

Massachusetts Medical Orders for Life Sustaining Treatment (MOLST)

Prepared by the Center for Developmental Disabilities Evaluation
and Research (CDDER) on behalf of the Massachusetts
Department of Developmental Services (DDS)



MOLST Training

This training pertains only to Massachusetts laws and practices. Forms and policies may vary from state to state.

Training developed by Center for Developmental Disabilities
Evaluation and Research on behalf of Massachusetts
Department of Developmental Services.





Plan Ahead

Choices are planned in the person's best interests.

MOLST

What is MOLST?

- * **Medical Orders for Life Sustaining Treatment**
- * Signed by the person or legally authorized representative and medical provider
- * Placed in a person's medical record
- * Appropriate only for a person facing a life-threatening condition or very serious life limiting illness



MOLST vs. DNR

- * **Do Not Resuscitate** is part of the MOLST
- * The MOLST form includes other options, such as requests to withhold dialysis or artificial ventilation



When Can DNR be Considered ?

“In order for DNR orders to be consistent with this Policy, one or more of the following conditions or health states must exist.”

- * Life threatening illness or injury*
- * Chronic progressive disease*
- * Dementia*
- * Serious chronic health condition that requires or will require advanced medical interventions*
- * Any “advanced” debilitating disease process*



When Can a MOLST be Considered?

- * MOLST should only be considered for someone who faces a serious condition
- * The DDS Life Sustaining Treatment policy states that “A MOLST shall not be executed for someone who is not seriously ill or near end-of-life”



Section A: Cardio-Pulmonary Resuscitation (CPR)

**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

Do Not Resuscitate

Attempt Resuscitation

IMPORTANT

A DNR order does not mean that other treatments, such as for relief from pain or respiratory distress, would be withheld



Section B: Ventilation

**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	CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest	
Mark one circle →	<input type="radio"/> Do Not Resuscitate	<input type="radio"/> Attempt Resuscitation
B	VENTILATION: for a patient in respiratory distress	
Mark one circle →	<input type="radio"/> Do Not Intubate and Ventilate	<input type="radio"/> Intubate and Ventilate
Mark one circle →	<input type="radio"/> Do Not Use Non-invasive Ventilation (e.g. CPAP)	<input type="radio"/> Use Non-invasive Ventilation (e.g. CPAP)



Section B:

Do Not Intubate or Ventilate

- * This means you would NOT insert a breathing tube in the person's airway either through their mouth or nose or to create a surgical opening directly into the person's airway
- * This would not prohibit you from attempting non-invasive measures if the person has indicated that as a choice



Section B: Intubate or Ventilate

- * This means you would insert a breathing tube via any means deemed necessary to provide artificial breathing to the person in respiratory distress
- * This could include a surgical procedure, such as tracheostomy



Do Not Use Non-Invasive Ventilation (Such as CPAP)

- * This means that no ventilation method, including continuous positive airway pressure (CPAP), would be used if the person experiences respiratory distress



Use Non-Invasive Ventilation (Such as CPAP)

- * This means that you would only use a non-invasive ventilation method, such as continuous positive airway pressure (CPAP) if the person experiences respiratory distress
- * This does not allow more invasive ventilation measures, such as tracheotomy or intubation
- * Non-invasive measures allow the person to swallow, speak and move around freely



Important Note

- * If a person stops breathing due to choking on food or other item lodged in the airway, you **WOULD** implement measures to clear the airway and begin airflow
- * The Ventilation options on the MOLST form pertain only when the person experiences respiratory distress



Section C: Transfer to Hospital

C

TRANSFER TO HOSPITAL

Mark one circle →

Do Not Transfer to Hospital (*unless needed for comfort*)

Transfer to Hospital



Signatures for Side 1

<p>PATIENT or patient's representative signature</p> <p>D Required</p> <p>Mark one circle and fill in every line for valid Page 1.</p>	<p>Mark one circle below to indicate who is signing Section D: <input type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor</p> <p>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. <i>*A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i></p> <p>X _____ Signature of Patient (or Person Representing the Patient) Date of Signature</p> <p>_____ _____ Legible Printed Name of Signer Telephone Number of Signer</p>
<p>CLINICIAN signature</p> <p>E Required</p> <p>Fill in every line for valid Page 1.</p>	<p>Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.</p> <p>X _____ Signature of Physician, Nurse Practitioner, or Physician Assistant Date and Time of Signature</p> <p>_____ _____ Legible Printed Name of Signer Telephone Number of Signer</p>



Who Can Sign Section D?

- * A legally competent and capable person may sign their MOLST order
- * A person's legal guardian may consent ONLY if the guardianship has been expanded to give them the authority to sign end of life orders
- * However, an involved family member who is also the guardian, may sign Section D without expanded authority - but only for a DNR order
- * A person's health care agent may sign if a physician has activated the Health Care Proxy
- * In Massachusetts, this form must also be sent to the DDS area office nurse
- * When the MOLST is signed by a guardian, the form must be reviewed by the DDS Regional Attorney to verify guardianship status



Who Can Sign Section E?

- * A medical provider signs Section E
 - * Doctor
 - * Nurse Practitioner
 - * Physician's Assistant



Final Details for Side 1

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 _____

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



Section F

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

Undecided

Use dialysis, but short term only

Did not discuss

ARTIFICIAL NUTRITION

Mark one circle →

No artificial nutrition

Use artificial nutrition

Undecided

Use artificial nutrition, but short term only

Did not discuss

ARTIFICIAL HYDRATION

Mark one circle →

No artificial hydration

Use artificial hydration

Undecided

Use artificial hydration, but short term only

Did not discuss

Other treatment preferences specific to the patient's medical condition and care _____

Side 2 Signatures

<p>PATIENT or patient's representative signature</p> <p>G Required</p> <p>Mark one circle and fill in every line for valid Page 2.</p>	<p>Mark one circle below to indicate who is signing Section G:</p> <p><input type="radio"/> Patient <input type="radio"/> Health Care Agent <input type="radio"/> Guardian* <input type="radio"/> Parent/Guardian* of minor</p> <p>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. <i>*A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.</i></p> <p>Signature of Patient (or Person Representing the Patient) _____ Date of Signature _____</p> <p>_____ Legible Printed Name of Signer _____ Telephone Number of Signer _____</p>
<p>CLINICIAN signature</p> <p>H Required</p> <p>Fill in every line for valid Page 2.</p>	<p>Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G.</p> <p>Signature of Physician, Nurse Practitioner, or Physician Assistant _____ Date and Time of Signature _____</p> <p>_____ Legible Printed Name of Signer _____ Telephone Number of Signer _____</p>



Additional Directions for Health Care Professionals

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.***



LST Case Referral Protocol: Review of Forms

- * If a MOLST form is completed for a person receiving DDS services, it must be immediately sent to the DDS Area Office Nurse for review
- * The AO Nurse completes the checklist and sends both the MOLST form and checklist to the DDS Regional Attorney for review
- * If signed by a guardian or health care agent, it must be reviewed by the Regional Attorney
- * If there are any questions about the validity or appropriateness of the MOLST, it must be reviewed by the Regional Attorney

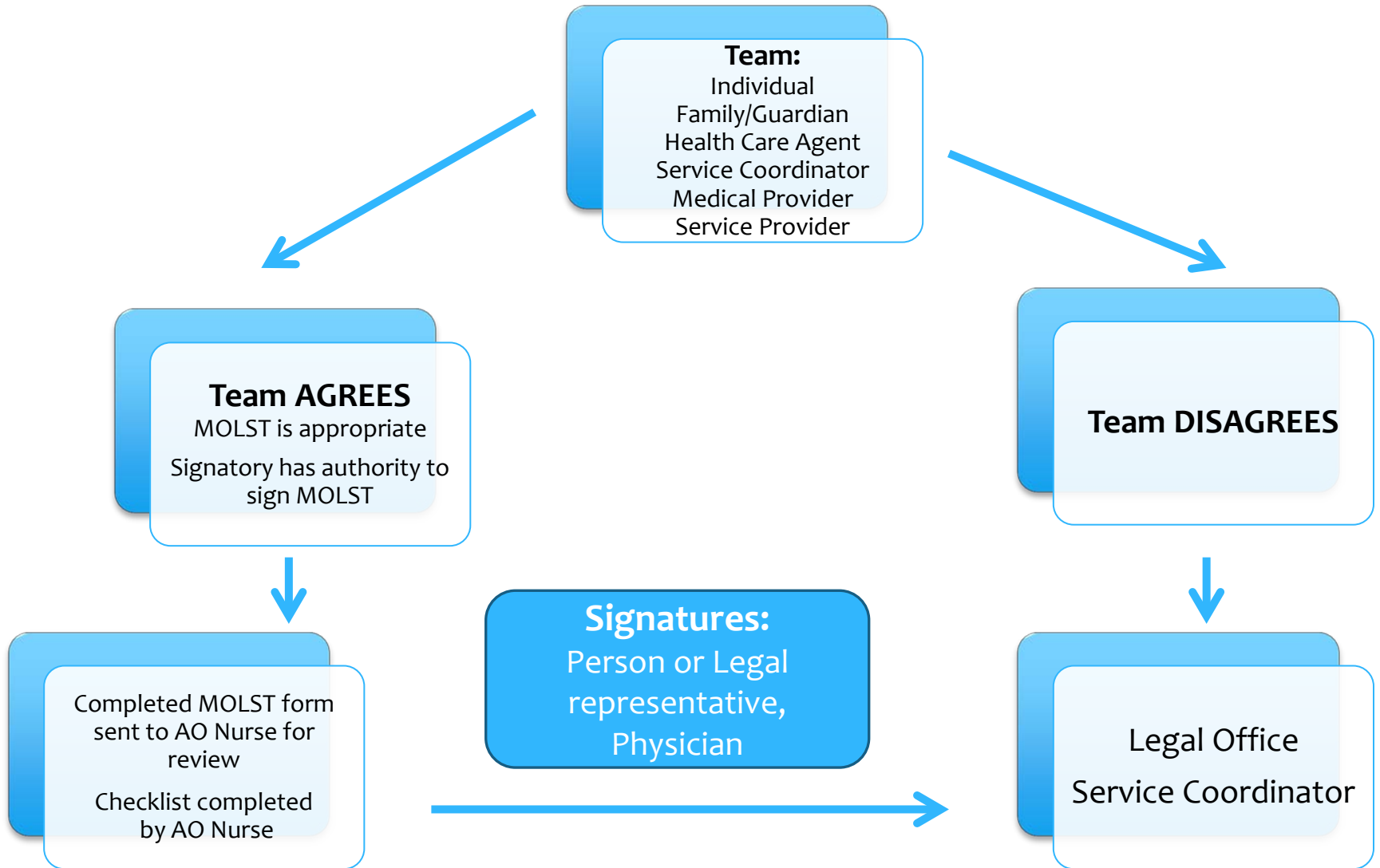


LST Case Referral Protocol: People Who are Seriously Ill or Hospitalized

- * When someone becomes seriously ill, injured or brought to the hospital in such a condition, notify the family, if not already aware, and the supervisor or area director
- * Check legal status as to ability to consent, guardianship status, existence of health care proxy, MOLST, DNR, or DNI
- * Verify legal status with Regional Attorney
- * Gather and share information about the person's condition and attending medical personnel
- * Regional Attorney will consult with General Counsel about all LST decisions
- * No decisions to withhold/withdraw LST or to accept or refuse LST will be made without consent of General Counsel



Implementation Process





MOLST CHECKLIST

Massachusetts Department of Developmental Services

Date Received: _____

Reviewed by: _____

Individual Name: _____ Individual D.O.B: _____

The Massachusetts MOLST form is a MA DPH-approved standardized medical order form for use by licensed Massachusetts's physicians, nurse practitioners and physician assistants. The Area Office Nurse should complete this checklist when a MOLST form is submitted from a provider within 7 days. Please review the case and the MOLST form with the provider, family and/or guardian and individual for accuracy, appropriateness and completion. Then forward the Checklist and the MOLST Form to the Regional legal office for final determination with a copy to the Service Coordinator.

Please check all that apply

- _____ This is a standardized MOLST form that has not be altered in any way
- _____ The MOLST form is printed on bright or fluorescent pink paper (Astrobrights[®] Pulsar Pink is highly recommended)
- _____ The MOLST form (pages 1 and 2) are printed as a double-sided document on a single sheet of paper
- _____ The MOLST form is signed by a physician, nurse practitioner or physician assistant

All items must be checked for the attached MOLST to meet DDS requirements

- _____ The attached MOLST form meets all DDS requirements. Why?

- _____ The attached MOLST form does NOT meet all DDS requirements. Why?

Who Else Gets the Form?

- * Ensure other family and staff know about the form
- * The form is printed on **bright pink paper** and keep it visible in the person's home. That way, emergency responders can find it easily and follow the order

A close-up photograph of the bright pink form. The form is titled "MEDICAL ORDER" and contains various sections for patient information, medical history, and treatment orders. It includes fields for name, date of birth, and medical history, as well as checkboxes for various medical conditions and treatments. The form is printed on bright pink paper.

A Few Final Notes

- * **End of life or DNR orders for individuals under care of the DDS must be reviewed at least annually.** Treatment decisions are based on how you and the team believe *the person* would want to be treated *if he or she could consent*
- * Decisions are made with input from the medical team, the provider, and the person – as much as he or she is able
- * Consider the religious and cultural background of the person
- * The order can be changed at any time



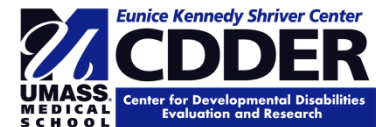
Thank You



Resources

For more information, visit

www.molst-ma.org



Additional Webinars

- * Guardianship and Aging in Intellectual Disability, Part I & Guardianship and Aging in Intellectual Disability, Case Studies Part II
- * Life Sustaining Treatment Policy
- * Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST)
- * End of Life Definitions



Additional Resources

Massachusetts Department of Developmental Services (DDS)
www.mass.gov/eohhs/gov/departments/dds/aging-with-id.html

Center for Developmental Disabilities Evaluation & Research
http://shriver.umassmed.edu/cdder/aging_idd_education



***Training produced by the
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on behalf of the

***Massachusetts Department of Developmental
Services (DDS)***

