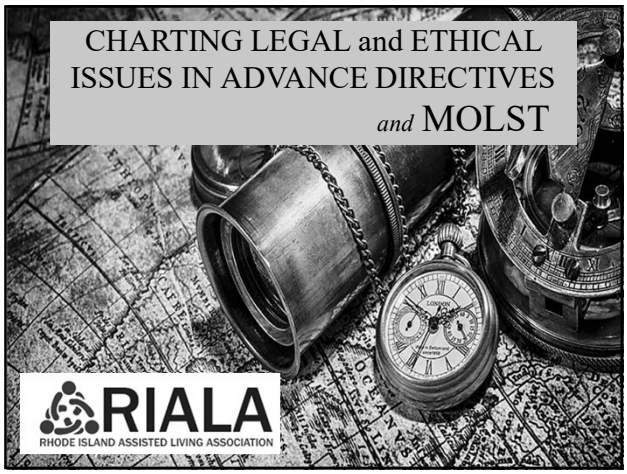


1

Presented By:

JAY M. ELIAS, ESQ.

General Counsel

DYER-LAKE FUNERAL HOME

North Attleboro, MA

2

3

THE BASICS

4

THE CONCEPT OF INDIVIDUAL AUTONOMY

- One of the primary ethical arguments for the use of advance directives derives from the principle of **individual autonomy**, reflecting respect for the wishes of competent adult patients.
- Even after an adult patient loses the capacity to be fully autonomous, health care providers may continue to respect their individual autonomy by abiding by the patient's prior expressed wishes through an Advance Directive.

In this way, patients can continue to participate in their medical care decisions.

5

WHAT IS AN ADVANCE DIRECTIVE

ADVANCE:

THIS REFERS TO A TIME IN THE FUTURE - THAT IS, "IN ADVANCE" - WHEN, FOR WHATEVER REASON, AN INDIVIDUAL IS UNABLE TO MAKE OR COMMUNICATE DECISIONS ABOUT THEIR OWN HEALTH CARE.

DIRECTIVE:

THIS REFERS TO THE ABILITY TO DIRECT ANOTHER PERSON, KNOWN AS A "HEALTH CARE AGENT", TO MAKE HEALTH CARE DECISIONS FOR ANOTHER PERSON WHEN THEY ARE UNABLE TO MAKE OR COMMUNICATE THEIR OWN DECISIONS.

AND SO, AN "ADVANCE DIRECTIVE".

6

PRINCIPAL: THIS IS THE COMPETENT ADULT (AGE 18 YEARS OR OLDER) WHO WISHES TO CREATE AN ADVANCE DIRECTIVE FOR HEALTH CARE DECISIONS FOR A TIME WHEN THEY ARE INCAPABLE OF MAKING OR COMMUNICATING THOSE DECISIONS FOR THEMSELVES.

AGENT: THIS IS THE PERSON TO WHOM THE PRINCIPAL ENTRUSTS RESPONSIBILITY FOR MAKING THEIR HEALTH CARE DECISIONS WHEN THEY ARE INCAPABLE OF MAKING OR COMMUNICATING THOSE DECISIONS FOR THEMSELVES.

7

ADVANCE DIRECTIVES

In Rhode Island, Advance Directives take two forms:

1. **A Durable Power of Attorney (DPOA) for Health Care**
2. **A "Living Will"**

8

DURABLE POWER OF ATTORNEY FOR HEALTH CARE:

THIS IS A SPECIFIC FORM OF ADVANCE DIRECTIVE WHICH IS RECOGNIZED UNDER RHODE ISLAND LAW AND WHICH ALLOWS A COMPETENT ADULT, (THE "PRINCIPAL") TO SELECT SOMEONE IN WHOM THEY HAVE GREAT TRUST AND WHO UNDERSTANDS THEIR HEALTH CARE WISHES AND PREFERENCES (THE "AGENT"), IN ORDER FOR THE AGENT TO MAKE HEALTH CARE DECISIONS IN PLACE OF THE PRINCIPAL.

LIVING WILL:

THIS IS A DOCUMENT CREATED PURSUANT TO A RHODE ISLAND LAW KNOWN AS THE "RIGHTS OF THE TERMINALLY ILL ACT", WHICH ALLOWS INDIVIDUALS TO INSTRUCT THEIR PHYSICIANS TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING PROCEDURES IN THE EVENT OF A TERMINAL CONDITION.

NOTE: NEIGHBORING MASSACHUSETTS DOES NOT RECOGNIZE THE LEGAL VALIDITY OF A LIVING WILL.

9

THE LAW

10

RHODE ISLAND LAW

RHODE ISLAND LAW PROVIDES THAT EVERY ADULT PERSON HAS THE FUNDAMENTAL RIGHT TO CONTROL THE DECISIONS RELATING TO THE RENDERING OF THEIR OWN MEDICAL CARE.

IN ORDER THAT THE RIGHTS OF PATIENTS MAY BE RESPECTED EVEN AFTER THEY ARE NO LONGER ABLE TO PARTICIPATE ACTIVELY IN DECISIONS ABOUT THEMSELVES, THE RHODE ISLAND STATE LEGISLATURE DECLARED THAT THE LAWS OF THE STATE SHALL RECOGNIZE THE RIGHT OF AN ADULT PERSON TO MAKE A WRITTEN DURABLE POWER OF ATTORNEY WHICH MIGHT INCLUDE INSTRUCTING THEIR PHYSICIAN TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING PROCEDURES IN THE EVENT OF A TERMINAL CONDITION.

NOTE: AN ADVANCE DIRECTIVE DOES **NOT** MEAN "DO NOT TREAT." THIS IS A COMMON MISCONCEPTION.

IF A PRINCIPAL DOES NOT WANT CERTAIN LIFE-SUSTAINING TREATMENTS TO BE PERFORMED, THEN THEY NEED TO COMMUNICATE THAT TO THEIR HEALTH CARE AGENT WHEN DISCUSSING THEIR WISHES.

11

THE REQUIRED ELEMENTS OF A HEALTH CARE PROXY

PURSUANT TO RHODE ISLAND LAW, A DURABLE POWER OF ATTORNEY FOR HEALTH CARE MUST:

- IDENTIFY BOTH THE PRINCIPAL AND THE AGENT;
- INDICATE THAT THE PRINCIPAL INTENDS THE AGENT TO HAVE AUTHORITY TO MAKE HEALTH CARE DECISIONS ON THEIR BEHALF;
- DESCRIBE ANY LIMITATIONS, IF ANY, THAT THE PRINCIPAL INTENDS TO IMPOSE ON THE AGENT'S AUTHORITY; AND
- INDICATE THAT THE AGENT'S AUTHORITY BECOMES EFFECTIVE IF IT IS DETERMINED BY THE PRINCIPAL'S ATTENDING PHYSICIAN THAT THE PRINCIPAL LACKS CAPACITY TO MAKE OR COMMUNICATE THEIR OWN HEALTH CARE DECISIONS.

12

A HEALTH CARE AGENT HAS THE RIGHT TO RECEIVE ANY AND ALL MEDICAL INFORMATION NECESSARY TO MAKE INFORMED DECISIONS REGARDING THE PRINCIPAL'S HEALTH CARE, INCLUDING ALL CONFIDENTIAL MEDICAL INFORMATION THE PRINCIPAL WOULD BE ENTITLED TO RECEIVE DIRECTLY.

EVEN IF A PHYSICIAN DETERMINES THAT AN INDIVIDUAL LACKS THE CAPACITY TO MAKE HEALTH CARE DECISIONS FOR THEMSELVES, WHEN THAT INDIVIDUAL - THE "PRINCIPAL" - OBJECTS TO A HEALTH CARE DECISION MADE BY THEIR AGENT, THE PRINCIPAL'S DECISIONS WILL STILL PREVAIL UNLESS A COURT OF LAW DETERMINES THAT THE PRINCIPAL LEGALLY (AS OPPOSED TO MEDICALLY) LACKS CAPACITY TO MAKE SUCH DECISIONS.

13

A RHODE ISLAND DPOA FOR HEALTH CARE
IS NOT VALID UNLESS IT IS WITNESSED BY EITHER:

- Option 1 – **Two (2)** ***Qualified Witnesses****: or
- Option 2 – **One (1)** ***Notary Public***

- AT LEAST ONE OF THE WITNESSES, OR THE NOTARY PUBLIC, MUST ALSO SIGN THE FOLLOWING DECLARATION:

I further declare under penalty of perjury that I am not related to the Principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the Principal under a Will now existing or by operation of law.

14

* A "QUALIFIED WITNESS IS SOMEONE OTHER THAN:

1. A person who is designated as the Agent or Alternate Agent;
2. Health care provider of the Principal;
3. An employee of a health care provider of the Principal;
4. The operator of a community care facility where the Principal resides or is a patient; or
5. An employee of an operator of a community care facility where the Principal resides or is a patient.

15

If there are attached any additional pages to the DPOA for Health Care form, such as specific instructions and insight from the Principal, then the Principal must also date and sign each of the additional pages at the same time they date and sign the DPOA for Health Care.

16

EXPIRATION AND REVOCATION

EXPIRATION: In Rhode Island, a DPOA of Attorney for Health Care does not expire unless the Principal states so in the document. It can, however, easily be revoked by the Principal.

Revocation: A Principal may revoke a DPOA for Health Care at any time by simply notifying their Agent or their health care provider, either orally or in writing, or by any other act evidencing their specific intent to revoke the Proxy.

NOTE: A DPOA for Healthcare is automatically revoked if a Principal executes a subsequent DPOA or, when the Principal is married to the Agent, They divorce or become legally separated.

17

- A revocation is only effective as to the attending physician or any health care provider or emergency medical services personnel upon communication to that physician or health care provider or emergency medical services personnel by the declarant or by another who witnessed the revocation.
- The attending physician or health care provider shall make the revocation a part of the declarant's medical record.
- For emergency medical services personnel, the absence of reliable documentation shall constitute a revocation of a durable power of attorney.

18

LIVING WILLS

- Generally speaking, a Living Will is a written declaration that instructs one's doctor regarding the use, withholding or withdrawal of life-sustaining treatment if an adult is terminally ill and lacks the capacity to make decisions.
- A Living Will directs one's physician's actions when the use of life-sustaining treatment would serve only to postpone the moment of death or maintain the individual in a permanent unconscious state, but would not provide a cure for the condition.
- It typically applies only in the limited situation where an individual has an end-stage medical condition or is permanently unconscious.

19

LIVING WILLS

- The "DECLARATION" of intent under the Rhode Island Law reads as follows:
- I, ..., being of sound mind willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:
- If I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.
- This authorization includes (___) or does not include (___) the withholding or withdrawal of artificial feeding (*checking only one box above*).

20

LIVING WILLS

ARE <u>NOT</u> LEGALLY BINDING IN MASSACHUSETTS

- Massachusetts is one of only a handful of states that does <u>NOT</u> recognize a Living Will as a legally binding document.
- *What does that mean?*

  It means that although not legally binding on a Massachusetts health care provider or a Massachusetts court of law, a Living Will may be used as a tool to provide useful insight into an individual's wishes.

  The document can serve as a "guide" and a "resource" for both a health care Agent and an individual's health care providers as to the choices that individual would make if they were able to make decisions on their own.

21

RECIPROCITY OF ADVANCE DIRECTIVES

- **RECIPROCITY:**
- All 50 states have laws regarding advance directives. The laws and the forms vary from state to state; however, most states will honor an advance directive that is properly executed in the state of residence where the document was executed.
- *Note again: Massachusetts will <u>not</u> honor an out of state Living Will as a legally binding document.*

22

The Choice of an Agent
Where to Start?

23

There are two initial key decisions when starting the process of preparing an Advance Directive:

<u>WHO</u> is the right choice as an Agent; and

<u>WHAT</u> actions the Principal wants their health care providers to take.

24

A PERSONAL ADVANCE DIRECTIVE STORY

25

IT BEGAN WITH A CALL ONE WINTER'S NIGHT

26

We often avoid speaking about end-of-life care. Perhaps it's out of fear or anxiety.

As a society, we're uncomfortable discussing - and preparing adequately for - death.

End-of-life conversations frequently occur at those moments: the end of life, when we're at our most vulnerable and when family members' strength is sapped and hearts are broken.

Effective "advance care planning", as it's often called, reflects conversations patients have with their doctors that evolve over time. Conversations about end-of-life care are among the most important interactions doctors and patients may have; but for some healthcare providers, they may be the most challenging.

Recognizing the importance of end-of-life ("advance care") planning and the fact these conversations between patients and their healthcare providers take time, the Centers for Medicare & Medicaid Services (CMS) began reimbursing physicians for advance care planning as a payable service for traditional Medicare beneficiaries.

27

WHO SHOULD YOU CHOOSE AS YOUR HEALTH CARE AGENT?

*Hint: It's **not** always a family member*

28

WHO **CANNOT** SERVE AS AN AGENT:

THE PRINCIPAL'S TREATING HEALTH CARE PROVIDER;

A NON-RELATIVE EMPLOYEE OF THE TREATING HEALTH CARE PROVIDER,

AN OPERATOR OF A COMMUNITY CARE FACILITY; OR

A NON-RELATIVE EMPLOYEE OF AN OPERATOR OF A COMMUNITY CARE FACILITY.

29

THEN WHO?

SOMEONE WHO IS "MEDICALLY LITERATE".

Need NOT be a health care professional, but they should be able to understand what the doctor is saying, be able to understand the medical words, and be able to understand the medical choices being offered. If the potential agent would easily be confused by what a health care provider would say, then they aren't the right choice.

SOMEONE WHO KNOWS YOU VERY WELL. What you would want in a medical crisis, and would tell the doctor what you have told them in the past about your wishes.

They will be asked to listen to medical information and then to use the Principal's values to make medical decisions. The decision maker is not supposed to use their own values; instead, they should speak as if they were the Principal. If the potential agent would not respect the principal's choices or they have very different beliefs, then they aren't the right choice.

THE RIGHT AGENT IS SOMEONE WHO WILL SPEAK AS IF THEY ARE SPEAKING WITH THE PRINCIPAL'S VOICE, NOT THEIRS.

30

SOMEONE WHO WILL NOT FALL APART IN A CRISIS.

It does not do anyone any good if a health care Agent tends to be hysterical, cannot function in a crisis situation, or cannot stand to visit the Principal in the hospital. A health care Agent needs to be brave enough to be by the Principal's side no matter how difficult things get. If a potential agent does not handle their own personal life very well, then they really shouldn't be in charge of the Principal's life.

SOMEONE WHO WILL DO RIGHT BY THE PRINCIPAL EVEN IF IT'S THE MOST DIFFICULT THING THEY HAVE EVER HAD TO DO.

The right decision maker needs to be able to live with the difficult decisions they have to make. They should be making decisions based on what the Principal would want, not what they would want - but that does not make it any easier.

If a potential agent is too afraid to talk about the "tough stuff" such as death and dying, then they're not the right person for the job. And, if they would refuse to follow through with what the Principal desires, then they aren't the right person.

31

IF POSSIBLE, CHOOSE SOMEONE WHO LIVES CLOSE BY OR CAN AFFORD TO TRAVEL QUICKLY TO WHERE THE HOSPITAL OR WHERE THE PRINCIPAL IS MOST LIKELY TO BE A PATIENT, SO THAT THEY MAY SPEAK IN PERSON TO HEALTH CARE PROVIDERS.

Too often, poor decisions are made because people cannot understand that their loved one's condition has changed drastically and the person is no longer as they remember. Sometimes it really does make a difference to see the situation and circumstances firsthand and not simply over the phone.

SELECT ONLY ONE PRIMARY HEALTH CARE AGENT, AS WELL AS AN ALTERNATE AGENT.

This can be problematic for some because they don't want to offend those whom they have not selected. When someone has several children, selecting one adult child as the health care Agent may seem offensive to the others. They need to realize, though, that sometimes the situation, which is already a stressful one, can become worse when multiple decision makers can't agree with one another. The result can often be that good decisions will not get made.

32

AND WHAT?

Should one be specific or vague about the specific medical treatments they would want?

An individual may have written on their Advance Directive that they would never want to have artificial breathing. But, how will this statement be interpreted by their health care providers?

Sometimes mechanical ventilation is needed for a short period of time. When the Principal provides some "specifics" about certain potential medical choices, they need to be certain that what they have written is applies often unpredictable or unanticipated medical situations.

Some people choose to remain vague because we seldom know the exact medical situation we may encounter.

33

SOMETIMES IT'S HELPFUL TO EXPRESS YOUR THOUGHTS IN WRITING AS A SUPPLEMENTAL PART OF A HEALTH CARE PROXY DOCUMENT.

Some individuals prefer to put in writing a statement as to the kind of life they would want to live if they were no longer able to make or communicate their health care wishes.

For some people, any condition is acceptable as long as they are "alive".

Others can't imagine a worse existence than being dependent on others to feed, clean, and clothe them, or if they are no longer able to recognize their loved ones.

The question becomes: How will their family and health care providers know what they would want if they don't tell them?

It can often be helpful for the Principal to memorialize their thoughts in a statement so that their Agent and health care providers will know what is important to them. One can write a statement that is meaningful to them and attach it to their DPOA for Health Care, or they can write it on the DPOA for Health Care form itself for greater assurance.

34

WHERE?

WHERE YOU STORE YOUR ADVANCE DIRECTIVE CAN BE ALMOST AS IMPORTANT AS PREPARING ONE IN THE FIRST PLACE.

A HEALTH CARE PROXY NEEDS TO BE READILY AVAILABLE AND EASY TO LOCATE!

35

DON'T HIDE AN ADVANCE DIRECTIVE!

DON'T KEEP IT IN A SAFE DEPOSIT BOX!

36

DO MAKE COPIES

37

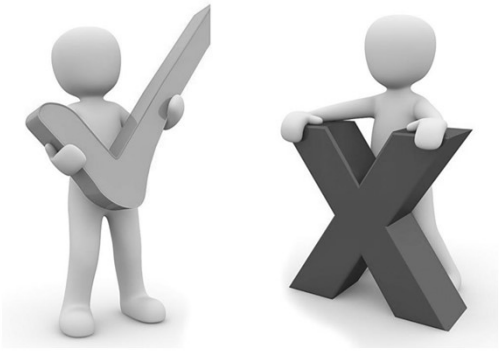
Unlike other legal documents such as a Last Will and Testament, photocopies of an executed Advance Directive are enforceable, and so it's wise to keep a copy of an Advance Directive in your purse, wallet, and even in the glove box of the car.

Remember that other people may need IMMEDIATE ACCESS to the document.

DO Provide copies to both your health care Agent and your Alternate Agent.

Be certain physicians providing care have copies and provide them to everyone who might be involved with your health care, including family, clergy, or friends. A local hospital might also be willing to file an advance directive in the event of a later admission, provided there's already an existing medical record established there.

38



39

DO

DO - APPOINT AN ALTERNATE AGENT IN THE EVENT THE PERSON CHOSEN AS THE AGENT IS UNAVAILABLE OR UNABLE TO MAKE DECISIONS.

DO - CONSULT WITH AN ATTORNEY IF DESIRED; HOWEVER, AN ATTORNEY IS NOT REQUIRED IN ORDER TO COMPLETE A HEALTH CARE PROXY.

DO - INFORM THE AGENT AND THE ALTERNATE AGENT OF THE FACT THAT A HEALTH CARE PROXY HAS BEEN PREPARED OR UPDATED AND THEY HAVE BEEN NAMED AS AGENTS.

IT'S NOT ENOUGH TO SIMPLY MENTION THE EXISTENCE OF AN ADVANCE DIRECTIVE - A PRINCIPAL SHOULD ALSO DISCUSS THEIR WISHES AND PREFERENCES WITH THEIR HEALTH CARE PROVIDERS SO THEY MAY ACT IN THE PATIENT/PRINCIPAL'S BEST INTERESTS AND CONSISTENT WITH THOSE WISHES.

40

DO

DO - CONSIDER WHAT IS THE STATE OF DOMICILE AND PRIMARY RESIDENCE WHEN CREATING A HEALTH CARE PROXY.

IT'S PRUDENT TO PREPARE AN ADVANCE DIRECTIVE CONSISTENT WITH THE LAWS OF THE STATE OF DOMICILE (THAT IS, THE INTENDED PRIMARY RESIDENCE).

41

THE KEY TO AN EFFECTIVE ADVANCE DIRECTIVE?

42

DON'T

DON'T WORRY THAT A DPOA FOR HEALTH CARE IN ANY WAY LIMITS THE CONTROL AN INDIVIDUAL HAS OVER THEIR OWN HEALTH CARE DECISIONS WHENEVER AND HOWEVER THEY ARE ABLE TO COMMUNICATE THOSE DECISIONS.

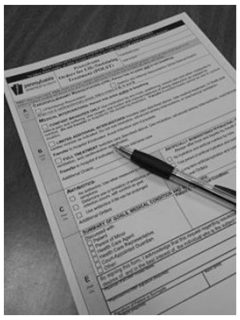
DON'T CONFUSE A DPOA FOR HEALTH CARE WITH A FINANCIAL POWER OF ATTORNEY.

DON'T THINK OF A DPOA FOR HEALTH CARE AS BEING ONLY FOR THE ILL OR THE ELDERLY. ANY ADULT WHO WISHES TO DIRECT THEIR MEDICAL CARE IN THE FUTURE, EVEN TEMPORARILY, SHOULD COMPLETE AN ADVANCE DIRECTIVE.

43

MOLST

MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT



44

MOLST

- A Medical Order for Life Sustaining Treatment – MOLST – is a medical order, similar to a prescription, authorized pursuant to Rhode Island laws and regulations pertaining to the rights of the terminally ill.
- It is used by terminally ill patients and their healthcare providers to document end-of-life wishes, regardless of who provides the patient's medical care or where the patient's medical care is provided. That is, it is "transportable" and can "travel" between care settings and honored by any health care provider who follows medical orders.

45

- A MOLST is entirely voluntary and may be used as a part of advance care planning.
- Communication is key to the creation and use of a MOLST. The patient (or their health care decision-maker or guardian)must first have discussions with their health car providers about their medical condition, prognosis, goals of care and benefits of treatment).
  - Decisions are made by the patient and their MOLST-qualified health care provider (a physician, physician's assistant (PA), or an advance practice registered nurse (APRN).
- It is signed by both the patient (or their health care decision-maker or guardian) and the qualified MOLST health care provider.

46

WHAT IS **MOLST**?

- It requires the signature of the patient's MOLST-Qualified Healthcare Provider – either a Physician, Registered Nurse Practitioner RNP, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA).
- It is suitable for persons of any age.
- It is honored by health care professionals across health care settings (including Emergency Medical Technicians), throughout Rhode Island.

47

- It is authorized for use by the Rhode Island Department of Health.
- Its voluntary implementation follows the patient's in-depth discussions with their health care provider about their medical condition, prognosis, goals of care, and benefits and burdens of treatment, and it is effective immediately upon signature.
- Those discussions should involve:
  - ✓ The patient's current medical condition;
  - ✓ What could happen next;
  - ✓ The patient's values and goals for care; and
  - ✓ Possible risks and benefits of treatment that may be offered.

48

MOLST

THE MOLST form has 5 sections:

Section A: Cardiopulmonary Resuscitation (CPR)

"*Person has no pulse and is not breathing.*"

The choice is to select either:

- "Attempt Resuscitation/CPR" or
- "Do Not Attempt resuscitation/DNR ("*Allow Natural Death*")

49

MOLST

Section B: Medical Intervention

"*Patient has a pulse and/or is breathing.*"

The choice is to select either:

- "Comfort Measures Only" (*medication, pain relief, oxygen etc. for comfort, antibiotics only for comfort*); or
- "Limited Additional Interventions" (*comfort measures as above and medical treatment, antibiotics, IV fluids, do not intubate, use non-invasive positive airway pressure, and generally avoid intensive care);* or
- "Full Treatment" (*includes all of above as well as additional treatment such as intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion.)*

50

MOLST

Section C: Transfer to Hospital

The choice is to select either:

- "Do not transfer to hospital for medical interventions" or
- "Transfer to hospital if comfort measures cannot be met in current location"

51

MOLST

Section D: Artificial Nutrition (For example a feeding tube)

"Offer food by mouth if feasible and desired."

The choice is to select either:

- "No artificial nutrition"; or
- "Defined trial period of artificial nutrition"; or
- "Long-term artificial nutrition, if needed"; or
- "Artificial nutrition until not beneficial or burden to patient".

52

MOLST

Section E: Artificial Hydration

"Offer fluid/nutrients by mouth if feasible and desired."

The choice is to select either:

- "No artificial hydration"; or
- "Defined trial period of artificial hydration"; or
- "Long-term artificial hydration, if needed"; or
- "Artificial hydration until not beneficial or burden to patient".

53

MOLST

Section F: Advance Directive (if any)

"Check all advance directives known to be completed."

- "Durable Power of Health Care";
- "Health Care Proxy";
- "Living Will";
- "Documentation of Oral Advance Directive".

Discussed with: Patient, Health Care Decision Maker, Parent/Guardian of Minor, Court-Appointed Guardian, or Other

54

MOLST

Section G: Signature

Signature of the MOLST-Qualified Healthcare Provider:

- *Physician, RNP, Advanced Practice Registered Nurse, or Physician Assistant*

Signature is required. Phone #, Date & Time, printed name, RI License #

_____

Signature of the Patient, Decision Maker, Parent/Guardian of Minor, or Guardian:

Signature is required. Phone #, Relationship (if patient write "self"; and printed name and address.

55

MOLST

At the bottom of the form:

"Send MOLST form with person whenever transferred or discharged."

RI General Laws §23-4.11-3.1

56

WHAT IS **MOLST**?

- It can be revoked at any time, and the patient or their health care Agent can request and receive previously refused medically-indicated treatment at any time. A patient may request to complete a new MOLST form at any time
- It does not expire unless expressly stated on the MOLST form.
- It is valid in copied, faxed, electronic, or original format.

57

AFTER THE **MOLST** IS SIGNED

- The original MOLST form stays with the patient.
- The MOLST form should be placed where it can be easily located (*e.g.* on the refrigerator, at the bedside).
- The form should *go with the patient* to all care settings and during any trips/appointments outside the home.
- Family and caregivers should be informed about the MOLST form, its contents, and where to find it.
- Copies of the MOLST *are* valid; make copies for all the patient's health care providers and to put in the EHR.

58

A MOLST IS NOT A "DNR" ORDER

- A MOLST is NOT a replacement or substitute for the Rhode Island Comfort Care/Do Not Resuscitate (CC/DNR) Verification Protocol for EMTs.
  - MOLST builds on and expands the experience of the CC/DNR Verification Protocol by containing a range of treatment options (not only resuscitation). With MOLST, patients can request that they receive or refuse certain treatments.
  - Can an individual have a CC/DNR form, a MOLST form, and a Health Care Proxy form?

  The answer is yes. All the forms are valid and should be maintained together. In the event of cardiac or respiratory arrest, the most recent orders will be followed; in other instances, MOLST orders will apply.

59

UPDATING A **MOLST**

- MOLST forms should be re-discussed with patients any time there is a significant change in the patient's health status, location, level or goals of care, or treatment wishes.
- A patient can ask to change or void their MOLST at any time, and they can always request and receive previously refused medically-indicated treatment.
- Any change to the MOLST form requires the form to be voided and a new form created and documented in the patient's medical record.

60

HOW TO VOID A **MOLST**

- Write "VOID" across both pages of the MOLST form.
- Instruct the patient that all copies of the outdated form must be destroyed.
- Document updates to MOLST instructions in the medical record.
- If requested, create a new MOLST form.

61

COMFORT ONE

- Comfort One is a mechanism for emergency medical personnel outside the hospital arena to honor the wishes of an individual who suffers from a terminal illness and has already declared their wishes via a DPOA for Health Care or a Living Will.
  - A physician must complete special forms which are kept on file with the Rhode Island Department of Health.
  - An orange Comfort One bracelet & identification number are issued to the individual, which alerts emergency medical personnel to provide only supportive care, and no resuscitative measures.
- The Comfort One protocol can be easily revoked at any time - orally or in writing - to the individual's physician or health care provider or by removing/destroying the bracelet.

62

WHAT HAPPENS WHEN THERE IS NO HEALTH CARE PROXY?

- You cannot be denied health care because you do not have an Advance Directive.
- In the absence of a properly executed Durable Power of Attorney for Health Care, decision-making authority regarding health-related matters generally defaults to a person's "next of kin," often the spouse or the closest adult biological family member, and always in collaboration with the attending healthcare provider.
- Clearly, if one has not told their family what it is they would want in a particular situation, the family, and the patient's health care providers, will be left to guess.
- This may be a difficult burden for both family and providers alike, and they may not make the decisions the patient would have wanted them to make.
- In extraordinarily circumstances, if a patient has no family, or if there is disagreement about what treatment the patient would want, a hospital or healthcare provider may ask that a court appoint a guardian to make decisions on the patient's behalf.

63

FINAL THOUGHTS

O
th
ac

64

RIALA
RHODE ISLAND ASSISTED LIVING ASSOCIATION

Jay M. Elias, Esq.

DYER-LAKE

Peace of Mind

161 Commonwealth Avenue
North Attleboro, MA 02763
Tel.: (508) 695-0200
www.Dyer-LakeFuneralHome.com

65