Honoring Patient Preferences: 
The Role of MOLST
in Advance Care Planning
for Hospital Professionals

Patricia Bomba, M.D., F.A.C.P.
Vice President and Medical Director, Geriatrics
Director, Education for Physicians on End-of-life Care
Director, Honoring Patient Preferences, The Role of MOLST
Co-Director, Community-wide End-of-life/Palliative Care Initiative

Excellus
A nonprofit independent licensee of the BlueCross BlueShield Association

NYSDOH Training Academy for Hospital and EMS Surveyors
Objectives

- Review a new advance directive vehicle called the Medical Orders for Life-Sustaining Treatment (MOLST)
- Define the role of MOLST in Advance Care Planning
- Discuss key New York State legislation
- Describe the MOLST community pilot in Monroe and Onondaga Counties
- Recognize approval by NYSDOH
Story with a Positive Outcome

- Advance Care Planning occurs
- Appropriate preparation for discussion
- Antecedent conversation occurs with physician and within family
- Goals guide care
- Documents exist, are regularly updated and are available
Difficult Clinical Stories

- Agent/Family disagree with physician assessment
- Agent/Physician agree while another family disagrees and interferes
- Agent/Family desire focus on QOL and physician disagrees
- Disagreement among physicians
- No agent/family; patient lacks capacity
Advance Care Planning: A Gift

- Clarify values, beliefs
- Choose a Spokesperson
- Understand life-sustaining treatments
- Practical issues

Compassion and Support at the End of Life
Advance Care Directives

For All Adults

- Health Care Proxy Form
- Living Will
- Organ Donation (optional)

For Those Who Are Chronically Ill or Near the End of Their Lives

- Nonhospital Do Not Resuscitate (DNR) Order
- Medical Orders for Life Sustaining Treatment (MOLST) form

Living Will
Health Care Proxy/Living Will and MOLST

**Health Care Proxy/Living Will**
- completed ahead of time
- applies only when decision-making capacity is lost

**MOLST**
- applies right now
- not conditional on losing decision-making capacity
- set of actionable medical orders
- approved by NYSDOH for use in hospitals and long-term care facilities
Advance Care Planning

- Appropriate for all adults and for the subset with life-limiting illness
- Process of planning for future medical care if you lose decisional capacity
- Focuses on conversation and addresses surrogate decision-making and end-of-life preferences
- Process results in the completion and use of legal documents
Advance Care Planning

- Reflect ongoing conversation with periodic reassessment and as needed
- Legal documents must be accessible
- Legal documents are helpful in preventing situations illustrated by Karen Ann Quinlan, Nancy Cruzan and Terri Schiavo
- Decreases turmoil and suffering and eases the burden for families of persons with life-limiting illness
Stages of Readiness to Complete

- See no need
- Recognize need, but have barriers
- Ready to complete
- Advance Care Directive reflects wishes
- Advance Care Directive needs update

Staging Questions: Health Care Proxy Readiness

Please complete the questionnaire and return it to Don Varnhoven, Medical Affairs Department, 4th Floor, Emergency, Inc., 11th Floor, Rochester, NY 14642. Thank you.

1. Formally designating a person to speak for you about your medical care if you become unable to speak for yourself is called designating a health care proxy. The best way to designate the person to speak for you is to complete a Health Care Proxy Form. Which answer best describes your level of readiness to fill out a Health Care Proxy Form?

- I see no need to fill out a Health Care Proxy Form.
- I see the need to fill out my Health Care Proxy Form, but I have barriers or reasons why I have not done it.
- I am ready to fill out a Health Care Proxy Form, or I have already started.
- I already filled out my Health Care Proxy Form and it reflects my wishes.
- I already filled out my Health Care Proxy Form, but it needs to be changed.

2. Are you: □ Male □ Female

3. Into which of the following age groups do you fall?

- 18 – 25
- 26 – 35
- 35 – 44
- 45 – 54
- 55 – 64
- 65 – 74
- 75 – 84
- 85 – 94
- 95 – 100
- 100 and over

4. What ethnic group best describes you:

- African American
- Hispanic, not of Hispanic origin
- American Indian/Alaska Native
- Asian/Pacific Islander
- White, not of Hispanic origin
- Other

5. Which of the following best describes the highest level of education you have completed?

- Up to and including some high school
- High School Graduate (including G.E.D.)
- Some College (including an Associate Degree)
- Four-Year College Degree
- Advanced Degree (i.e., Masters, Ph. D., MD)

6. Have you ever worked in a health care related job? (note: nurse, therapist, aides, health insurance worker, etc.)

- Yes, I currently work in a health care related field.
- Yes, I have worked in a health care related job in the past.
- No, I have never worked in a health care related job.

Dr. Bomba and Doniger, 2002
Advance Care Planning

Compassion, Support and Education along the Continuum

Advancing chronic illness

Chronic disease or functional decline

Healthy and independent

Maintain & maximize health and independence

Multiple co-morbidities, with increasing frailty

Death with dignity
How to Choose a Spokesperson

- Knows me well
- Understands what is important to me
- Will talk about sensitive wishes now
- Will listen to my wishes
- Willing to speak on my behalf
- Would act on my wishes
- Can separate his/her feelings from mine
How to Choose a Spokesperson

• Will be available in the future
• Lives close by or willing to come
• Could handle responsibility
• Can manage conflict resolution
• Meets legal criteria
How to Clarify Values and Beliefs

- Your values
- Your personal beliefs
- Your spiritual beliefs
- What makes life worth living
- What really matters to you
- Your hopes and wishes

- Speak to your
  - Spokesperson (Agent)
  - Family
  - Spiritual Adviser
  - Physician
Life-Sustaining Treatment

- Benefits and burdens
- Treatment can be refused or accepted
- Cannot always predict recovery
- Life support may be short-term
- Time-limited trials
- Treatments can be discontinued
Shared Medical Decision Making

• Making treatment decisions
  – Will treatment make a difference?
  – Does burden outweigh benefits?
  – Is there hope for recovery?
    • If so, what will life be like afterward?
  – What does patient value?
    • What is the goal for care?
Long Term Artificial Hydration and Nutrition

- Risks and benefits vary in the individual
  - depend on age, overall health status, goals for care, timing and course of disease
- Often hard to predict outcome
- Decision based on goals for care
- When someone is dying, AHN
  - Does not prevent aspiration
  - Does not improve comfort
  - Does not change prognosis or prevent dying
Long Term Artificial Hydration and Nutrition

• Can be discontinued at any time

• When burden outweigh benefits
  – patient repeatedly pulls out tube
  – quality of life deteriorates
  – excessive agitation
  – terminal condition
  – recurrent aspiration

• Appropriate legal consent
Cardiopulmonary Resuscitation

- The purpose of cardiopulmonary resuscitation is the prevention of sudden, unexpected death.

- Cardiopulmonary resuscitation is *not* indicated in . . . cases of terminal irreversible illness where death is expected or where prolonged cardiac arrest dictates the futility of resuscitation efforts.

*JAMA, Feb. 18, 1974, Vol. 227, No. 7, Standards for CPR and ECC*
Cardiopulmonary Resuscitation

- For many people the last beat of their heart *should* be the last beat of their heart.

- These people simply have reached the end of their life. A disease process reaches the end of its clinical course and a human life stops.
Cardiopulmonary Resuscitation

- In these circumstances resuscitation is unwanted, unneeded and impossible. If started, resuscitative efforts for those people are inappropriate, futile and undignified.

- They are demeaning to both the patient and rescuers.
Cardiopulmonary Resuscitation

- Good ACLS requires careful thought about when to stop resuscitative efforts and—even more important—when not to start.

ACLS Provider Manual, American Heart Association, 2001
Cardiopulmonary Resuscitation

• Without oxygen, the human brain begins to suffer irreversible brain damage after about 5 minutes. The heart loses the ability to maintain a normal rhythm.

• Current standards reflect a more conservative view of the success of potential bystander CPR and stress the importance of rapid defibrillation.

Standards, American Heart Association, 2000
CPR: In-hospital

• 1960-introduction of closed cardiac massage

• Steady increase in application of technology and techniques

• However, no improvement in hospital survival rates of CPR in the past 40 years

Anesthesiology. 2003 Aug; 99(2): 248-50
CMAJ. 2002 Aug 20; 167 (4): 343-8
CPR: In-hospital Arrests

- Physicians overestimate the likelihood of survival to hospital discharge
- Literature
  - Survival 6.5%-32% - Average 15%
- At least 44% of survivors have significant decline in functional status

CPR Good Outcomes: In-hospital

• Improved survival rates with good functional recovery
  – Duration of CPR shorter than 5 minutes
  – CPR in the ICU

CPR and Elderly

• 22% may survive initial resuscitation

• 10-17% may survive to discharge, most with impaired function

• Chronic illness, more than age, determines prognosis (<5% survival)

(Annals Int Med 1989; 111:199-205)
(JAMA 1990; 264:2109-2110)
(EPEC Project RWJ Foundation, 1999)
CPR Poor Outcomes: All Sites

- Unwitnessed Arrest
- Asystole
- Electrical-Mechanical Dissociation
- >15 minutes resuscitation
- Metastatic Cancer
- Multiple Chronic Diseases
- Sepsis
# CPR Outcomes

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Average rate of success (overall)</td>
<td>15%</td>
</tr>
<tr>
<td>2</td>
<td>Ventricular fibrillation after myocardial infarction</td>
<td>26-46%</td>
</tr>
<tr>
<td>3</td>
<td>Drug reaction or overdose</td>
<td>22-28%</td>
</tr>
<tr>
<td>4</td>
<td>Acute stroke</td>
<td>0-3%</td>
</tr>
<tr>
<td>5</td>
<td>Bedfast patients with metastatic cancer who are spending fifty percent of their time in bed</td>
<td>0-3%</td>
</tr>
<tr>
<td>6</td>
<td>End stage liver disease</td>
<td>0-3%</td>
</tr>
</tbody>
</table>
CPR Outcomes

7. Dementia requiring long-term care 0-3%
8. Coma (traumatic or non-traumatic) 0-3%
9. Multiple (2 or more) organ system failure with no improvement after 3 consecutive days in the ICU 0-3%
10. Unsuccessful out-of-hospital CPR 0-3%
11. Acute and chronic renal failure 0-10%
12. Elderly patients Same as general population
13. Chronically ill elderly 0-5%
Public Perceptions

• 67% of resuscitations are successful on TV
• Educating patients
  – 371 patients, age >60yrs
  – 41% wanted CPR
  – After learning the probability of survival only 22% wanted CPR

(NEJM 1996: 334:1578-1582)
(NEJM 1994: 330:545-5498)
DNR Discussions

- Physicians speak 75% of the time and use medical jargon
- After discussions
  - 66% did not know that many patients need mechanical ventilation after resuscitation
  - 37% thought ventilated patients could talk
  - 20% thought ventilators were O2 tanks

(JGIM 1995; 10:436-442)
(JGIM 1998; 13:447-454)
CPR: Functional Health Illiteracy

• Effect of a multimedia educational intervention on knowledge base and resuscitation preferences among lay public
  – 8-minute video
  – median estimates of predicted postcardiac arrest survival rate:
    • 50% before and 16% after video
  – series of hypothetical scenarios:
    • significantly more participants indicated that they would refuse CPR in scenarios involving terminal illness post video

*Ann Emerg Med. 2003 Aug;42(2): 256-60*
Treatment Preferences Based on Burden of Treatment, Outcome

Low Burden, Return to Current Health

- Wants RX 98.7%
  - High Burden Return to Current Health
    - RX 88.8%
    - No RX 11.2%
- No RX 1.3%
  - Low Burden Severe fxnl impairment
    - RX 25.6%
    - no RX 74.4%
  - Low Burden Severe CNS impairment
    - RX 11.2%
    - no RX 88.8%

Fried TR, et al. NEJM, 2002
Practical Issues: Accessibility

• Keep a copy
• Provide a copy
  – Spokesperson (Agent)
  – alternate Spokesperson
  – family members / loved ones
  – primary care physician
  – all health care providers
  – primary hospital
  – spiritual adviser
Practical Issues: Review & Update

- Periodically
- Major life events
- Newly diagnosed chronic illness
- Advancing chronic illness
- After complicated life-sustaining treatments
Community-wide End-of-life/Palliative Care Initiative

**Advance Care Planning**
- Community Conversations on Compassionate Care

**Honoring Preferences**
- Medical Orders for Life-Sustaining Treatment (MOLST)

**Pain Management and Palliative Care**
- Community Principles of Pain Management
- CompassionNet

**Education and Communication**
- Education for Physicians on End-of-life Care (EPEC)
- Community web site: [www.compassionandsupport.org](http://www.compassionandsupport.org)
POLST

• A decade of research in Oregon has proven that the POLST Program more accurately conveys end-of-life preferences and yields higher adherence by medical professionals.

Lee, Brummel-Smith, et al. JAGS. 2000; 48(10): 1219-1225
Schmidt, Hickman, Tolle, Brooks. JAGS. 2004; 52(9): 1430-1434
The POLST Program has been a key vehicle in Oregon’s successful efforts to increase the effectiveness of advance care planning and decrease unwanted hospitalizations at the end of life.

POLST is Spreading

National POLST Paradigm Initiative
Paradigm of communication, documentation, and system responsiveness
MOLST

Created by the Community-wide End-of-Life/Palliative Care Initiative - November 2003
Adapted from Oregon’s POLST
Combines DNR, DNI, and other Life-Sustaining Treatments
Revised October 2005
Incorporates NYS law

www.compassionandsupport.org
DNR Law

- Adult patients/residents who lack capacity to consent
  - Require “Supplemental Documentation”
- Exceptional circumstances
  - Therapeutic exception
    - Patient with capacity would suffer immediate and severe harm
  - Medical futility and no surrogate
  - Residents of OMH and OMRDD Facilities
  - Residents of correctional facilities
- Minor patients/residents who are under 18, are not married and are not parents
  - Require “Supplemental Documentation”
  - If under 18, are married or are parents: treated as adults
MOLST Program
New York State POLST Paradigm Program

- Designed to improve quality of care at end of life
- Based on communication between the patient or surrogate and health care professionals
- Assists health care professionals in discussing and developing treatment plans that reflect patient wishes
- Results in completion of MOLST form
- Helps physicians, nurses, health care facilities and EMS personnel honor patient wishes for life-sustaining treatment
Goals of the MOLST Program

• Document an individual’s treatment preferences:
  – DNR
  – Intubation and mechanical ventilation
  – Other life-sustaining treatment
  – Future hospitalization and transfer

• Coordinate physician orders with patient preferences

• Communicate wishes across health care settings

• Improve EMS personnel’s ability to treat according to patient wishes

• Reduce repetitive documentation
Core Elements of MOLST

• Contains actionable medical orders

• Recommended for use in persons who have advanced chronic progressive illness and anyone interested in further defining their end of life care wishes

• May be used either to limit medical interventions or to clarify a request for all medically indicated treatments including resuscitation
Core Elements of MOLST

• Provides explicit direction about resuscitation status if the patient is pulseless and apneic

• Includes directions about other types of intervention that the patient may or may not want

• Is a bright pink color that is easily identifiable in case of emergency
Core Elements of MOLST

• Accompanies the patient and orders apply as he or she is transferred home or to a new care setting (e.g. long-term care facility or hospital).

• Should be reviewed and renewed:
  – Periodically
  – As required by NYS and federal law & regulations
  – If the individual’s preferences change
  – If the individual’s health status changes
  – If the patient is transferred to another care setting
Core Elements of MOLST

• Includes training of health care professionals about the goals of the program and use of the form

• Features a plan for ongoing monitoring of the program and its implementation
Revised MOLST Form

Page 1: **DNR**

  Complete Section A, B, C for DNR
  Section D: Advance Directives

Page 2: **Life-Sustaining Treatment**

Page 3 and 4: **Renew/Review Section**

Supplemental Documentation Forms for DNR: Adult and Minor

*Revised October 2005, Approved for use by NYSDOH*
MOLST

Pre-Hospital & Acute Care

LTC

Office
MOLST: Who Should Have One?

- Anyone choosing:
  - Allow, embrace natural death
  - Do not resuscitate
- Anyone choosing to limit medical interventions
- Anyone eligible/residing in LTC facility
- Anyone who might die within the next year
How to Complete a MOLST

• Must be completed by a health care professional, based on patient preferences

• Must be signed by a NYS licensed physician to be valid

• Verbal orders are acceptable with follow-up signature by a physician, in accordance with facility/community policy
How to Complete a MOLST

• Use of the original form is strongly encouraged
  – Readily identifiable pink color easier to locate in emergency

• Photocopies and faxes of signed MOLST forms are legal and valid

• Completion of the entire form is strongly recommended
  – Any section not completed implies full treatment
How to Complete a MOLST

- Consent for DNR must be obtained and documented in Section B of page 1
  - Individual with capacity can provide consent
  - Individual lacks capacity and designated Agent in Health Care Proxy, Agent can provide consent
  - Individual lacks capacity and without Agent, surrogate:
    - Designated health care agent
    - Court-appointed committee or guardian
    - Spouse
    - Son or daughter, age 18 or older
    - Parent
    - Brother or sister, age 18 or older
    - Close friend or person, age 18 or older
    - no appropriate surrogate decision-maker available
How to Complete a MOLST

• Authorization for ‘Orders for Life-Sustaining Treatment and Future Hospitalization’
  – Individual with capacity can provide consent
  – Individual lacks capacity, has designated Agent in Health Care Proxy: Agent can provide consent
  – Individual lacks capacity and without Agent: “clear and convincing evidence” of the individual’s preferences is required
    • Living will
    • Repeated oral expression
"There's no easy way I can tell you this, so I'm sending you to someone who can."
8-Step Protocol

1. Prepare for discussion
   – Understand the patient and family
   – Understand the patient’s condition and prognosis
   – Retrieve completed Advance Care Directives
   – Determine “Agent” (Spokesperson) or responsible party

2. Determine what the patient and family know
   – re: condition, prognosis

3. Explore goals, hopes and expectations

*Developed for NYS MOLST, Bomba, 2005*
8-Step Protocol

4. Suggest realistic goals
5. Respond empathetically
6. Use MOLST to guide choices and have patient/family share wishes
   – Shared medical decision making
   – Conflict resolution
7. Complete and sign MOLST
8. Review and revise periodically

*Developed for NYS MOLST, Bomba, 2005*
When to Review and Renew

- Physician should review and renew MOLST
  - Periodically
  - If the individual’s preferences change
  - If the individual’s health status changes
  - If the patient is transferred to another care setting

- Physician must review and renew DNR order
  - Hospital: at least every 7 days
  - Nursing home/SNF: at least every 60 days
  - Nonhospital/community setting: at least every 90 days
MOLST Form Location

• **In the home**
  - Front of refrigerator, by the phone in the kitchen
  - Individual’s bedside table
  - Kept with patient between care settings

• **Health care setting**
  - Front of Medical Chart
  - Hospital and LTC facility
  - Kept with patient between care settings
What to Do at Time of Transfer

• **In the home**
  - EMS personnel are trained to look for MOLST
  - MOLST should accompany patient at time of transfer

• **Health care setting**
  - Make copy of the MOLST to keep in the medical chart
  - Original should accompany patient at time of transfer
  - Original should be placed in front of the patient’s chart at new care setting
State of New York
Department of Health

Nonhospital Order Not to Resuscitate
(DNR Order)

Person's Name:__________________________

Date of Birth _____/_____/_____

Do not resuscitate the person named above.

Physician's Signature ____________________

Print Name ________________________

License Number ______________________

Date _____/_____/____

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart.

The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90 day period.

DOH-3474 (2/92)

Regional Pilot in Monroe and Onondaga Counties, Approved NYSDOH, October 2005

Governor signed MOLST bill, October 11, 2005
MOLST Community Pilot

• EMS personnel will follow orders on the MOLST form for individuals living in Monroe and Onondaga counties
  – *Individuals living in Monroe and Onondaga counties*: a completed MOLST form can replace the NYS Nonhospital DNR form
  – *Individuals living outside Monroe and Onondaga counties*: The NYS Nonhospital DNR form must be completed in addition to the MOLST
MOLST Community Pilot

- Do Not Intubate (DNI) orders can not be honored in pre-hospital settings
- Chapter amendment (S.36365 and A.9479) to MOLST Pilot Project legislation
  - Authorizes EMS in Monroe and Onondaga counties to honor Do Not Intubate (DNI) orders prior to full cardiopulmonary arrest when the patient/resident still has pulse and/or is breathing
- MOLST provides “clear and convincing” evidence to EMS Medical Control outside Monroe and Onondaga counties
Key New York State Legislation

- Nonhospital DNR Law (Public Health Law § 2977)
- MOLST Pilot Project Legislation (A.8892)
- Chapter Amendment (S.36365 & A.9479)
- Health Care Decisions Act for Persons with Mental Retardation (Surrogate’s Court Procedure Act § 1750-b)
- Legislation Adding Persons with Developmental Disabilities to the Health Care Decisions Act (S.5323)
Nonhospital DNR Law

- Nonhospital DNR – Must be on “standard form” issued by the Department of Health (by contrast, hospital-based DNR order can be on any form)
- Current “Standard form” – one page form with little detail beyond instruction not to resuscitate
- Nonhospital DNR – Can be honored only if patient is in full cardiopulmonary arrest
- If patient is NOT in full cardiac or respiratory arrest, FULL treatment must be provided
MOLST Pilot Project Legislation (A.8892)

- Permits community pilot of the MOLST program in Monroe and Onondaga Counties
- Allows for use of MOLST form in lieu of NYS Non-Hospital DNR form (DOH 3474)
- Governor Pataki signed legislation on October 11, 2005
- Carve-out: OMH and OMRDD
Chapter Amendment (S.36365 & A.9479)

• Introduced January 2006

• Authorization for EMS to honor Do Not Intubate (DNI) instructions prior to full cardiopulmonary arrest in Monroe and Onondaga Counties during MOLST pilot

• DNI is not covered in Nonhospital DNR Law (Public Health Law § 2977)
Clear and Convincing Evidence

• “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.”

In the Matter of Westchester County Medical Center, on behalf of Mary O’Connor, p8
Clear and Convincing Evidence

• “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.”
Persons with Mental Retardation

- Patient with MR with capacity can complete MOLST form
- Health Care Decisions Act for Persons with Mental Retardation (Surrogate’s Court Procedure Act § 1750-b)
- Physician should consult legal counsel for MR patients without capacity. See Surrogate’s Court Procedure Act § 1750-b.
Persons with Developmental Disabilities

- Patient with DD with capacity can complete MOLST form

- Legislation Adding Persons with Developmental Disabilities to the Health Care Decisions Act (S.5323)

- Physician should consult legal counsel for DD patients without capacity. See Surrogate’s Court Procedure Act § 1750-b.
MOLST 2005 Review and Revision

- MOLST is consistent with New York State law
- New York State Department of Health has approved MOLST
- MOLST can be used in health care settings, including hospitals and nursing homes
- In counties other than Monroe and Onondaga, the NYS Nonhospital DNR form to indicate DNR orders in non-hospital settings should be attached.
- Do Not Intubate Orders cannot be honored in pre-hospital settings
- Chapter Amendment (S.36365 & A.9479)
Case #1

- 80 year old male with advanced emphysema, peripheral vascular disease, and other chronic, but not imminently terminal diseases
- Had two short intubations in the past; survived to go home
- Does not want CPR, but would like a trial of intubation
- Does not want long term intubation, but would try up to a week on a ventilator
- How would you complete MOLST?
Case #1

• If he has an acute cardiac arrest, should he be intubated but not shocked?

• If he develops a pneumonia, and goes into respiratory failure over several days, should he be intubated?

• Should he go to the ICU?

• If he subsequently has a cardiac arrest, should he be resuscitated?

• If he is still intubated after one week, should he be automatically extubated?
Case #2

- 75 year old white female with idiopathic pulmonary fibrosis and severe osteoporosis
- On hospice at home
- Completed MOLST: DNR, DNI, no tube feedings, no IV fluids, comfort measures only
- She falls and breaks her hip
- Neighbor finds her on the floor and calls 911
- When EMS arrives, what is plan of care?
Case #3

- 62 year old with longstanding COPD due to smoking, on chronic $O_2$
- Lives in Monroe County and goes to Strong Memorial Hospital for care (located in Monroe County)
- Completed MOLST with physician in the office after his latest bout of respiratory failure that required intubation and mechanical ventilation
- MOLST form indicates DNR, DNI, Limited medical interventions, Hospitalization with limitations per MOLST
Case #3

- Develops acute respiratory insufficiency
- Wife calls 911
- EMS arrives
- MOLST reviewed and is accurately completed
- Patient’s wife affirms that her husband wants treatment but does not want to be intubated
- What does EMS do?
Case #3

• Same scenario but patient lives in Livingston County and receives care at Strong Memorial Hospital (located in Monroe County)

• What happens if MOLST is accurately completed but NYSDOH Nonhospital DNR form is not attached?

• Patient’s wife affirms that her husband wants treatment but does not want to be intubated

• What does EMS do?
Case #4

• 80 year old retired businessman, former athlete, currently resides in SNF
  – 25-year history of Parkinson’s Disease
  – 10-year history of associated dementia
  – Host of other medical problems
  – Dependent in all ADL’s
  – Rarely “recognizes” his wife but no other family
  – 2 years ago, he was moved from a private to semi-private room and became delirious; delirium lasted several months.
Case #4

• Health Care Proxy and Living Will completed when he had decision-making capacity
• Wife is his named Agent and she has decision-making capacity
• Nursing staff at SNF discussed DNR
• Wife recognizes that this would be her husband’s wish but she is conflicted, as is son
• Daughter believes her father’s wishes should be honored regardless of personal feelings.
• Family meeting arranged
Case #4

- Patient develops fever and is sent to ED before family meeting occurs
- What would be the best way to initiate conversation with family re DNR?
- When is best time to initiate conversation re DNR? Is it best in SNF before transfer, in ED or on hospital floor?
- Under these circumstances, do you recommend a DNR order, or should you leave it fully up to the proxy to decide?
Case #4

- Are there other decisions triggered by the MOLST that should be addressed with this family?
- Do the legal standards of proof vary between decisions?
- How would you have proceeded if there was not a named Agent?
Questions?

Patricia.Bomba@lifethc.com

“Knowing is not enough; we must apply. Willing is not enough; we must do.”

Goethe