be creative
 - Use conflict resolution when necessary
5. Respond empathetically
 - Acknowledge
 - Legitimize
 - Explore (rather than prematurely reassuring)
 - Empathize
 - Reinforce commitment and non-abandonment
6. Use MOLST to guide choices and finalize patient/family wishes
 - Review the key elements with the patient and/or family
 - Apply shared medical decision making
 - Manage conflict resolution
7. Complete and sign MOLST
 - Get verbal or written consent from the patient or designated decision-maker
 - Get written consent from the treating physician, and witnesses
 - Document conversation
8. Review and revise periodically

*MOLST is a medical order form designed to provide a single, community-wide document that would be easily recognizable and enable patient wishes for life-sustaining treatment to be honored. It was created by a workgroup of the *Community-Wide End-of-Life/Palliative Care Initiative* in Rochester, New York. MOLST is adapted from the Oregon Physician Orders for Life-Sustaining Treatments (POLST) and incorporates New York State law.

When to Review and Renew a MOLST Form

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

- The patient/resident is transferred from one facility to another.
- There is a substantial change in the patient/resident 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

Renewal orders must be signed by a New York State licensed physician. The outcome of the review will result in:

1. No change
2. Changes - Additions only
3. FORM VOIDED, new form completed
4. FORM VOIDED, **no** new form

NOTE: This order remains valid and must be followed, even if it has not been reviewed within the appropriate time period. Under New York State law, this order should be considered valid unless it is known that it has been revoked.

Completing a new form is NOT required every time the MOLST form is reviewed and renewed. If an update is needed, it can be recorded in the appropriate section of the form.

It is the responsibility of the physician to determine, within the appropriate period of time, whether the orders contained on the MOLST form continue to be appropriate.

The physician must document this in the individual's medical chart and sign the renewal orders located on pages 3 and 4 of the MOLST form.

What to 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 old 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.

Appendix 1

Medical Orders for Life-Sustaining Treatment (MOLST) Frequently Asked Questions (FAQs)

1. What is Medical Orders for Life-Sustaining Treatment (MOLST)?

The Medical Orders for Life-Sustaining Treatment (MOLST) is a program designed to improve the quality of care people receive at the end of life by translating patient/resident goals and preferences into medical orders.

MOLST is based on communication between the patient/resident, Health Care Agent or other designated decision-maker and health care professionals that ensures informed medical decision-making.

2. What is the MOLST form?

The MOLST form is a bright pink medical order form signed by a New York State Licensed physician that communicates patient wishes regarding life-sustaining treatment to health care providers. 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

3. What is the MOLST Pilot Project?

Governor Pataki signed the MOLST bill (**A.8892, S.5785**) establishing a pilot of the MOLST program in Monroe and Onondaga Counties on October 11, 2005. This bill allows 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 (**A.9479, S.6365**), signed by Governor Pataki on July 26, 2006, permits 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.

4. How long will the MOLST Pilot Project last?

The MOLST Pilot legislation is set to expire on June 30, 2008.

5. 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.

6. Does the MOLST form replace traditional Advance Directives?

No. Although the MOLST form summarizes Advance Directives, it is not intended to replace traditional Advance Directives like the Health Care Proxy and Living Will.

7. 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.

8. 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.

9. Can the MOLST be used for any persons with mental retardation or developmental disabilities or persons with mental illness?

In the inpatient setting, the MOLST form may be completed by persons with mental retardation or developmental disabilities or persons with mental illness *with capacity* (capable of making their own decisions). The MOLST may be completed for persons with mental retardation or developmental disabilities or persons with mental illness *who lack capacity* in accordance with Surrogate’s Court Procedure Act §1750-B; however, legal counsel should be consulted.

In the community, the MOLST form may be completed by persons with mental retardation or developmental disabilities or persons with mental illness *with capacity* (capable of making their own decisions). The Chapter Amendment provides for a carve-out, such that authorization does not extend the use of the MOLST form to persons with mental retardation or developmental disabilities or persons with mental illness *who lack capacity*.

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

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.

11. Will the MOLST form be honored in the community?

Governor Pataki signed the MOLST bill (**A.8892, S.5785**) establishing a pilot of the MOLST program in only Monroe and Onondaga Counties on October 11, 2005. This bill allows 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 (**A.9479, S.6365**), signed by Governor Pataki on July 26, 2006, permits EMS to honor Do Not Intubate (DNI) instructions prior to full cardiopulmonary arrest in only 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.

12. Does the MOLST take the place of the current New York State Order Not to Resuscitate (also called the New York State Nonhospital DNR form) in the community?

Governor Pataki signed legislation on October 11, 2005 that allows for the use of alternative forms like the MOLST form in lieu of the NYS Nonhospital Do Not Resuscitate (DNR) form (A8892, S.5785).

This legislation permits a demonstration pilot of use of the MOLST in lieu of the NYS Nonhospital Do Not Resuscitate (DNR) form in Monroe and Onondaga counties.

In all counties other than Monroe and Onondaga, the NYS Nonhospital DNR form is required to indicate DNR orders in nonhospital settings and should be attached to the MOLST form.

13. 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.

14. Does the MOLST form indicate treatment preferences other than DNR?

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.

15. Can Do Not Intubate Orders be followed in the community?

The Chapter Amendment to the MOLST Pilot legislation permits EMS to follow a Do Not Intubate (DNI) order only in Monroe and Onondaga Counties.

Do Not Intubate (DNI) is not covered in Nonhospital DNR Law (PHL § 2977). As per current New York State Department of Health policy, Do Not Intubate (DNI) orders can not be honored in the pre-hospital settings and thus is not currently in the scope of practice for EMS.

In counties other than Monroe and Onondaga, EMS cannot directly follow a DNI order. However, as always, EMS can contact Medical Control as is currently within the scope of practice.

16. 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.

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

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.

18. Who can complete a MOLST form with the patient or Health Care Agent?

MOLST must be completed by a health care professional, based on patient preferences and medical indications. Health care professionals should be trained, competent and comfortable with having the conversation in accordance with the MOLST 8-Step Protocol.

MOLST must be signed by a NYS licensed physician to be valid.

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.

Conflict often arises when the wrong person is chosen as the Health Care Agent or if there is no antecedent conversation.

19. 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.

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.

20. 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.

21. 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.

22. Can residents (physicians in training) sign a MOLST form that serves as an in-patient DNR?

Yes. The MOLST is approved for use in all health care facilities in NYS by NYSDOH. The resident (physician in training) may complete MOLST after a discussion with the attending physician or covering physician and the physician issues a verbal order. The resident notes this in the medical record and the MOLST form and the physician signs the order later.

23. Can residents (physicians in training) sign a MOLST form that will also serve as a Nonhospital DNR in Monroe or Onondaga counties during the MOLST pilot program?

No. The New York State Nonhospital DNR must be signed by a New York State licensed MD. Thus, DNR orders signed by a resident (physicians in training) in the inpatient setting, consistent with facility policy, must be co-signed a New York State licensed MD, at the time of discharge.

24. Who provides consent for a Do Not Resuscitate (DNR) order?

Consent for DNR must be obtained and documented in Section B of Page 1.

Consent can be provided by the patient, resident, a duly appointed Health Care Agent or a surrogate decision-maker, in accordance with NYS Public Health law (PHL § 2977):

- An individual *with capacity* (the ability to make health care decisions) can provide their own consent.
- 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 the individual.
- If the individual *lacks capacity and does not have a designated health care agent or proxy*, then the surrogate must be selected from the following list [in order of priority with a) as the highest priority and h) as the lowest priority]:
 - a) Designated health care agent
 - b) Court-appointed committee or guardian
 - c) Spouse
 - d) Son or daughter, age 18 or older
 - e) Parent
 - f) Brother or sister, age 18 or older
 - g) Close friend of the person, age 18 or older (affidavit of close friend required)
 - h) No appropriate surrogate decision-maker is available

25. May a parent provide verbal consent to a DNR order for a minor child?

Yes. As per Public Health Law §2967(4)(b), a parent may give a verbal consent in the presence of 2 witnesses one of whom must be a MD affiliated with the hospital in which the patient is being treated. The decision must be noted in the patient's medical chart.

26. How does a designated health care agent or proxy named in a legal Health Care Proxy make DNR decisions?

The Health Care Agent makes DNR decisions based on known patient wishes and is not limited to specific situations. Thus, Step 3 outlined in the "Supplemental" Documentation Form for Adults does *not* apply and does *not* need to be completed.

27. Under what circumstances does a surrogate chosen from a hierarchy list make decisions for DNR?

The physician must determine the lack of utility of cardiopulmonary resuscitation to a reasonable degree of medical certainty. The physician must indicate all pertinent circumstances that apply in Step 3 of the "Supplemental" Documentation Form for Adults:

- The patient/resident has a terminal condition.
- The patient/resident is permanently unconscious.
- Resuscitation would be medically futile.
- Resuscitation would impose an extraordinary burden on the patient/resident in light of the patient/resident's medical condition and the expected outcome of resuscitation.

28. Can a Health Care Agent serve as a witness of the signature for a DNR order for the patient?

For the patient *with capacity*, the Health Care Agent can serve as a witness for a DNR order.

For the patient *without capacity*, the Health Care Agent is providing consent and someone else needs to witness the signature.

29. Are DNR orders completed when a patient has capacity still valid when the patient loses capacity?

Yes. The patient's preference and expressed wishes for DNR are **not** lost due to *loss of capacity* (the ability to make health care decisions). Attach the previously completed DNR form when the patient had capacity and attach to the MOLST. Check the box 'Prior form attached'. Proceed to complete the rest of the MOLST form with the appropriate consent as outlined in 'Who provides consent for 'Orders for Life-Sustaining Treatment and Future Hospitalization'? Use the process outlined in the 8-Step Protocol.

30. 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.

31. 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.

32. 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.

33. 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".

34. 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.

35. 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.

36. Who provides consent for 'Orders for Life-Sustaining Treatment and Future Hospitalization'?

Consent for 'Orders for Life-Sustaining Treatment and Future Hospitalization' should be obtained and documented in Section E of Page 2.

- An individual *with capacity* (the ability to make health care decisions) can provide their own consent.
- If the individual *lacks capacity and has a designated health care agent or proxy*, then the agent or proxy can provide consent for the individual.
- If the individual *lacks capacity and does not have a designated health care agent or proxy*, then "clear and convincing evidence" of the individual's preferences is required in the form of a Living Will or repeated oral expression. Confirmation of the person's treatment preferences must be obtained and consent documented in Section E.

37. Does the supplemental form for adults always need to be completed?

No. The MOLST supplemental form for adults must be completed *only* when the adult patient *lacks capacity* to consent for himself or herself.

38. What is capacity?

Capacity is the ability to take in information, understand its meaning and make an informed decision using the information. Intact capacity permits functional independence. Capacity requires a cluster of mental skills people use in everyday life and includes memory, logic, the ability to calculate and "flexibility" to turn attention from one task to another.

39. How does one assess capacity?

Medical determination of capacity is often difficult. There is no standard "tool." Capacity assessment is a complex process and is not simply determined by the Mini-Mental Status Exam (MMSE). Capacity assessment should involve a detailed history from the patient, collateral history from family, focused physical examination, including cognitive, function and mood screens and appropriate testing to exclude reversible conditions.

40. How does capacity vary?

Capacity requirements vary by task.

For example, the capacity to choose a trusted individual as an appropriate Health Care Agent differs from the capacity to make health care decisions such as agreeing to a medical procedure or treatment.

41. Who determines capacity?

The physician determines capacity. This determination must be affirmed by a concurring physician.

42. Who determines capacity in the case of “mild dementia” in a new resident in a long term care facility who requests a DNR order?

The physician determines capacity. This determination must be affirmed by a concurring physician.

Remember that capacity requirements vary by task.

The patient with dementia may retain the capacity to choose a trusted individual as an appropriate Health Care Agent but not the capacity to make health care decisions such as agreeing to a medical procedure or treatment.

In this situation, a Health Care Proxy may be completed and the designated Health Care Agent can then make the health care decisions.

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

No. The physician can determine capacity and should seek consultation if there is a question regarding capacity determination.

44. When do I need a psychiatric consultation?

If the individual *lacks capacity* because of a mental illness, the concurring physician must be board certified in psychiatry.

Mental illness is defined by conditions such as schizophrenia or acute psychotic episode and *does not* refer to dementia.

45. 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.

46. Is documentation in the medical record important and part of the process?

Yes. The health care professional should document:

- Conversations with the patient, Health Care Agent or ‘family’, as defined by the patient.
- Patient capacity assessments.
- Evidence of ‘clear and convincing’ evidence.

47. What is ‘clear and convincing’ evidence?

‘Clear and convincing evidence’ can be in the form of a living will or repeated oral expression, established *In the Matter of Westchester County Medical Center, on behalf of Mary O’Connor, p 8.*

“The ideal situation is one in which the patient’s wishes were expressed in some form of a writing, perhaps a ‘living will,’ while he or she was still competent. The existence of the writing suggests the seriousness of purpose and ensures that the court is not being asked to make a life-or-death decision based upon casual remarks”.

The decision went on to state, “Of course, a requirement of a written expression in every case would be unrealistic. Further, it would unfairly penalize those who lack the skill to place their feelings in writing. For that reason, we must always remain open to applications such as this, which are based upon the repeated *oral expressions* of the patient”.

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

If there is 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.

49. Does the presence of MOLST eliminate the need for hospitals to establish clear and convincing evidence of the incapacitated patient's wishes for end of life treatments?

If the MOLST is completed after the person loses capacity, the Adult Supplemental Form must be completed.

For incapacitated patients, 'clear and convincing evidence', as defined by New York State case law, should be established.

Ideally, once established capacity assessment and clear and convincing evidence should be documented in the medical record and should travel with the patient.

50. In the absence of a Health Care Proxy, is it acceptable for only one family member to state what the patient/resident's wishes were?

The physician must focus on what clearly represents 'clear and convincing evidence' and then achieving family consensus.

Conversation should be focused to provide evidence of previous repeated oral expression of wishes instead of applying a literal interpretation of an isolated, out-of-context, patient statement made earlier in life. If conflict persists, an Ethics or Palliative Care Consult may help.

51. Is there a difference between a decision to withhold or discontinue life sustaining treatments?

No. Ethical or legal distinctions exist between withholding or withdrawing treatment. If such a distinction existed, the patient would refuse treatment fearing that treatment could not be discontinued.

52. Can hospitals rely solely on the MOLST form to withhold or discontinue life sustaining treatments?

Yes. Similar to the NYS Nonhospital Do Not Resuscitate (DNR) form, a properly completed MOLST form records actionable medical orders written by a licensed NYS physician. In addition to DNR orders, MOLST contains 'Orders for Life-Sustaining Treatment and Future Hospitalization'.

The presence of a MOLST signifies the occurrence of a thoughtful prior discussion between a patient and health care professional, shared with 'family', as designated by the patient/resident. It is based on informed medical decision-making and patient preferences. Further, a set of medical orders has been signed by a licensed NYS physician.

When the need occurs in an emergency, *first follow* these orders, and then contact the physician. The form should be reviewed at the time of transfer as indicated in the guidelines for review and renewal of orders.

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.

If the patient now *lacks capacity*, review orders with the Health Care Agent and affirm the prior conversation.

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

No. The original MOLST forms have undergone 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.

54. 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.

55. 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.

56. 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.

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.

57. If a patient from another county completes a MOLST in a health care facility in Monroe or Onondaga county, can the MOLST be used in the community after discharge?

The Chapter Amendment and the MOLST Pilot legislation apply to the county in which the patient resides, not the county in which MOLST is completed. A New York State Department of Health Nonhospital DNR Order form must be completed in addition to the MOLST.

58. Is a copy of the MOLST form acceptable and legal?

Yes.

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

Yes.

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

No.

61. 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.

62. 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.

63. 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.

64. How is MOLST implemented for a patient receiving Home Care services?

If the patient is homebound and the physician is making home visits, the physician completes the MOLST form, makes a copy and returns the original MOLST to the patient. If the patient is seen by the physician in the office, the MOLST form is completed, a copy is made and the original MOLST is given to the patient.

65. How is MOLST implemented for a patient receiving Hospice services?

If the patient is homebound and the physician is making home visits, the physician completes the MOLST form, makes a copy and returns the original MOLST to the patient.

If the patient is seen by the physician in the office, the MOLST form is completed, a copy is made and the original MOLST is given to the patient.

66. Is honoring a DNR order in the outpatient dialysis unit prohibited by Public Health Law?

Public Health Law does not prohibit a free standing Art 28 renal dialysis site from honoring a DNR rather it does not require that they follow it. Because this setting is not contemplated under the statute it would be a Nonhospital DNR that the center would be considering. If there is a DNR from a hospital or nursing home to the ESRD then the hospital form may or may not be honored.

67. Should the completion of Advance Directives be a routine part of quality of care measures similar to pain assessment?

Yes. *The National Quality Forum Framework and Preferred Practices for Quality Palliative Care & Hospice Care* issued in 2006 recommends preferred practices for advance care planning.

Adapted for New York State, these include:

- Document the designated agent (surrogate decision maker) in a Health Care Proxy for every patient in primary, acute and long-term care and in palliative and hospice care.
- Document the patient/surrogate preferences for goals of care, treatment options, and setting of care at first assessment and at frequent intervals as condition changes.
- Convert the patient treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital, i.e., the Medical Orders for Life-Sustaining Treatments—MOLST, a POLST Paradigm Program.

- Make Advance Directives and surrogacy designations available across care settings.
- Develop and promote healthcare and community collaborations to promote advance care planning and completion of Advance Directives for all individuals.

68. Where can I get MOLST forms?

MOLST forms are available at participating health care facilities in New York State.

Excelsus BlueCross BlueShield is offering the forms free-of-charge to the community. MOLST forms can be ordered by downloading the Educational Resource Order Form from www.excellusbcbs.com.

Appendix 2

Monroe and Onondaga Counties MOLST Community Implementation Team

Chair: Patricia Bomba, MD, FACP

Excellus BlueCross BlueShield

Monroe County Team Members:

Nancy Adams	Monroe County Medical Society
Cynthia Bileschi, RN, BSN	ViaHealth
Paul Bishop	Monroe Community College
Kathy Cantaben	NYSDOH – Western Region
Thomas Caprio, MD	Monroe Community Hospital, URM
Jeanne Chirico, MPA	Lifetime Care
Tim Czapranski, EMT-P	Monroe County
Jason Dauenhauer, PhD	SUNY Brockport
Judy Deter	Unity
Andrew Doniger, MD	Monroe County Department of Health
Tim Frost, CCEMT-P	Rural / Metro Medical Services
Suzanne Gillespie, MD	Highland Hospital, URM
Emily Martinez-Vogt	Excellus BlueCross BlueShield
Daniel Mendelson, MD	Highland Hospital
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Richard Russotti, Sr.	Monroe-Livingston Regional EMS Council
Manish Shah, MD	Dept. of Emergency Medicine, URM
Mark Sarnov, MD	Hilton Health Care
Heidi Schult Gregory	Monroe County Bar Association
Rufus Timberlake, MD	VA Rochester Outpatient Clinic
Ann Williams	Volunteer Legal Services Project

Onondaga County Team Members:

Mark Buttiglieri	University Hospital
Cheryl Brunacci-Morrow, MD	Elder Medical Services, P.C.
Janet Dauley-Altwarz	LTC Executive Council
Pauline Frazier	Onondaga County Department of Health
Robert Friedman, MD	St. Joseph's Hospital
Troy Hogue	Rural Metro CNY
Gerry Hoffman	Onondaga County Medical Society
Mary Rose Kott, RN	St. Joseph's Hospital
Cynthia Morrow, MD	Onondaga County Department of Health
Dan Olsson, MD	REMAC
Tim Perkins	CNY EMS
Joel Potash, MD	Upstate Medical University
Donnaline Richman	Onondaga County Bar Association
Judy Setla, MD	Hospice of CNY

Appendix 3

MOLST Creation Workgroup

Co-leaders:

Kathy McGrail, MD	VNS Hospice
Albert Hooke	Community Member
Bernard Shore, MD	Jewish Home of Rochester

MOLST Creation Workgroup Team Members:

Judith Baggs, RN, PhD	University of Rochester Medical Center
Patricia Bomba, MD	Excellus BlueCross BlueShield
Gail Brocious	ROHM
Steven M. Chernow, MD, MBA	Preferred Care
Jeanne Chirico	Lifetime Care
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David K.P. Lee	ViaHealth
Daniel Labowitz	Monroe County Health Department
Gary Mervis	Camp Good Days & Special Times, Inc.
Mary Jane Milano	Rochester Health Commission
Maria Millela	University of Rochester Medical Center
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Sally Norton, RN, PhD	University of Rochester School of Nursing
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Dorene Pizer	Rochester Psychiatric Center
Timothy Quill, MD	University of Rochester Medical Center
Mary Pat Stabley, RN	Fairport Baptist Home
Helena Temkin-Greener	CCLTC
Dan Vermilyea	Excellus BlueCross BlueShield
Jan Wolpin	Consumer Advocate

Appendix 4

MOLST Information for Patients/Family

Topic

Page

Medical Orders for Life-Sustaining Treatment (MOLST) Program	A
MOLST Community Pilot	A
Goals of the MOLST Program	B
Core Elements of the MOLST Program	B
Who Should Complete a MOLST Form	B
Development of the MOLST Program	C
Forms used in the MOLST Program	C
o Medical Orders for Life-Sustaining Treatment (MOLST) Form	C
o MOLST Supplemental Documentation Form for Adults	D
o MOLST Supplemental Documentation Form for Minors	D
Completing a MOLST Form	
o How to Complete a MOLST Form	E
o When to Review and Renew a MOLST Form	E
o What to do with a Completed MOLST Form	E
Glossary of Terms	F

Medical Orders for Life-Sustaining Treatment (MOLST) Program

MOLST is based on the belief that individuals have the right to make their own health care decisions.

The Medical Orders for Life-Sustaining Treatment (MOLST) Program is designed to improve the quality of care people receive at the end of life by translating people's goals and preferences into medical orders. MOLST is based on communication between the patient, resident, Health Care Agent or other designated decision-maker and health care professionals that ensures informed medical decision-making.

The MOLST Program:

1. Assists you and your health care professionals discuss and develop treatment plans that reflect your wishes.
2. Results in the completion of the MOLST form.
3. Helps physicians, nurses, health care facilities and emergency personnel honor your wishes for life-sustaining treatments.

MOLST Community Pilot

NOTE: *MOLST Community Pilot pertains only to Monroe and Onondaga Counties.*

In October 2005, the New York State Department of Health (NYSDOH) approved the MOLST form for use in all health care facilities throughout the state. Health care professionals and institutional providers can use the MOLST form as the legal equivalent of an inpatient Do-Not-Resuscitate (DNR) Order and to record end-of-life wishes.

The community pilot began May 1, 2006.

During the MOLST Community Pilot:

Individuals living in Monroe or Onondaga Counties: A completed, signed MOLST form can replace the New York State Department of Health Nonhospital DNR form. EMS can follow Do Not Intubate (DNI) orders prior to full cardiopulmonary arrest.

Individuals living outside of Monroe and Onondaga Counties: The New York State Department of Health Nonhospital DNR form must be completed in addition to the MOLST. In counties other than Monroe and Onondaga, EMS cannot directly follow a Do Not Intubate (DNI) order prior to full cardiopulmonary arrest. However, as always, EMS can contact Medical Control as is currently within the scope of practice.

All hospitals, long-term care facilities, home care and hospice agencies and community health care professionals in these two counties are encouraged to participate in the community pilot.

The *Monroe and Onondaga Counties MOLST Community Implementation Team* was formed to help introduce and oversee the pilot. Team members include representatives from hospitals, long term care facilities, hospice and home care agencies, EMS, NYSDOH Western Region – Rochester and Syracuse offices, local medical societies, and the respective county health departments.

The team is:

1. Helping to introduce and oversee the pilot in Monroe and Onondaga Counties.
2. Assuring adequate training and utilization of MOLST.
3. Collecting and reviewing quality data.
4. Developing a system that ensures that the form and program are appropriately used as the project moves beyond the pilot phase.

Special thanks to Monroe and Onondaga Counties MOLST Community Implementation Team Members.

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:

1. Document a person's treatment preferences regarding:
 - Cardiopulmonary resuscitation (CPR)
 - Intubation and mechanical ventilation
 - Other life-sustaining treatments
2. Coordinate physician orders with an individual's wishes.
3. Communicate an individual's wishes regarding care across health care settings.
4. Improve emergency medical services (EMS) personnel's ability to treat according to the individual's wishes.
5. Reduce repetitive documentation.

Core Elements of the MOLST Program

The MOLST Program is based on communication between the patient or surrogate (the Health Care Agent or proxy) and health care professionals. This communication is recorded as medical orders on the MOLST form that:

1. Contains medical orders that direct the care provided by health care professionals.
2. Is recommended for individuals with advanced chronic progressive illness or terminal illness or for anyone interested in detailing their end-of-life care wishes.
3. May be used to limit medical treatments or request all appropriate medical treatments including cardiopulmonary resuscitation (CPR).
4. Contains explicit directions about cardiopulmonary resuscitation (CPR) status if the patient does not have a heartbeat and/or is not breathing.
5. Includes directions about other types of treatments that may or may not be wanted.
For example: Decisions about future hospitalizations, Intensive Care Unit (ICU) care, antibiotics, artificial nutrition, intubation and mechanical ventilation.
6. Accompanies the person as he or she is transferred home or to a new care setting (e.g. long-term care or hospital). The form is used in the new care setting.
In a facility, the form should be placed in the front of the person's medical chart.
At home, the form should be displayed on the refrigerator, by the phone or by the person's bed side.
7. Is a readily-identifiable bright pink color.

Who Should Have a Completed MOLST Form

The MOLST form is used to record wishes for end-of-life care.

People should consider having a completed MOLST form if they:

- Reside in a long-term care facility
- Reside in the community and need long-term care services
- Might die within the next year
- Want to avoid some or all life-sustaining treatments

Individuals who meet the above criteria should speak with their physicians about whether MOLST is right for them.

MOLST: Supplemental Documentation Form for Adults

The *MOLST: Supplemental Documentation Form for Adults* must be completed only when an adult patient *lacks capacity* (the ability to make health care decisions) to consent for him or herself or under exceptional circumstances that include:

- *Therapeutic Exception* – when an individual with capacity would be harmed by a discussion of Do Not Resuscitate.
- *Medical Futility* – when CPR would be ineffective given the individual’s condition and the individual has no appointed surrogate (the health care agent or proxy).
- When the individual is a resident of a care setting administered by the Office of Mental Health or Office of Mental Retardation and Developmental Disabilities facilities.
- When the individual resides in a correctional facility.

Consent for DNR can be provided by the patient, resident, a duly appointed health care agent or proxy or surrogate decision-maker, in accordance with NYS Public Health law (PHL § 2977).

Decisions made by a Health Care Agent are based on patient wishes and not limited to any situations. If a Health Care Agent is *not* chosen, DNR decisions can only be made under any of the following situations:

- The patient/resident has a terminal condition.
- The patient/resident is permanently unconscious.
- Resuscitation would be medically futile (CPR would be ineffective given the patient’s condition).
- Resuscitation would impose an extraordinary burden on the patient/resident in light of the patient/resident’s medical condition and the expected outcome of resuscitation.

Individuals considering MOLST should make decisions after having discussions with their health care professionals about personal wishes and existing medical evidence. For example:

Cardiopulmonary resuscitation (CPR) is intended to prevent sudden, unexpected death. CPR is *not* indicated in cases of:

- Terminal, irreversible illness where death is expected, or
- In certain medical situations where CPR is deemed ineffective.

For many people resuscitation is unwanted, unneeded and impossible. Depending on the situation and the person’s preferences, CPR may be inappropriate, futile and undignified.

Statistics to keep in mind when having discussions about CPR:

- Survival rate of CPR on television shows: -----> 66%
- Actual in-hospital survival rates for CPR:
 - All hospital patients: -----> 15%
 - Frail elders*: -----> <5%
 - Individuals with advanced chronic illness**: -----> <1%

* An older person with trouble performing activities of daily living because of weakness or fatigue. Frail elders are more vulnerable to acute illness due to low activity level.

**Advanced chronic illnesses such as Alzheimer’s, Parkinson’s or end-stage heart, lung or kidney disease.

The *MOLST: Supplemental Documentation Form for Adults* is a supplement to the MOLST form and should be kept with it.

To view the *MOLST: Supplemental Documentation Form for Adults*, visit www.compassionandsupport.org

MOLST: Supplemental Documentation Form for Minors

If MOLST is completed for an individual under 18 years old who is not married and/or is not a parent, the *MOLST: Supplemental Documentation Form for Minors* must be completed as well. Individuals under 18 who are married and/or are parents are treated as adults under New York State law. A lawyer should be contacted if there is any uncertainty about the situation.

As per Public Health Law §2967(4)(b), a parent may give a verbal consent in the presence of 2 witnesses one of whom must be a MD affiliated with the hospital in which the patient is being treated. The decision must be noted in the patient's medical chart.

After completion, the *MOLST: Supplemental Documentation Form for Minors* should be kept with the MOLST form.

To view the *MOLST: Supplemental Documentation Form for Minors*, visit www.compassionandsupport.org

How to Complete a MOLST Form

To make a MOLST form valid:

1. A health care professional must complete the MOLST form based on the individual's preferences and current medical condition.
2. A physician with a valid New York State license must sign the MOLST form.
3. Patient consent must be provided and the form must be signed.

Who can provide patient consent and sign the form?

1. A patient with capacity (the ability to make health care decisions) can provide their own consent.
2. If the patient lacks capacity *and has designated a Health Care Agent or proxy* by completing a Health Care Proxy form, then the health care agent or proxy can provide consent for the patient.
3. If the patient lacks capacity *and has not designated a Health Care Agent or proxy* by completing a Health Care Proxy form, then "clear and convincing evidence" must be provided. This may be in the form of a Living Will or repeated oral expression by the patient.

When to Review and Renew a MOLST Form

The entire MOLST form should be reviewed and renewed by a physician:

- Periodically.
- When the individual is transferred from one facility to another.
- When there is a substantial change in the person's health status (improvement or deterioration).
- The individual's preferences for treatments 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

NOTE: This order remains valid and must be followed, even if it has not been reviewed and renewed within the appropriate time period. Under New York State law, this order is valid unless revoked.

Completing a new form is NOT required every time a MOLST is reviewed and renewed. If an update is needed, it can be recorded in the appropriate section of the form.

What to 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 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.

Glossary of Terms

Advance Care Planning: Using open communication and Advance Directives to plan future care. Advance directives apply **only** when you are unable to make decisions about your medical care.

Advance Directives/Advance Care Directives: Advance Directives are written instructions on how you want future medical decisions made in case you are unable to communicate or make the decisions yourself. The two most common Advance Directives are the health care proxy form and the living will. Advance Directives are used in Advance Care Planning.

Antibiotics: Medications used to fight infections. Used to treat illnesses or relieve symptoms.

Artificial Nutrition and Hydration: When a person can no longer eat or drink, liquid food or fluids can be given by tube.

Capacity: Capacity is the ability to take in information, understand its meaning and make an informed decision using the information. Capacity varies by task. The capacity to choose a trusted individual as an appropriate Health Care Agent differs from the capacity to agree to a medical procedure or treatment.

Cardiopulmonary Resuscitation (CPR): Attempts to restart breathing and the heartbeat of a person who has no heartbeat or has stopped breathing. CPR involves “mouth-to-mouth” breathing and forceful pressure on the chest to restart the heart. Usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation).

Comfort Measures/Comfort Care: Medical care provided with the primary goal of keeping a person comfortable rather than prolonging life. Comfort measures are used to relieve pain and other symptoms.

Frail Elder: An older person who has trouble performing activities of daily living because of weakness or fatigue. Frail elders are vulnerable to acute illness due to low activity level.

Health Care Proxy Form: The form used to designate an “agent” (also called the Health Care Proxy). Your agent makes health care decisions on your behalf **only** if you are unable to make decisions yourself. This is the legal advance directive form in New York State.

Intravenous (IV) fluids: A small plastic tube (catheter) is inserted directly into the vein and fluids are given through the tube.

Intubation/Intubate: Placing a tube down an individual’s windpipe to assist in breathing. Intubation is followed by mechanical ventilation.

Living Will: A form permitting you to state your wishes ahead of time in case you develop a terminal, irreversible condition that prevents you from making and communicating your wishes. Although not a legal New York State form, the Living Will provides the “clear and convincing evidence” needed to have your wishes carried out.

Mechanical ventilation: If a person is unable to breathe, a tube is placed down the throat. The tube is connected to a machine that pumps air into and out of the lungs.

Medical Futility/Medically futile: The treatment is ineffective and does not follow commonly accepted community standards for treatment. It is inconsistent with the person’s preferences or goals of care.

MOLST Form: The MOLST form is a medical order form. MOLST tells others your wishes for life-sustaining treatments. The form is on bright pink paper so it can be easily identified in case of an emergency. You use MOLST when you have a serious health condition.

MOLST Program: The Medical Orders for Life-Sustaining Treatment (MOLST) Program improves the quality of medical care people receive at the end of life by turning patient/resident goals and preferences into medical orders. MOLST is based on communication between the patient/resident, Health Care Agent or other designated decision-maker and health care professionals that ensures informed medical decision-making.

POLST: The Physician Orders for Life Sustaining Treatment was started in Oregon in the early 1990's to improve the quality of medical care provided by turning people's wishes regarding life-sustaining treatments into medical orders. It is the basis for Medical Orders for Life Sustaining Treatment (MOLST).

Tube-feeding: Providing fluids and/or nutrition by way of a tube placed into the stomach or intestines. On a short-term basis, the tube (Nasogastric tube or "NG-tube") is placed into the nose, down the throat and into the stomach. For the long-term, the tube is placed directly into the stomach (Gastric, or "G-tube") or the intestines (jejunal, or "J-tube") by means of a brief surgical procedure.



As part of The Community-Wide End of Life / Palliative Care Initiative,
we are pleased to produce this brochure.

For additional copies of this booklet or the MOLST form, please
contact Customer Service at Excellus BlueCross BlueShield or visit
www.excellusbcbs.com or www.compassionandsupport.org

For more information about this initiative, please contact Dr. Patricia
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websites.

Produced May 2006; Updated September 2006.