



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

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General

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 is 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 communicates 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

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.

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.

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."

Is use of the MOLST form mandatory?

Use of the MOLST form is strongly encouraged but not mandatory. MOLST expands on the DNR order and provides additional orders for life-sustaining treatment and future hospitalization.

As noted by State Health Commissioner Richard F. Daines, M.D., "I congratulate Governor Paterson on signing this bill. This will give patients more choices for end-of-life care. It expands patients' instructions beyond a do-not-resuscitate order into areas of intubation and medication, which many end-stage patients would like to control for themselves as much as possible."

Legal

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.

EMS

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.

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.

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)?

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.

Special Populations

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

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 *who lack capacity* in accordance with Surrogate's Court Procedure Act §1750-B; however, legal counsel should be consulted.

If the patient lacks capacity because of a developmental disability, the concurring opinion regarding capacity determination must be rendered by a physician or psychologist with special experience or training in the field of developmental disabilities. A concurring physician certifies lack of utility of CPR.

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). For residents of OMRDD without capacity in the community, also complete the NYSDOH Nonhospital DNR form.

Additional documentation for DNR orders is required for residents of OMRDD facilities.

Can the MOLST be used for any persons with mental illness?

In the inpatient setting, the MOLST form may be completed by persons with mental illness *with capacity* (capable of making their own decisions).

In the community, the MOLST form may be completed by persons with mental illness *with capacity* (capable of making their own decisions).

If the patient lacks capacity, seek legal counsel.

Additional documentation for DNR orders is required for residents of OMH facilities.

Completion of the MOLST Form

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.

Details of the conversation should be documented in the medical record. Consider using the MOLST chart documentation form.

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.

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.

Should the conversation be documented in the medical record?

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.

Consider using the MOLST chart documentation form.

How does one ensure informed medical decision-making regarding decisions regarding cardiopulmonary resuscitation vs. a DNR order?

Cardiopulmonary resuscitation (CPR) is intended to prevent sudden, unexpected death.

CPR is not indicated in cases of:

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

Studies have shown that physicians speak 75% of the time and use medical jargon. Learn more about survival rates post-CPR, including statistics to keep in mind when having discussions about CPR, the [Myths and Truths of CPR and conversations based on evidence](#).

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.

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.

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.

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.

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 signs the MOLST form. The attending or covering physician signs the order later, in accordance with facility policy.

Can residents (physicians in training) sign a MOLST form that will also serve as a Nonhospital DNR in the pre-hospital setting?

No, unless the resident (physician in training) is a New York State licensed MD. 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 by a New York State licensed MD, at the time of discharge. Residents (physicians in training) who are New York State licensed physicians may sign a MOLST form that will also serve as a DNR in the pre-hospital setting.

Who may sign a MOLST form that serves as both an inpatient and community medical order form if the patient/resident sees a primary care physician who practices outside New York State? (e.g. Patient is a New York State resident but receives care from a physician who is licensed in the state of Vermont?)

If a New York State resident routinely receives care from a physician who is licensed in a border state, that physician may issue the orders on the MOLST form. There are no legal requirements that dictate that only New York State licensed physician can issue orders on the MOLST form.

Consent for Medical Orders

Who provides consent for a Do Not Resuscitate (DNR)/Accept Natural Death order?

Consent for DNR/Accept Natural Death 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

May a patient with capacity provide verbal consent to a DNR order?

Yes. As per Public Health Law §2967(), a patient with capacity can provide verbal consent in the presence of two adult witnesses. If verbal consent is given, one witness must be a physician. In a facility, the physician must be affiliated with the facility. Thus, a resident (physician-in-training) qualifies.

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.

What are the rights of a live-in companion vs. the rights of family when it comes to making medical decisions for that family's parent who is ill?

Consent for health care decisions depends on:

- whether or not the parent has capacity to make decisions, and
- who is chosen as the Health Care Agent and is designated in the Health Care Proxy.

The following applies:

- If the parent has capacity to make decisions, the individual (parent) retains the right.
- If parent has lost capacity to make health care decisions, the decisions fall to the Health Care Agent identified in the Health Care Proxy. A person may have lost the capacity to make health care decisions but may retain the capacity to choose a Health Care Agent (Proxy).
- If the parent has lost capacity to make health care decisions and there is no Health Care Proxy, the only decision covered in the law is a decision re CPR vs. DNR. The surrogate selection is as outlined in Step 4 on the MOLST "Supplemental" Documentation form for Adults.

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.

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.

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.”

Does the MOLST provide “clear and convincing evidence?”

Yes, MOLST does provide “clear and convincing” evidence, as MOLST is completed in consultation with a physician when the patient’s life expectancy is less than a year. Unless the living will provides every treatment that a patient would /would not want under every possible circumstance, facilities are reluctant to determine “clear and convincing” evidence from the document itself. The facilities may ask family, friends and caregivers what the patient would/would not want and, if satisfied, honor the living will. If there is any dissension, however, the facility will take the matter to court.

MOLST provides much **better** proof that the patient holds a firm and settled commitment to the termination of life supports under the circumstances that actually exist when the decision whether to terminate life-sustaining treatment must be made.

If the patient lacks capacity to make health care decisions, can the Health Care Agent and family disagree with clearly written advance directives that provide “clear and convincing evidence?”

The Health Care Agent and family cannot override “clear and convincing” previously expressed wishes. Public Health Law states that when a Health Care Agent is empowered to act, he/she must act either (1) according to the patient’s wishes, if known; or (2) if the wishes are not known, in the patient’s best interest. If the patient has clearly expressed his/her wishes in a living will, the Health Care Agent must honor those wishes.

To learn more about traditional advance directives (i.e. Health Care Proxy and Living Will), view the [Community Conversations on Compassionate Care \(CCCC\) video](#) on-line.

The (CCCC) video aims to motivate healthy individuals to complete traditional advance directives. The program uniquely combines a storytelling approach with “Five Easy Steps” based on Prochaska’s behavioral readiness theory and has been recognized by the National Quality Forum. The video identifies how to choose an effective Health Care Agent.

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. If the conflict still persists, the facility must take legal action.

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. As above, if the conflict still persists, the facility must take legal action.

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 “Supplemental” Documentation Form for Adults 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. Consider using the MOLST chart documentation form.

Medical Orders – Do Not Resuscitate (DNR)/Accept Natural Death, Do Not Intubate (DNI) and Artificial Hydration and Nutrition

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.

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.

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 or in the patient’s best interests 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 a patient/resident opted for a DNR order on the MOLST form when the patient/resident had the capacity to make health care decisions, can the Health Care Agent subsequently rescind the DNR order and make them a full code when they lack capacity?

No. Because a patient loses capacity, the patient does not lose their rights. Presuming the patient had an honest, informative conversation and the patient made an informed decision, completion of the MOLST is an actionable medical order and “clear and convincing evidence of the patient’s wishes. The purpose of MOLST and advance directives is to ensure that the patient’s own wishes are honored. This right comes from the federal Patient Self-Determination Act. An agent, health care provider, or facility may not base a decision based on what they think is the right thing to do.

To avoid such potential conflict, the conversation between the patient and physician should be shared with the Health Care Agent and the family.

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.

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.

How should one approach discussions regarding artificial hydration and nutrition (e.g. feeding tubes)?

In discussions with patients/residents and families, focus on the PATIENT’S OWN values, preferences and beliefs:

- Focus on the underlying disease process as cause of decline and loss of appetite
- Emphasize the active nature of providing comfort care
- Recognize the concerns about “starvation”, inadequate nutrition or hydration and potentially hastening death that many individuals deal with in facing this decision and address these issues
- Clarify that withholding or withdrawing artificial nutrition and hydration is NOT the same as denying food and drink

For further information on the benefits and burdens of tube feedings, view [PEG Tube Feeding Guidelines](#).

Completion of the “Supplemental” Documentation Form for Adults

Does the “Supplemental” Documentation 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 and a DNR order is being issued.

If the patient has capacity, does the Health Care Agent or family have the right to make health care decisions?

No. If the patient has the capacity to make health care decisions, the Health Care Agent or family do not have the right to make health care decisions, unless requested by the patient and that said decisions are consistent with the patient’s values and beliefs.

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.

How does one access 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. Through the process of capacity assessment, the physician must be comfortable that the patient understands the issue and the consents being discussed.

How does capacity vary?

Capacity requirements vary by task. In other words, capacity is task-specific. With regards to advance care planning, capacity assessment includes consideration of several abilities:

- Does the patient have the capacity to choose a Health Care Agent?
- Does the patient have the capacity to make simple health care decisions?
- Does the patient have the capacity to make complicated decisions regarding health care?
- Does the patient have the capacity to refuse life-sustaining treatment?

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

Who determines capacity?

The physician determines capacity.

Under NYS Public Health Law, before issuing a DNR order, a determination of the lack of capacity to consent to a DNR order must be affirmed by a concurring physician for a patient who lacks decision-making capacity and does not have a legal and valid DNR order executed when the patient had decision-making capacity.

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 before issuing a DNR order. The concurring physician does **not** need to be board certified or board eligible in psychiatry.

Remember that capacity requirements vary by task.

The patient with mild dementia may retain the capacity to choose a trusted individual as an appropriate Health Care Agent and may have the capacity to make some but not all health care decisions as described above.

In the situation where the capacity to choose a trusted individual as an appropriate Health Care Agent remains, a Health Care Proxy may be completed and the designated Health Care Agent can then make the health care decisions.

Aside from dementia, what other types of patients may lack decision-making capacity?

Some individuals with mental retardation, developmental disabilities, head injury, delirium or mental illness may lack decision-making capacity.

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

No. A psychiatric consultation is **not** required in all cases to determine decision-making capacity. The physician can determine capacity and should seek consultation **only** if there is a question regarding capacity determination.

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.

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.

Who determines capacity for individuals with mental retardation?

If the individual *lacks capacity* because of mental retardation, the concurring opinion must be provided by a physician or psychologist with special experience or training in the field of developmental disabilities.

Does the supplemental form for adults need to be completed if the patient chooses a CPR order?

No. The supplemental form for adults does not need to be completed if the patient chooses a CPR order. The legal presumption is that all adults want CPR.

How do you complete the “Supplemental” Documentation Form for Adults for MOLST Program?

The “Supplemental” Documentation Form for Adults documents the capacity assessment by the physician. There are nine steps.

Steps 1 – 9

- Steps 1, 2, 4, 6, 8 and 9 are needed in **ALL** cases. These steps include:
 - Step 1: Physician determination of lack of capacity
 - Step 2: Patient/resident notice of the determination that he or she lacks capacity.
 - Step 4: Surrogate selection
 - Step 6: Patient/resident notice of the determination that surrogate has signed a DNR order on the patient/resident’s behalf.
 - Step 8: Physician certification and signature
 - Step 9: Concurring physician certification and signature
 - All patients require concurring physician certification and signature to attest to both lack of utility of CPR and capacity determination
 - Patients with developmental disability require a physician signature to attest to both lack of utility of CPR **and** a physician or psychologist with special experience or training in the field of developmental disabilities to attest to capacity determination.
- Step 5 (Surrogate consent) is not needed on Supplemental form as consent is on MOLST Form. Be sure to complete the subsection of B on page 1 of the MOLST form.
- Step 3 (Physician Determination of lack of utility for CPR) is **not** needed if consent is provided by Health Care Agent (#1 choice in Step 4)
- Step 7 is **only** needed if consent by close friend (#7 choice in Step 4) – signature, name, date

Step 4 – special considerations if surrogate selection choice is:

- # 1 - Step 3 is not needed.
- # 7 - Step 7 is needed.
- # 8 - Section 2B is needed.

Section 2A – meets requirements for therapeutic exception.

- Requires
 - physician signature, name and date
 - concurring physician signature, name and date

Section 2B – meets requirements for medical futility exception and is required if no appropriate surrogate decision-maker is available (surrogate selection in Step #4 is choice #8.)

- Requires
 - physician signature, name and date
 - concurring physician signature, name and date

Section 2C – applies to residents of OMH/OMRDD facilities and meets requirements that must be met by providing documentation of notification of OMH/OMRDD facilities.

- Notify director of A and B
- Include:
 - name of facility notified
 - name of person notified
 - physician signature, name and date

Section 2D – applies to residents of correctional facilities and meets additional requirements that must be met by providing documentation of notification of correctional facilities.

- Notify director of A and B
- Include:
 - name of facility notified
 - name of person notified
 - physician signature, name and date

Do the dates for the consent (section B) by resident/HCA/Surrogate, need to match the MD signature date on section C because the MD is the one that should have determined capacity & spoken with them about the DNR?

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. In this circumstance, the dates for the consent (section B) by resident/HCA/Surrogate will not match the MD signature date on section C.

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.

Does the MD signature on main MOLST form (section C) always need to be dated on or after the date of the concurring physician signature (step 9 on adult supplemental form) when the resident does NOT have capacity?

Not always. The highest person on the surrogate list may consent to a DNR order only after there has been a determination of lack of capacity by the attending physician, with concurrence by another physician. This determination and concurrence must be recorded in the patient's record. Thus, ideally, the MD signature on main MOLST form (section C) will be dated on or after the date of the concurring physician signature (step 9 on adult supplemental form) when the resident does NOT have capacity.

This may not be practical if the patient suffers a cardio-pulmonary arrest before this determination can be made. At the time of the arrest, it would be absolutely clear that the patient lacked capacity and the highest person on the surrogate list could ask the physician to issue a verbal order not to initiate CPR. The circumstances could then be described later in the medical record.

Likewise, if the patient came in comatose or severe end-stage dementia, practicality demands that there is a mechanism for conveying a DNR order when two physicians are not on site and a DNR order is immediately needed and requested by the highest person on the surrogate list.

In that circumstance, the midlevel provider (NP/PA) in joint practice with the attending may assess capacity and complete the 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 and concurring physician sign the order later, in accordance with facility policy.

Consider using the MOLST chart documentation form.

If capacity has been determined and the MOLST Adult Supplemental form is completed at another facility and signed by two physicians or facility documents are available that provide similar documentation, does the MOLST Supplementation Documentation form for Adults need to be completed again.

No. The MOLST Supplementation Documentation form for Adults does not need to be completed again. To further clarify, if

- 1) The patient has been determined by 2 physicians to lack capacity to make health care decisions,
- 2) A DNR order has been issued in the hospital after discussion with the appropriate, surrogate, ensuring the surrogate understands the decision they are making.
- 3) The documentation is complete, and
- 4) There is no change in the patient's capacity (e.g. end stage Alzheimer's Disease),

Complete the MOLST form and check the box Prior form attached in the Consent Subsection of B that refers to surrogates for patients without decision-making capacity. You can obtain a verbal order to confirm the DNR with the physician of record in your facility. 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 and document this process in the medical record on the day of admission.

Completion of the “Supplemental” Documentation Form for Minors

How do you complete the “Supplemental” Documentation Form for Minors for MOLST Program?

The “Supplemental” Documentation Form for Minors documents the capacity assessment by the physician. There are eight steps.

Steps 1 – 8

- Steps 1, 2, 3, 7, and 8 are needed in **ALL** cases include:
 - Step 1: Physician determination of lack of capacity
 - Step 2: Physician determination of lack of utility for CPR)
 - Step 3: Notification of other or non-custodial parent
 - Step 7: Physician certification and signature
 - Step 8: Concurring physician certification and signature
- Step 4 is only needed if the minor is a resident in OMH/OMRDD facility. Notify the director and include:
 - name of facility notified
 - name of person notified
- Step 5: Parent’s/Legal Guardian’s Consent or Step 6: Patient/Resident Consent is based on Step 1: Physician determination of capacity.

Step 5

- If the minor does not have capacity, parent/guardian consent is required. Include:
 - parent/guardian signature, name and date
 - witness signature, name and date
- If verbal consent, witness signature and physician signature suffices

Step 6

- If the minor does have capacity, the patient/resident provides their own consent.

Completed MOLST Form

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.

If a resident in a long term care facility (e.g. nursing home or assisted living facility) or a person resides in their home goes to a physician office, must the original MOLST form accompany them?

Yes. The MOLST form should travel with the individual between care settings.

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.

If an individual travels out of state, should the patient take the MOLST form?

Yes. The MOLST form and information listed in the MOLST LIFE Pack should travel with the patient.

What is a MOLST LIFE Pack?

The MOLST LIFE Pack is the MOLST Life Information Forms in case of Emergency (Life) Pack. The MOLST LIFE Pack contains a uniform set of personal health information and medical orders that is available and accessible in the event of an emergency.

What does the MOLST LIFE Pack contain?

The MOLST LIFE Pack contains the following forms:

- Medical Orders for Life Sustaining Treatment (MOLST)
- Health Care Proxy
- Medical Problem List
- Medication List
- Recent Hospital Discharge Summary, if available
- Recent EKG, if available and pertinent
- Emergency Contact List
 - Primary Physician and Specialists
 - Preferred Hospital
 - Family/Friends

To obtain copies of the MOLST LIFE Pack forms, go to www.compassionandsupport.org.

Keep the original MOLST form in the MOLST LIFE Pack as you travel to different care settings. At home keep the MOLST LIFE Pack on the refrigerator door, by the phone in the kitchen, or by your bedside.

Reviewing and Renewing the MOLST

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.

Can a Health Care Agent request a change in the MOLST?

Yes. The MOLST form should be reviewed if there is a substantial change in the person's health status (improvement or deterioration). If the patient lacks capacity to make health care decisions, the Health Care Agent should be consulted.

The Health Care Agent can act in the same capacity as a patient and is obligated to make sound informed decisions. Public Health Law provides for a Health Care Agent to interpret the advance directive, but it also clearly states that the Health Care Agent must abide by the advance directive and not override it. Thus, the Health Care Agent cannot override clear and convincing previously expressed wishes.

Can the Review and Renewal of medical orders on the MOLST form be signed by a mid-level provider (NP or PA) or must the physician sign the review of the MOLST?

The review and renewal of orders meets the requirements of NYS Public Health Law re DNR orders and requires a physician signature.

Since patient/resident goals for care often change over time, a change in treatment preferences often results in a change in the medical orders for life-sustaining treatment and future hospitalization.

Interpretation of the MOLST Form

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.

If a completed MOLST form is present upon admission or transfer to a health care facility, should the MOLST be honored if the physician who signed the MOLST orders does not have privileges at the facility where the patient is transferred?

Yes. As indicated on the MOLST form, "When the need arrives, first follow these orders, then contact physician." Once the patient stabilizes, the entire MOLST is reviewed and medical orders are renewed as the patient/resident is transferred from one facility to another, presumably because there is a substantial change in the person's health. This review is done by a physician who has facility privileges.

This process is similar to a DNR order that is transferred from a long term care facility to the Emergency Department of a hospital in the event of an emergency. These DNR orders are effective immediately.

If a patient chooses to have a DNR order issued but would still accept all other life-sustaining treatment and that patient suffers a choking episode unresponsive to the Heimlich maneuver and patient suffers a cardiopulmonary arrest, should chest compressions be initiated?

No. If a patient chooses to have a DNR order issued but would still accept all other life-sustaining treatment and that patient suffers a choking episode, the Heimlich maneuver should be attempted. If the Heimlich fails and the patient suffers a cardiopulmonary arrest (no pulse, no blood pressure and no respiration), respect the patient's request for a DNR order. Chest compression and CPR should not be initiated.

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

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

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 actionable 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.

What are the Legal requirements for withholding or withdrawing artificial hydration and nutrition (e.g. feeding tubes)?

For patients/residents with capacity, the usual standards of informed consent (or refusal) apply.

For patients/residents without capacity, the challenge is to make the decision according to the individual's wishes, or if not known, in the individual's best interest. Mechanisms to do this include:

- A health care "agent," as properly appointed on a health care proxy form when the individual had capacity is legally empowered to make decisions regarding withholding or withdrawing tube feeding based on "reasonable knowledge" of the individual's wishes. One way to achieve this is for the Health Care Proxy form to indicate that the Health Care Agent "knows my wishes, including those regarding artificial hydration and nutrition."
- If there is no formally designated health care agent, the legal standard for withholding or withdrawing a feeding tube is "clear and convincing evidence" of the patient's wishes. A prior written statement about feeding tubes or artificial nutrition in a Living Will, or clear prior oral statements by the patient about his or her wishes provides "clear and convincing evidence."
- Such "clear and convincing evidence" may be provided by family members, close friends, health care professionals, caregivers, or others who have had close contact with the individual.
- **MOLST can be used now ANYWHERE in New York State to provide "clear and convincing evidence" of a patient's wishes regarding withholding or withdrawing life-sustaining treatment, including tube feeding, provided the section addressing these issues is completed in advance, after discussions with the patient's physician.**

If there is no health care agent and no clear and convincing evidence of an individual's wishes, the facility must begin a court action.

In all clinical situations, focus on honest conversation and sound medical decision-making.

MOLST in Minors

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.

Will the MOLST be honored for children with terminal illnesses?

Yes. The MOLST will be honored for children with terminal illnesses.

Will the MOLST be honored in schools as well?

Yes. The MOLST will be honored in schools and all other community settings.

Must a copy of the MOLST form be with the child and/or on file in the school if some sentinel event were to occur while the child is in school, on a school bus or on a school sponsored event/trip?

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

Thus, a copy of the MOLST form should be with the child and/or on file in the school if some sentinel event were to occur while the child is in school, on a school bus or on a school sponsored event/trip

Practical Questions

Where can I get MOLST forms?

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

Excellus BlueCross BlueShield is offering the forms free-of-charge to the New York State community. MOLST forms can be ordered by downloading the Educational Resource Order Form found at the MOLST Training Center at www.CompassionandSupport.org. Follow the directions found on the form. Use the process outlined on most recent form at the website.

How can I learn more about the MOLST Program?

View the MOLST DVD, read the MOLST FAQs and explore [CompassionandSupport](http://CompassionandSupport.org), the community Web site that serves as the repository for information on the MOLST program, particularly the [MOLST Training Center](#).

The MOLST DVD was produced to educate and empower patients and families and serve as a standardized training tool for professionals.

It includes 2 videos and 3 refresher videos:

- “Writing Your Final Chapter: Know Your Choices...Share Your Wishes” is designed to inform patients, families and professionals about MOLST.
- “Honoring Patient Preferences: The Role of Medical Orders for Life-Sustaining Treatment (MOLST) in New York State”, an educational video for professionals, provides the core curriculum on MOLST.

Healthcare professionals can earn a maximum of 2.0 free educational credit hours by viewing both videos and completing the MOLST DVD posttest. Follow the simple steps on the [MOLST Training Video](#) page.

Professionals are encouraged to share the MOLST DVD with seriously ill patients and their families. The videos and additional information can also be viewed at the [MOLST Training Center](#).

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 a properly completed 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.

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.

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 two copies of the MOLST form. An original MOLST is kept in the home to be available in the event of an emergency; the second copy is kept in the physician's record.

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.

If the patient is seen in the home by the hospice nurse and the MOLST program is initiated, the nurse initiates two MOLST forms and obtains verbal orders, in accordance with community policy. Verbal orders are acceptable, in accordance with community policy. The MOLST form with signed verbal orders should remain in the patient's home. The orders should be faxed to be cosigned by an attending physician within a specified brief period of time, in accordance with community policy. The signed MOLST form is returned to the patient's home at the time of the next nurse visit. A copy of the signed MOLST form is retained in the Hospice patient record.

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. Since the MOLST form can now be substituted for the Nonhospital DNR, as per NYS PHL§2977, the center will now consider the MOLST. If there is a DNR from a hospital or nursing home to the ESRD then the hospital form may or may not be honored.

If a facility completes a Quality Audit focusing on accurate completion of the MOLST and Supplemental forms and finds forms fail to have properly completed section on consent for Life-Sustaining Treatment and Future Hospitalization, what should a facility do?

The facility should validate that appropriate consent was initially obtained and get consent, signature and date consent. The orders should be reviewed by the physician and the physician should sign the review/renew section of the MOLST form and document a note in the chart.

The note should indicate that the MOLST form lacked consent signatures and dates were found as part of MOLST Quality Assurance Audit. Indicate the original consent was obtained and valid. If there is no change in the orders or only additions, this can be documented on the review form; if there is substantial change, a new MOLST may be needed. A note of this nature explains the reason for the difference in the dates for the orders and the consent.

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.