Honoring Choices Massachusetts   Minuteman Senior Services

Things to Know about MOLST and CC/DNR

A Conversation with Mary A. Valliere, MD,
Clinical Consultant Massachusetts MOLST Expansion Project

1. What is Medical Orders for Life Sustaining Treatment also known as "MOLST"?

MOLST is a medical document that communicates your decisions about life-sustaining treatments to your care providers. It's like a prescription from your doctor that gives medical orders to the rest of your health care team (doctors, nurses, EMTs).The MOLST form tells the care team that you and your doctor or care provider have discussed your current medical condition and the role of life-sustaining treatments, and that you made decisions about the treatments you want or do not want and documented those decisions on the MOLST form. Anyone involved in your care will follow the MOLST form and honor your choices.

2. What is on the MOLST form?

The MOLST form, which is attached, is a one page document that has a front side and a back side.

The *front side* lists three life-sustaining treatment decisions often made in emergency situations: *1).* whether or not to be resuscitated in the event that your heart stops, *2).* whether or not you want to have ventilation (help with breathing), and *3).* whether or not you want to be transported to the hospital. You write down your decisions about each so the emergency medical team can look at the form and know the care you want.

The *back side* of the MOLST form lists other life-sustaining treatment decisions where you document your preferences and choices regarding ventilation, dialysis, artificial nutrition and artificial hydration. This information is important for the health care team when you reach the emergency room or a hospital. They will read the back of the MOLST form and follow your specific decisions.

3. Who can use a MOLST form and how does it work?

The MOLST form is not for everyone. It is appropriate to use if you have an advanced illness, and you reach a point in your illness where your doctor would not be surprised if you died in the next year. Your doctor or care provider will talk to you about the kinds of treatments you may or may not want to be attempted as your disease progresses. You will make decisions about the treatments and document them on the MOLST form. Both you and your doctor or care provider sign the form. You keep the original MOLST form and take it with you when you go to different care setting (hospitals, nursing facilities, etc).

4. Can patients ask their doctor or care providers about completing a MOLST form?

Yes. You can simply ask, "Is it time to talk about life-sustaining treatments and write down my decisions in a MOLST form?" Your doctor or care provider, who knows the clinical progression of your illness, might respond that it is not yet time, or agree that it is the right time to start to a MOLST conversation. The MOLST form is not designed for patients to fill out on their own. Your doctors and care providers will have a copy of the MOLST form to use after your discussion about life-sustaining treatments.

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5. What happens after the MOLST form is completed?

After the MOLST form is filled out and signed, the original form stays with the patient to be shared with the next person on the health are team. The MOLST form acts like a baton. For example, if a doctor sees you in the emergency room and you have a conversation about your life-sustaining treatments decisions, you can fill out the MOLST form to reflect how far you got in your conversation. You keep the original form and take it to the next health care provider, for example, your primary care doctor, to say "this is how far we got and I'd like to pick up the conversation with you."

6. Can a patient change the decisions he or she made on the MOLST form?

Yes. The MOLST form is the patient's property and can be updated, changed or even canceled. The form is intended to be changed as your health care needs and your decisions for care change overtime.

7. What is the difference between the MOLST form and a Comfort Care/Do Not Resuscitate Verification Form (CC/DNR)?

The Comfort Care/Do Not Resuscitate Verification Form (CC/DNR) was created as a quick communication tool for emergency medical teams (EMT) coming to your residence in an emergency, which verifies for the EMT that you had a conversation with your physician and there is a Do Not Resuscitate medical order in effect. Only EMTs are obligated to follow the CC/DNR form; other licensed health care professionals are not. The CC/DNR form only documents one decision- Not to be resuscitated if your heart or breathing stops.

The MOLST form gives you the choice to decide: yes, I do want to be resuscitated or no, I do not want to be resuscitated. MOLST also lets you document your preferences and choices about a range of other life-sustaining treatments that could be attempted in the course of your illness.

8. Which form should I use, MOLST or CC/DNR?

MOLST is considered a more advanced version and will someday replace the CC/DNR form. While both documents are valid, the recommendation in the state is not to create new CC/DNR forms, but to honor the forms for people who already have a CC/DNR. Doctors are beginning to use MOLST forms in place of CC/DNR forms because MOLST is a better tool to communicate treatment decisions.

Read more about MOLST at www.molst-ma.org

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MOLST Sample Form – Page 1

MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT (MOLST) www.molst-ma.org

Patient's Name ______________________________

Date of Birth ________________________________

Medical Record Number if applicable: ___________

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

→ This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the signing clinician.
→ Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
→ If any section is not completed, there is no limitation on the treatment indicated in that section.
→ The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A Mark one circle →	**CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest** O Do Not Resuscitate O Attempt Resuscitation
B Mark one circle → Mark one circle →	**VENTILATION: for a patient in respiratory distress** O Do Not Intubate and Ventilate O Intubate and Ventilate O Do Not Use Non-invasive Ventilation (e.g. CPAP) O Use Non-invasive Ventilation (e.g. CPAP)
C Mark one circle →	**TRANSFER TO HOSPITAL** O Do Not Transfer to Hospital (*unless needed for comfort*) O Transfer to Hospital
PATIENT or patient's representative signature **D** *Required* Mark one circle and fill in every line for valid Page 1.	**Mark one circle below to indicate who is signing Section D:** o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. ***A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*** X________________________ ________________ Signature of Patient (or Person Representing the Patient) Date of Signature ________________________ ________________ Legible Printed Name of Signer Telephone Number of Signer
CLINICIAN signature **E** *Required* Fill in every line for valid Page 1.	Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D. X________________________ ________________ Signature of Physician, Nurse Practitioner, or Physician Assistant Date and Time of Signature ________________________ ________________ Legible Printed Name of Signer Telephone Number of Signer
Optional Expiration date (if any) and other information	This form does not expire unless expressly stated. *Expiration date (if any) of this form:* ______________ Health Care Agent Printed Name ______________________ Telephone Number ___________ Primary Care Provider Printed Name ______________________ Telephone Number ___________

SAMPLE

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.
HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

Approved by DPH   August 10, 2013   MOLST Form Page 1 of 2

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MOLST Sample Form – Page 2

Patient's Name: ____________________ Patient's DOB __________ Medical Record # if applicable________________

F	Statement of Patient Preferences for Other Medically-Indicated Treatments		
	INTUBATION AND VENTILATION		
Mark one circle →	○ Refer to Section B on Page 1	○ Use intubation and ventilation as marked in Section B, but short term only	○ Undecided ○ Did not discuss
	NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)		
Mark one circle →	○ Refer to Section B on Page 1	○ Use non-invasive ventilation as marked in Section B, but short term only	○ Undecided ○ Did not discuss
	DIALYSIS		
Mark one circle →	○ No dialysis	○ Use dialysis ○ Use dialysis, but short term only	○ Undecided ○ Did not discuss
	ARTIFICIAL NUTRITION		
Mark one circle →	○ No artificial nutrition	○ Use artificial nutrition ○ Use artificial nutrition, but short term only	○ Undecided ○ Did not discuss
	ARTIFICIAL HYDRATION		
Mark one circle →	○ No artificial hydration	○ Use artificial hydration ○ Use artificial hydration, but short term only	○ Undecided ○ Did not discuss
	Other treatment preferences specific to the patient's medical condition and care ____________________		

SAMPLE

PATIENT or patient's representative signature **G** *Required* Mark one circle and fill in every line for valid Page 2.	Mark one circle below to indicate who is signing Section G: o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section H signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. ****A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*** X ____________________ Signature of Patient (or Person Representing the Patient) — ____________ Date of Signature ____________________ Legible Printed Name of Signer — ____________ Telephone Number of Signer
CLINICIAN signature **H** *Required* Fill in every line for valid Page 2.	Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G. X ____________________ Signature of Physician, Nurse Practitioner, or Physician Assistant — ____________ Date and Time of Signature ____________________ Legible Printed Name of Signer — ____________ Telephone Number of Signer

Additional Instructions For Health Care Professionals

→ Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.

→ Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. *If no new form is completed, no limitations on treatment are documented and full treatment may be provided.*

→ Re-discuss the patient's goals for care and treatment preferences as clinically appropriate to disease progression, at transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences.

→ The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment. ****A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.***

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