Maryland MOLST
Medical Orders for Life-Sustaining Treatments

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Objectives
1. Review background for MOLST
2. Discuss order form and process
3. Review next steps

What is Maryland MOLST?
• Standardized medical order form covering cardiopulmonary resuscitation (CPR) and other life-sustaining treatments (LST)
• Order valid across all health care settings and community
• Completed by MDs or NPs
• Based Maryland Health Care Decisions Act
• Original start date 10/1/11, now TBD
How fits into existing process?

• Combines/replaces MIEMSS DNR order form and LSTO form
• Guides EMS and care in various settings
• Old forms still valid

Benefits?

• Consolidates important information into orders valid across settings
• Standardizes definitions
• Lists options
• Increases likelihood patient’s wishes honored

Based on?

• Patient’s wishes and goals (or substitute decision maker)
• Current medical situation/prognosis
• Potential treatment options
• Determination of medical ineffectiveness
Who completes MOLST?

- Physician or NP.
- Before signing, provider must validate accuracy orders.
- Do not pre-sign any blank order forms.

Form

- 2 pages
- Sections
  - Certification for basis of orders
  - CPR options
  - Other treatments
    - Artificial ventilation
    - Hospital transfer
    - Antibiotics
    - Dialysis
    - Blood transfusion
    - Medical workup
    - Fluids/nutrition
    - Other

What is certification for orders?

- Certify that orders based on:
  - Instructions in patient’s advance directive;
  - Certification by 2 physicians that CPR and/or other LST medically ineffective.
What is basis of orders?

- Provider is certifying that order is entered as result of discussion with and informed consent of:
  - The patient, or
  - The patient's health care agent as named in advance directive, or
  - The patient's surrogate, or
  - The patient's guardian of person, or
  - If the patient is a minor, the patient's parent or legal guardian.

What is an Advance Directive?

Written or electronic document or oral directive that:

1. Appoints health care agent to make health care decisions (health care proxy) - and/or
2. States patient's intentions about medical treatments when patient no longer has capacity (living will)

Is Advance Directive a medical order?

- No
- MOLST form may be completed to document orders that reflect patient's wishes in Advance Directive.
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**Does MOLST cover process of making health care decisions?**

- No
- MOLST is order form and end point health care decision making process.

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**Box 1 First Option: Attempt CPR**

- Attempt CPR if cardiac or pulmonary arrest occurs.
- Note: If patient/authorized decision maker declines or unable to make selection, CPR will be attempted as medically indicated.
- Default = Attempt CPR

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**Box 1: No CPR Options**

- **No CPR, Option A-1, Intubate:** Comprehensive efforts to prevent arrest
- **No CPR, Option A-2, Do Not Intubate:** Comprehensive efforts to prevent arrest. Do not intubate, but use CPAP or BiPAP (DNI)
- **No CPR, Option B: Palliative and supportive care only (DNR/DNI)**
### Other Options/Boxes

- Artificial ventilation
- Blood transfusion
- Hospital transfer
- Medical workup
- Antibiotics
- Fluids/nutrition
- Dialysis
- Other

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### Box 2: Artificial Ventilation Options

2a. Accept artificial ventilation indefinitely, including intubation, CPAP, and BiPAP
2b. Time-limited trial intubation
2c. Time-limited trial CPAP and BiPAP, but no intubation
2d. No artificial ventilation: No intubation, CPAP, or BiPAP

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### Box 3: Blood Transfusion Options

3a. Accept transfusion of blood products
3b. No blood transfusions
Box 4: Hospital Transfer Options

4a. Accept transfer to hospital
4b. Hospital transfer only for limited situations, ie severe pain or symptoms that cannot be controlled otherwise
4c. No hospital transfer, but treat with options available outside of hospital

Box 5: Medical Test Options

5a. Accept any medical tests
5b. Limited medical tests when necessary for symptomatic treatment/comfort
5c. No medical testing for diagnosis or treatment

Box 6: Antibiotic Options

6a. Accept antibiotics
6b. Limited use oral antibiotics
6c. Antibiotics for symptoms only
6d. No antibiotics
Box 7: Artificially Administered Fluids and Nutrition Options

7a. Accept artificial fluids and nutrition indefinitely
7b. Accept time-limited trial artificial fluids and nutrition
7c. Accept time-limited trial artificial hydration only
7d. No artificial fluids or nutrition

Box 8: Dialysis Options

8a. Accept dialysis
8b. Accept time-limited trial dialysis
8c. No dialysis

Box 9: Other Orders

- Blank lines
- Indicate preferences for other LST, i.e., chemotherapy, radiation, surgery
- Not used to indicate “comfort care” or “slow code”
Who may discuss life-sustaining issues with patients?

- Physicians, NPs, other health care professionals.
- However, only physician or NP sign MOLST order form and accountable for content.

When do LST conversations occur?

- Ideally, at routine medical visits
- Whenever serious illness diagnosed
- Whenever health/functional status changes
- When we bring up
- Document in medical chart

What is standard of care for LST discussions?

- If patient currently has or is likely to develop condition that may require LST now or in the future, that treatment should be discussed.
- Examples
  - Dementia and artificial feeding/hydration
  - COPD and intubation
  - ESRD and dialysis
  - Cancer and palliative chemotherapy/radiation, etc
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Can You and Your Loved Ones Answer These Questions?

1. On a scale of 1 to 5, where do you fall on this continuum?

1 2 3 4 5

Let me die without medical intervention

Don’t give up on me no matter what, try any medical treatment possible

2. If there were a choice, would you prefer to die at home or in a hospital?

3. Could a loved one correctly describe how you’d like to be treated in case of a terminal illness?

4. Is there someone you trust whom you’ve appointed to speak on your behalf when the time is near?

5. Have you completed any of the following: a living will, an advance directive, appointed a healthcare power of attorney?

6. Do you have a copy of your MOLST form?

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5 Wishes

1. The person I want to make care decisions for me when I can’t

2. The kind of medical treatment I want or don’t want

3. How comfortable I want to be

4. How I want people to treat me

5. What I want my loved ones to know

http://www.agingwithdignity.org/forms/5wishes.pdf

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Goals of Medical Care

• Central to medical decision-making.
  • “If you don’t know where you are going, you will end up somewhere else.” Y Berra

• Four primary goals of medical treatment:
  – Cure
  – Rehabilitation
  – Prolonging life
  – Comfort/symptom management
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Tips for Conversations

• Focus on goals, not treatments
• Present as routine
• Make recommendations judiciously
• Be supportive
• May take several attempts

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Legal requirements for MOLST?

• MOLST must be completed, or existing form reviewed, when patient admitted:
  1. Nursing home
  2. Assisted living facility
  3. Home health agency
  4. Hospice
  5. Kidney dialysis center

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All Hospitalized Patients…

• Transferred to another facility (nursing home, assisted living facility, home health agency, hospice, and kidney dialysis center) must have completed MOLST.
• Who have limitations on cardiopulmonary resuscitation must have a completed MOLST upon discharge.
• Any hospitalized patient may request MOLST.
What happens when patient discharged or transferred?

- MOLST shall accompany patient when transferred to new facility.
- Medics shall take copy or original MOLST form when patient transported.
- Transferring facility or program should keep original or copy of MOLST in medical record.

Is photocopy of MOLST valid?

- Both original and copies MOLST valid.
- Fax acceptable.
- Within 48 hours of completion, patient or substitute decision maker shall receive copy MOLST form.

If patient/decision maker declines?

- If CPR choice not made, default is Attempt CPR
- If choices regarding other LST not made, LST will be offered when medically indicated
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Does choice have to be made in each section?

• Box 1, CPR status, must be completed for everyone.
• Boxes 2-9 only completed if patient or substitute decision maker makes selection.
• Other parts can be left blank or line drawn through.

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Must MOLST be witnessed?

• No, MOLST not an advance directive so not witnessed.

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Is adherence to an order on MOLST mandatory in all settings?

• Yes, MOLST order written in one setting in effect in that and subsequent settings unless voided.
• Even if provider who signed order not on staff at current facility, orders valid and shall be honored.
How are MOLST orders changed?

- Choices can be updated, revised, or rescinded any time by competent patient or authorized decision maker.

How is MOLST revised or voided?

- Changes to MOLST should be voided by drawing single diagonal line across page, then signing/dating.
- Voided order form shall be kept in medical record.
- New MOLST should be completed.

When should MOLST orders be reviewed?

1. When patient transferred between health care facilities
2. When patient discharged
3. When patient has substantial change in health status
4. When patient loses capacity
5. When patient changes wishes
6. At least annually
Do MOLST orders expire?

- No
- MOLST orders do not expire.
- Previous versions of MIEMSS DNR order do not expire.

Electronic MOLST registry?

- CRISP has received grant to develop pilot electronic MOLST registry.

Next Steps

- Form and process being reviewed key stakeholders
- Likely start date mid-2012
- Already effective in meantime
- Training programs throughout state
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Summary

1. New form to improve process of knowing/honoring patient wishes
2. NPs included
3. Start filling them out now!

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More information?

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