

TOOL 2-7A *Sample* MOLST Policy for Home Health Care or Hospice



SAMPLE/DRAFT MOLST POLICY and PROCEDURE

Home Health Care or Hospice Agencies

Caution – It is not advisable to use MOLST policy written for other institutions, especially policies from out of state. Each institution needs to develop its own MOLST policy as appropriate within the context of state, local and institutional clinical practice.

PURPOSE

The purpose of this policy is to define a process for home health or hospice providers to follow when a patient is enrolled in home health or hospice with a Medical Orders for Life Sustaining Treatment (MOLST) form.

This policy also outlines procedures regarding steps for the home health or hospice providers to follow to involve a clinician to: discuss life-sustaining treatments with a patient; fill out and sign a MOLST form for the patient; or review or revise a patient's existing MOLST form.

PREAMBLE

The Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) form is a standardized medical order form signed by a clinician (physician, nurse practitioner, physician assistant) that is available for use with patients with advanced illness. The choice to use the MOLST form must be made voluntarily by suitable patients. The signed MOLST form documents the patient's decisions about life-sustaining treatments by converting them into standardized, actionable medical orders. The form is designed as a statewide mechanism for a patient to communicate his or her decisions about a range of life-sustaining measures. It is designed to be a portable, authoritative and immediately actionable medical order that is consistent with the individual's preferences and current medical condition, and which can be honored across health care settings.

The Massachusetts MOLST form:

- Is a standardized form originally created on hot pink-colored paper and clearly recognizable;
- Is considered a valid medical order;
- Can be honored across health care settings;
- Expands upon the MA Department of Public Health (DPH) Comfort Care/DNR (CC/DNR) Order Verification Protocol that was the original Massachusetts "out-of-hospital" DNR verification program. CC/DNR Verification has been in place to allow Emergency Medical Services (EMS) personnel to honor a previously completed DNR in an out-of-hospital setting. In contrast to the

CC/DNR form, the MOLST form is an actual medical order and can to attempt or not attempt resuscitation as well as other life-sustaining treatments;

- Should be made available to any patient with advanced illness or medical frailty, regardless of age, diagnosis, or disability, who wishes to document their decisions about life-sustaining treatments.
- Is intended to remain in the possession of the patient and be transferred or transported with the patient across all health care settings.
- Is revised or revoked at any time by a patient with decision-making capacity, or by the legally designated health care agent for a patient who has been declared to lack capacity to make medical decisions.

A patient cannot be required to utilize a MOLST form. However, a health care provider is expected to treat an individual in accordance with a valid MOLST form, if one exists. This does not apply if the MOLST requires medically ineffective health care or health care contrary to generally accepted health care standards.

A legally authorized health care agent may execute, revise or revoke the MOLST form for a patient only if the patient lacks decision-making capacity and the HCP has been invoked. A guardian may be able to execute, revise or revoke the MOLST form for the patient, depending on the facts and circumstances, to the extent of MA law. Consult legal counsel with questions about a guardian's authority. Spouses, other next of kin or other close family friends of the patient (sometimes referred to as an informal or default surrogate) are not authorized to sign a patient's MOLST form.

This policy, however, does not address the criteria or process for determining or appointing a legally recognized health care decision maker, nor does it address the criteria or process for determining decision-making capacity. See policy # regarding capacity determination and policy # regarding decision makers.

While a home health care provider such as a home health or hospice nurse or home health or hospice social worker can explain the MOLST form to a patient and/or to the patient's legally recognized health care decision maker or family members, the patient's physician/nurse practitioner/physician's assistant or the hospice physician/nurse practitioner is responsible for discussing any concerns or questions on the efficacy or appropriateness of the treatment options with the patient, or if the patient lacks decision-making capacity, with the patient's legally recognized health care decision-maker.

Once the MOLST form is filled out to reflect the patient's goals of care and decisions as discussed with the physician/nurse practitioner/physician's assistant, it must be signed by the patient's physician/nurse practitioner/physician's assistant or the hospice physician or nurse practitioner AND by the patient; If the patient lacks decision making capacity, the patient's legally authorized health care decision maker can sign for the patient. Signature by the patient or their legally authorized health care decision maker, and by the signing clinician confirms that the form accurately reflects the discussion held between the patient (or their legally recognized health care decision-maker) and the signing clinician and the decisions reached by the patient or their decision maker.

The MOLST form is intended to be suitable for persons who have a serious advancing illness or injury, or who are medically frail or elderly with a life expectancy of one year of life or less. The MOLST form should be executed as one possible outcome of a comprehensive advance care planning process, and should reflect a process of careful decision making by the patient, or if the patient lacks decision making capacity, by the patient's legally authorized health care decision-maker, in consultation with the patient's clinical team concerning the patient's current medical condition and known treatment preferences.

HOME HEALTH CARE and HOSPICE PROCEDURES

I. Patient Admitted with a Signed MOLST Form

1. The admitting nurse will note the existence of the MOLST form on the admission assessment and review the form for validity (e.g. signed by patient or legally recognized healthcare decision-maker, and by a clinician) and confirm with the patient, if possible, or the patient's legally recognized health care decision-maker, that the MOLST form in hand has not been revoked or superseded by a subsequent MOLST form. A valid MOLST form is a valid medical order and is immediately actionable.
2. Once reviewed, the MOLST form should be scanned or copied, with a copy provided to the hospice. (Insert suggested method for scanning/copying the MOLST form of a patient being visited at home).
3. The current original MOLST form should be returned to the patient and should go with the patient as the patient moves from one health care setting to another.
4. If a patient resides at home, the original MOLST form (preferably printed on hot pink-colored paper) should be prominently displayed in an easily accessible and visible location, with consideration of respect for privacy balanced with the clinical team's need for easy access to the form.
5. MOLST may co-exist with the DPH CC/DNR Verification Protocol form, and both are considered valid. If there is any discrepancy between the two forms, the most recently dated document should be used to determine resuscitation status. If the MOLST form is changed or updated, previous copies should be "VOIDED" per instructions on the MOLST form and replaced by a newly executed MOLST form reflecting the patient's most recent decisions about life sustaining treatments.
6. A qualified health care provider, preferably a physician, registered nurse or social worker, will conduct an initial review of the MOLST form with the patient, or if the patient lacks decision-making capacity, with the patient's legally authorized health care agent, within the first required assessment period as part of the comprehensive assessment and care planning process defined by agency policy and home care or hospice regulations.
7. If the patient, or when the patient lacks decision-making capacity, the legally recognized health care agent, expresses concern about the MOLST form, or if there has been a significant change in the patient's condition or decisions, then the patient's physician/nurse practitioner/physician's assistant or hospice physician or nurse practitioner will be notified as

soon as possible to discuss the potential changes with the patient, or if the patient lacks decision-making capacity, with the legally authorized health care agent.

8. The initial review and any discussion about continuing, revising or revoking the MOLST should be documented in the medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed. If new decisions are made about life-sustaining treatments, the outdated MOLST form should be "VOIDED" per instructions on the MOLST form, after a new MOLST form is executed, and orders consistent with home care or hospice regulations should be entered into the plan of care.

II. Reviewing/Revising Existing MOLST forms

1. The presence and content of the MOLST form will be reviewed by the hospice or home care interdisciplinary team during the initial Interdisciplinary Team Meeting or any patient Plan of Care review after admission to hospice or home care and at any time that the patient, or if the patient lacks decision-making capacity, the legally authorized health care agent, requests it.
2. At any time, a patient with decision-making capacity can revoke the MOLST form or change his/her mind about his/her treatment decisions by expressing a verbal desire to revise or revoke the MOLST form. If a patient with decision making capacity, expresses a desire to receive previously documented refusal of life sustaining treatments, the health care provider discussing that desire with the patient will notify the signing clinician, or another physician/nurse practitioner/physician's assistant involved in the patient's care patient of the patient's decisions.
3. If a new MOLST form is executed after discussion between the patient and the physician/nurse practitioner/physician's assistant or hospice physician or nurse practitioner, the outdated MOLST form should be "VOIDED" per instructions on the MOLST form. The new MOLST orders should be updated in the home health care or hospice medical record and the patient care interdisciplinary team should be notified of the changes.
4. At any time, a patient may decide to revoke the MOLST form without executing another MOLST form. The revoked MOLST form should be "VOIDED" per instructions on the MOLST form and the patient's physician/nurse practitioner/physician's assistant or hospice physician or nurse practitioner should be notified so that appropriate changes to the MOLST orders should be obtained as soon as possible to ensure that the patient's decisions are accurately reflected in the home care or hospice plan of care.
5. If the patient lacks decision-making capacity and the legally authorized health care agent wants to consider revising or revoking the MOLST form, he/she may notify the health care provider who will consult with the patient's physician/nurse practitioner/physician's assistant or hospice physician/nurse practitioner to arrange a discussion to update the MOLST. The legally authorized health care agent, may revise the MOLST form, and would be encouraged to honor the previously expressed decisions of the patient.
6. All discussions about revising or revoking the MOLST should be documented in the patient's home care or hospice medical record. This documentation should include the time and date of

the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.

7. To void MOLST, draw a line through the entire Section A through D and write, "VOID" in large letters. If the original MOLST form is voided and no new MOLST form is completed, no limitations on treatment are documented and full treatment may be provided to the patient.

III. Facilitating Patient-Clinician Discussions about Treatment Decisions/MOLST

1. If a patient, or if the patient lacks decision-making capacity the legally authorized health care agent, wishes to utilize DNR orders or a MOLST form while a patient is receiving services from the home health care or hospice agency, notify the clinician responsible for the plan of care of the patient's request.
2. A qualified health care provider such as a home health or hospice nurse or home health or hospice social worker may introduce the concept of the MOLST form to the patient and/or the patient's legally authorized health care agent. However, the physician/nurse practitioner/physician's assistant and the patient or the patient's legally authorized health care agent must discuss the decisions about life-sustaining treatments, and sign the MOLST form to accurately reflect their discussions.

Generally, the signing clinician (physician/nurse practitioner/physician's assistant) should discuss the benefits, burdens, efficacy and appropriateness of treatment and medical interventions, or any areas of concern with the patient, or if the patient lacks decision-making capacity, with the patient's legally authorized health care agent.

The MOLST form must be signed by the physician/nurse practitioner/physician's assistant and the patient, or if the patient lacks decision-making capacity, the patient's legally authorized health care agent, who confirm by their signatures that the MOLST form reflects the discussion that they had with each other and the patient's decisions related to life sustaining treatments.

3. Enter the MOLST information into the home care or hospice medical record and obtain an order for DNR, if needed from the physician responsible for the home care plan of care.
4. The current original (pink) MOLST form is considered the property of the patient, and must remain with the patient across all treatment settings. The MOLST form or MOLST instructions should be entered into the relevant medical records sections related to Advance Care Planning, Medical Decision Making, or Medical orders.

IV. MOLST and the Home Health and Hospice Medical Record

1. The most current MOLST form in its original format will always be kept with the patient. Copies are considered valid and actionable medical orders.
2. If possible, a copy of the MOLST form should be placed in the home care or hospice medical record.

3. If the patient has a Health Care Proxy form, a copy should be placed in the home health care or hospice medical record as well.
4. If the patient is transferred, admitted to a facility, or discharged from home health care or hospice, the current original MOLST must remain with the patient.
5. A fully executed, dated copy of the MOLST form should be retained in the traditional paper medical record in the advance directive or legal section of the home health or hospice medical record, if possible.
6. All voided versions of the MOLST form, clearly marked "VOID," should be retained in the medical record if available.
7. Whenever the MOLST form is reviewed, revised, and/or revoked, this will be documented in the medical record by the physician/nurse practitioner/physician's assistant. All discussions about revising or revoking the MOLST should be documented in the patient's home care or hospice medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.
8. If possible, for home health and hospice agencies with electronic health records, the MOLST should be scanned in and placed in the appropriate section of the health care record per facility/agency policy.

V. Conflict Resolution

In the event of a conflict between the MOLST form decisions and the family or caregivers present in the home when EMS is called, the EMS protocol will recommend initiating treatment and transporting the patient to the emergency department for further discussion and intervention by a physician/nurse practitioner/physician's assistant. While all efforts will be made to honor a patient's valid MOLST form decisions about life sustaining treatments, conflicts are better resolved in a setting where full support, including palliative care and ethics consultation, legal and risk management services may be available, and not in the home or hospice setting.

During conflict resolution, consideration should always be given to: a) the assessment by the patient's physician/nurse practitioner/physician's assistant or hospice physician or nurse practitioner of the patient's current health status and the medical indications for care or treatment; b) the determination by the clinician as to whether the care or treatment specified by MOLST is medically ineffective, non-beneficial, or contrary to generally accepted health care standards; and c) the patient's most recently expressed decisions about treatment and the patient's treatment goals.