

ADVANCE CARE PLANNING



COMMUNITY-WIDE END-OF-LIFE / PALLIATIVE CARE INITIATIVE COMMUNITY CONVERSATIONS ON COMPASSIONATE CARE

Know your choices, share your wishes:

Maintain control, achieve peace of mind,
and assure your wishes are honored.



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Compassion and Support

CompassionAndSupport.org

Dear Fellow Citizens,

What would happen if you experienced a sudden illness that prevented you from making your own medical decisions? How would you ensure that you receive the kind of care that you wanted? Would your family or loved ones know enough about what you value and what matters to you to feel comfortable about making decisions about your care?



According to the 2008 End-of-life Care Survey of Upstate New Yorkers, nearly nine of ten local adults said it is important to have someone close to them making medical decisions for them if they were to have an irreversible terminal condition and were unable to make these decisions. Yet fewer than half have designated a Health Care Agent, (known as a "Durable Power of Attorney for Health Care" in other states) someone you trust to make your health decisions if or when you can't.

With the input of more than 150 community volunteers, the Community-wide End-of-life/Palliative Care Initiative developed a two-step approach to Advance Care Planning that is outlined in this comprehensive Advance Care Planning booklet. Section One outlines the Community Conversations on Compassionate Care (CCCC) Program that encourages all adults 18 and older to start a conversation and use **Five Easy Steps** to complete an advance directive:

1. Learn about Advance Directives
 - New York State Health Care Proxy and Living Will
 - Advance Directives from other states
2. Remove Barriers
3. Motivate Yourself by watching testimonial videos at CompassionAndSupport.org.
4. Complete Your Health Care Proxy and Living Will
 - Talk to your family and physician or nurse practitioner about what matters to you
 - Choose the right Health Care Agent
 - Discuss your values, beliefs and what is important to you
 - Understand life-sustaining treatment
 - Share copies of your completed advance directives
5. Review and Update

Section Two describes the Medical Orders for Life-Sustaining Treatment (MOLST) Program that was developed for those who are seriously ill or near the end of their lives to ensure a person's end-of-life wishes are followed whether the person is at home, in a nursing home, in a hospital or in any community setting. In July 2008, Gov. David A. Paterson signed into law a bill that makes MOLST a permanent, statewide program. The New York State Department of Health's (DOH) revised MOLST form (DOH-5003) is included in this easy to understand booklet and aligns with the Family Health Care Decisions Act (FHCDA). The FHCDA **DOES NOT** eliminate the need for open and honest conversations with loved ones about your wishes and desires for medical care and completion of advance directives.

We are pleased to produce this revised Advance Care Planning booklet on behalf of the Community-wide End-of-life/Palliative Care Initiative to help individuals "Know Your Choices and Share Your Wishes." While advance directives may differ from state to state, the Advance Care Planning process outlined in this booklet is the same. Additional information to assist in medical decision-making is available at the community website CompassionAndSupport.org. Conversations change lives. Start your conversation today! Complete your advance directive today!

Sincerely yours,

Patricia A. Bomba MD

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Leader, Community-wide End-of-life/Palliative Care Initiative
Chair, MOLST Statewide Implementation Team

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Step 1: Learn about Advance Directives

Advance Care Planning: What is it?

Advance Care Planning (ACP) is a process of planning for future medical care in case you are unable to make your own medical decisions. It is a continual process and not merely a document or isolated event.

Advance Care Planning assists you in preparing for a sudden unexpected illness, from which you expect to recover, as well as helping us to live well when we are approaching death.



Advance Care Planning is a gift to you and your family. Advance Care Planning lets you authorize someone you trust to make your health decisions if or when you can't. It allows you to maintain control over how you are treated and to ensure that you experience the type of care that will help you live well as you are approaching death and attain the type of death that you desire.

The Advance Care Planning process involves the following:

- Becoming educated about the topic
- Removing barriers or reasons for not completing the process
- Motivating yourself to "Know Your Choices and Share Your Wishes" with your loved ones and physician or nurse practitioner
- Clarifying what matters to you and documenting your values, beliefs and goals
- Choosing a Health Care Agent identified in the Health Care Proxy, (known as a "Durable Power of Attorney for Health Care" in other states) and an alternate Health Care Agent identified in the Health Care Proxy to work with your physician or nurse practitioner to make medical decisions on your behalf in case you are unable to speak for yourself
- Reviewing your wishes and desires about death as well as organ donation with your Health Care Agent, alternate Health Care Agent, and the people you trust and/or those whose decisions will impact the manner in which you die (e.g. family, close friends, spiritual advisor, physicians or nurse practitioners, lawyers)
- Completing the New York Health Care Proxy and Living Will forms (also known as advance care directives, or directives) or advance directives from other states that identify your Health Care Agent and alternate Health Care Agent and specify your desires and wishes. Put it in writing!
- Reviewing and updating these forms periodically or after major life-altering events
- Conducting *ongoing* discussions and updates about your wishes and desires about death with your Health Care Agent, alternate Health Care Agent, those you trust and/or those who may care for you when you are approaching death

Advance Care Planning begins with conversations among families and other trusted individuals, such as close friends, a physician or nurse practitioner, etc. The process builds trust and establishes relationships among family, close friends, health care professionals and others who will care for you or be with you as you approach death. **Advance Care Planning permits peace of mind for you and your family by reducing uncertainty and helping to avoid confusion and conflict over your care.**

Remember: Directives apply **only** when the need arises and you are unable to make your own medical decisions.

Learn more about Advance Care Planning at CompassionAndSupport.org.

Information about the Forms

This booklet contains two types of **Advance Directives** that protect your right to request treatments *you want* and to refuse medical treatments *you do not want* in case you lose the ability to make medical decisions yourself:

1. The **New York Health Care Proxy** is a legal document that lets you name someone to make decisions about your medical care, including decisions about life-sustaining treatment. The Health Care Proxy form appoints someone to speak for you *any time you are unable to make your own medical decisions, not only at the end of life*.
2. The **New York Living Will** lets you state your wishes about medical care in the event that you develop an *irreversible* condition that prevents you from making your own medical decisions. The Living Will becomes effective if you become terminally ill, permanently unconscious or minimally conscious due to brain damage and will never regain the ability to make decisions. Persons who want to indicate under what set of circumstances they favor or object to receiving any specific treatments use the New York Living Will.



You do not need to notarize your New York Health Care Proxy form or New York Living Will.
You do not need a lawyer to fill out these forms.

These documents will be legally binding only if the person completing them is a competent adult (at least 18 years of age); the documents are properly signed, witnessed and dated; and the documents are available when needed.

Frequently Asked Questions

1. Do I need to complete both of these documents?

Completing both documents helps to ensure that you receive the medical care you desire. However, you should continue to have ongoing discussions with your Health Care Agent to ensure that that person knows your values and wishes and can speak on your behalf regardless of what your circumstances may be. In addition, it is beneficial to have completed both documents in case you suffer an injury or acute medical episode while traveling and are unable to make medical decisions for yourself. Completing both documents increases the likelihood that at least one of the documents will be legally recognized in another state.

2. How can I be sure that my New York Health Care Proxy will be honored?

To be legally valid, you must sign and date your Health Care Proxy form in the presence of **two** adult witnesses. The witnesses must sign a statement in your Health Care Proxy to confirm that you signed the document willingly and free from duress. Your Health Care Agent and alternate Health Care Agent cannot act as witnesses.

3. How do I make sure that my New York Living Will is going to be honored?

Unlike most states, New York does not have a specific law recognizing living wills but relies upon "clear and convincing evidence" of your wishes. Documenting your wishes in a Living Will may help to show the required level of "clear and convincing evidence." You should follow the witnessing procedures established in the Health Care Proxy Act and sign your Living Will in the presence of two adult witnesses.

4. Can I list more than one alternate Health Care Agent?

Yes, you may list as many as you would like. However, each alternate Health Care Agent must meet the criteria listed on page 7 (see "What to Keep in Mind When Choosing a Health Care Agent").

5. Do I need to add personal instructions to my New York Health Care Proxy?

You do not need to add personal instructions to your Health Care Proxy except regarding artificially administered fluids and nutrition. One of the strongest reasons for naming a Health Care Agent is to have someone who can respond *flexibly* to changes in your medical situation. Adding personal instructions to the New York Health Care Proxy may unintentionally restrict your Health Care Agent's power to act in your best interest.

6. Can I add personal instructions to my Living Will?

Yes. Personal instructions may be added to the section titled "Other Directions." If there are specific treatments you wish to refuse that are not already listed on the document, you may list them here. Also, instructions such as "I want maximal pain medications, even if it hastens my death," "I do not want to be placed in a nursing home," or "I want to die at home" can be added to this section. If you have appointed a Health Care Agent, it is a good idea to include a statement such as, "Any questions about how to interpret or when to apply my Living Will are to be decided by my Health Care Agent."

7. What are life-sustaining treatment such as cardiopulmonary resuscitation (CPR), intubation and mechanical ventilation, and artificially administered fluids and nutrition?

See page 9 and 10 of this booklet for a detailed explanation of life-sustaining treatment.

8. What if I change my mind about my New York Health Care Proxy or Living Will?

You may revoke your New York Health Care Proxy or Living Will by notifying your physician, nurse practitioner or Health Care Agent orally or in writing of your revocation, or by any other act that clearly shows your intent to revoke the document. Once informed, your physician or nurse practitioner must record the revocation in your medical record and notify your Health Care Agent and any medical staff responsible for your care. Additionally, an updated form voids any previous forms.

9. If I live in another state or spend extended periods of time in another state, will my New York or other state-specific advance directives be honored in that state?

Each state has its own laws governing Advance Care Planning and the use of Health Care Proxy forms, Living Wills, MOLST and Do Not Resuscitate Orders. Therefore, it is important that you investigate that state's laws on Advance Care Planning. You may want to begin by checking out the state's Department of Health website or going to caringinfo.org where you can find Advance Directives from other states, or POLST.org that describes medical orders programs in other states.

10. Are there any restrictions on who can be my Health Care Agent?

Your Health Care Agent **cannot** be:

- a. An operator, administrator or employee of a health care facility in which you are a resident or patient, or to which you have applied for admission, at the time you sign your proxy, unless that person is a relative by blood, marriage or adoption;
- b. A physician or nurse practitioner, if that person also acts as your attending physician or nurse practitioner.

11. What do I do if I am a resident in a facility licensed or operated by the Office of Mental Health or the Office for People with Developmental Disabilities?

Special witnessing requirements exist for residents of facilities operated or licensed by the Office of Mental Health or the Office for People with Developmental Disabilities (OPWDD). For more information, in NYS, contact OPWDD at opwdd.ny.gov, call 1 (866) 946-9733 or visit CompassionAndSupport.org.

Step 2: Remove Barriers

Common reasons given for not completing a Health Care Proxy form in the 2008 End-of-Life Care Survey of Upstate New Yorkers: Advance Care Planning (ACP) Values and Actions* include:

- **Don't need it/don't think it's important:** Acute illness or injury can occur unexpectedly at any time.
- **Don't know enough about it:** You have begun by reading this ACP booklet. For more information, visit CompassionAndSupport.org.
- **Too young to be concerned about it:** Acute illness or injury can occur unexpectedly at any time and knows no age boundary.
- **Not having the time/haven't gotten around to it:** ACP is an important aspect of planning, similar to creating a financial plan and legal planning like writing a will.
- **Not knowing where to get the forms:** All the necessary forms are contained in this ACP booklet and are also available on CompassionAndSupport.org.
- **Don't know whom to designate as my Health Care Agent:** Read more about how to choose your Health Care Agent.
- **Uncomfortable thinking about such things:** If you are uncomfortable, you are not alone. Talking about death can be difficult but conversation does not make death happen.

Step 3: Motivate Yourself

If you are having difficulty beginning the conversation, start with stories that show how Advance Care Planning helps to maintain control, achieve peace of mind and is an important step in assuring that personal wishes are honored. Knowing what is important to an individual can reduce the burden of decision-making and avoid potential conflict and confusion for loved ones. Ten personal stories and the Five Easy Steps are highlighted in the Community Conversations on Compassionate Care videos that are available on the CompassionAndSupport.org website.

Step 4: Complete Your Health Care Proxy and Living Will

Talk to Your Family and Your Physician or Nurse Practitioner

Problems may arise if you fail to plan or fail to share your wishes with your Health Care Agent, your family, your physician or nurse practitioner. Problems may arise if your goals for care or treatment change, but these wishes are not reflected in your documented forms. At times, an individual's preferences may be unclear or the focus may be too narrow. It is important to clarify wishes with your Health Care Agent ahead of time so that he or she can avoid making assumptions.

Be sure to talk to your Health Care Agent, alternate Health Care Agent, physician or nurse practitioner, spiritual advisor, family and close friends about your goals for care and wishes concerning medical treatment. Discuss your goals for care and wishes with them often, particularly if your medical condition changes.

Be aware that your New York documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that is called a Do Not Resuscitate Order (DNR). Read more on DNR and the Medical Orders for Life-Sustaining Treatment (DOH-5003 MOLST) in this booklet and on MOLST.org. Information on programs in other states can be found on POLST.org.



Choose the Right Health Care Agent

It is important to choose the right Health Care Agent identified in the Health Care Proxy, (or Advance Directives from other States) because **this person will serve as your spokesperson to ensure that your wishes are carried out based on your previously expressed and discussed values and beliefs.** In addition, you should also choose the right alternate Health Care Agent identified in the Health Care Proxy, (or Advance Directives from other states) to substitute if your primary Health Care Agent is unable or unavailable. In some states, a Health Care Agent is known as a "Durable Power of Attorney for Health Care."



You indicate your Health Care Agent and alternate Health Care Agent using a legal document called the New York Health Care Proxy, or Advance Directives from other states. This form identifies your Health Care Agent (the individual you have designated to make decisions about your medical care, including decisions about life-sustaining treatment) if you can no longer decide for yourself.

What to Keep in Mind When Choosing a Health Care Agent

This person must:

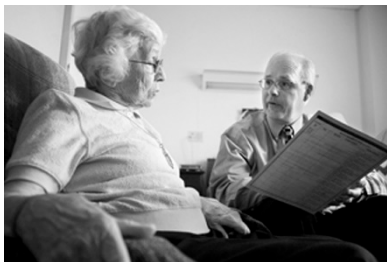
- Meet legal criteria (competent adult, at least 18 years old)
- Be willing to speak on your behalf
- Be willing to act on your wishes
- Be able to separate his/her own feelings from yours
- Live close by or be willing to come
- Know you well
- Understand what is important to you
- Be willing to talk with you now about sensitive wishes
- Be willing to listen to your wishes
- Be able to work with those providing your care to carry out your wishes
- Be available in the future
- Be able to handle potential conflicts between your family, close friends
- Be able to handle responsibility

Questions for the Person That You Might Designate as a Health Care Agent

Your Health Care Agent may be required to speak for you in a variety of circumstances. These situations might include those in which your desires may not mesh with the opinions and beliefs of either your Health Care Agent or others concerned about your welfare. **Below are questions to discuss with the individual(s) you may be considering choosing as your Health Care Agent.** Discussing these questions with a potential Health Care Agent beforehand will help you feel confident that the person chosen for this function is the best one to decide for you when you cannot do so.

1. Will you respect my wants and needs, even if they are different from what they used to be, or if you think they are unusual or foolish?
2. If I cannot communicate for myself, will you make sure that what I have asked is done, even if you would make different choices yourself?
3. Will you talk with me openly and lovingly about any unfinished business between us and listen if I need to apologize or ask for forgiveness for anything that has hurt you in the past?
4. Will you talk with me about my coming death – my fears, my sorrows, my joys and gratitude?
5. Will you care for yourself so that you are not drained by my illness?
6. Will you stay with me even if the going gets rough?
7. Will you seek out information about my disease and what to expect as I get sicker and near the end of life?

Discuss Your Values, Beliefs and What is Important to You



Many people have strong opinions about what would be important to them at the very end of their lives. Others want to make sure that certain things they dislike or fear will be avoided. Therefore, it is important for you to take some time to explore your own values and beliefs.

After investigating your values and beliefs, it is important that your Health Care Agent and alternate Health Care Agent, family, close friends, spiritual advisor, physician or nurse practitioner, and lawyer understand your specific values and beliefs. Below are some questions for you to think about and discuss with your Health Care Agent and alternate Health Care Agent in order to make sure that he/she understands you and can act on your behalf.

Exploratory Questions: Your Feelings about End-of-Life Care

What are some of the things that you would hope for that could make your last weeks, days, or hours the most peaceful?

What are your biggest hopes about the end of your life?

What are your biggest fears about the end of life?

Instructions: For each row, check one answer to express how important these issues would be to you if you were dying.

	Not Important	Moderately Important	Very Important	Extremely Important
a. Avoiding pain/suffering, even if it means that I might not live as long				
b. Being alert, even if it means I might be in pain				
c. Being around my family and close friends				
d. Being able to feel someone touching me				
e. Having religious or spiritual advisors at my side when I die				
f. Being able to tell my life story and leave good memories for others				
g. Reconciling differences and saying "good-bye" to my family and close friends				
h. Being at home when I die				
i. Being in a hospital when I die				
j. Being kept alive long enough for my family to get to my bedside to see me before I die, even if I'm unconscious				

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Understand Life-Sustaining Treatment

Note: In New York State, it is essential for your Health Care Agent to know your wishes about artificially administered fluids and nutrition. Documentation of these wishes is vital.

According to New York State Public Health Law, if you fail to include your wishes on artificially administered fluids and nutrition, your Health Care Agent **cannot** make these decisions.

The statement “My agent does know my wishes regarding artificial nutrition and hydration” as noted in the New York Health Care Proxy form included in this booklet is sufficient to allow your Health Care Agent to make these decisions.

Life-sustaining treatment or life support replaces or supports ailing bodily function. When patients have curable or treatable conditions, life support is used temporarily until the illness or disease can be stabilized and the body can resume normal functioning. At times, the body never regains the ability to function without life-sustaining treatment.

When making decisions about specific forms of life-sustaining treatment, gather the facts you need to make informed medical decisions. In particular, understand the benefit as well as the burdens that the treatment will offer you or your loved one. A treatment may be beneficial if it relieves suffering, restores functioning, or enhances the quality of life. The same treatment can be considered burdensome if it causes pain, prolongs the dying process without offering benefit, or detracts from a person’s quality of life. When gathering information about specific treatments, understand why the treatment is being offered and how it will benefit your care.

Given the rapid advances in medicine and technology, it is difficult to know all of the possible treatment choices in advance. This is why taking the time to clarify values and beliefs and to discuss personal goals of medical care is so important.

Understand How to Make Medical Decisions

When making decisions about life-sustaining treatment, it is important to consider the following questions:

- Will the treatment make a difference?
- Do the burdens of treatment outweigh the benefits?
- Is there hope for recovery? If so, what will life be like afterward?
- What do I value? What is important? What is the goal for my medical care?

Difficulty in decision-making arises when recovery cannot be predicted. In this case, a short-term trial of life-sustaining treatment may be desired. These trials must begin with clarifying the patient’s goals of care and require active discussions between your physician or nurse practitioner and your Health Care Agent about the most appropriate course of treatment. The patient’s goals for medical care should drive the choice of interventions.

Additional information to help make decisions regarding life-sustaining treatment can be found at MOLST.org.

Commonly Used Life-Sustaining Treatment

- **Cardiopulmonary resuscitation:** Cardiopulmonary resuscitation (CPR) involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital. When used quickly in response to a sudden event like a heart attack or drowning, CPR can be lifesaving. However, the success rate is extremely low for people who are at the end of a terminal disease process. Critically ill patients who receive CPR have a small chance of recovering. Patients who choose a DNR order indicate that they do not wish to have medical personnel attempt resuscitation in an emergency and prefer to allow natural death.
- **Intubation and mechanical ventilation:** Intubation and mechanical ventilation involves placing a tube down the patient's throat that is connected to a breathing machine (a ventilator or respirator) that pumps air into and out of the lungs. Mechanical ventilation is used to support or replace the function of the lungs. Mechanical ventilation is often used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure exists. Some people on long-term mechanical ventilation are able to enjoy themselves and live a quality of life that is important for them. For the seriously ill patient approaching death, however, mechanical ventilation often merely prolongs the dying process until some other body system fails. It may supply oxygen but it cannot improve the underlying condition. If a patient chooses not to be intubated and placed on a breathing machine, treatments are available for shortness of breath, such as oxygen and morphine.
- **Artificially administered fluids and nutrition (also referred to as, "artificial hydration and nutrition"):** When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. Artificially administered fluids and hydration can save lives when used until the body heals. Long-term artificially administered fluids and nutrition may be given to people with serious intestinal disorders that impair their ability to digest food, thereby helping them to enjoy a quality of life that is important to them. Long-term use of feeding tubes is frequently given to people with irreversible and end-stage conditions. For these patients, the treatment will not reverse the course of the disease itself or improve the quality of life and very often causes more harm than good.

The distinction often is made between not starting treatment and stopping treatment. **However, no legal or ethical difference exists between withholding and withdrawing a medical treatment in accordance with a patient's wishes.** If such a distinction existed in the clinical setting, a patient might refuse treatment that could be beneficial out of fear that once started it could not be stopped.

It is legally and ethically appropriate to discontinue medical treatments that are no longer beneficial. It is the underlying disease, not the act of withdrawing treatment, which causes death.

Additional information to help make decisions regarding life-sustaining treatment can be found on MOLST.org.

Practical Issues to Consider after Completing Your Documents

Share Copies of Your Completed Advance Directives: Assure Accessibility

Guarantee accessibility to your New York Health Care Proxy and Living Will or Advance Directives from other States.

- Keep a copy for yourself in a secure place. Do not put the documents in a safe deposit box or any other security box that would keep others from having access to them.
- Give a copy to your Health Care Agent and alternate Health Care Agent, your primary care physician or nurse practitioner, all specialist physicians or nurse practitioners who participate in your care and the primary hospital where you receive care. You may wish to give a copy to your spiritual advisor.
- A copy should be shared with an electronic registry, if one exists in the community.
- If you enter a nursing home or hospital, have copies of your documents placed in your medical records.

Talk to Your Physician or Nurse Practitioner

Your physician or nurse practitioner and the other professionals caring for you when you are seriously ill or approaching death may play an important part in ensuring that your wishes are understood and met. Work with your physician or nurse practitioner and consider asking your physician or nurse practitioner to fill out a Medical Orders for Life-Sustaining Treatment (MOLST) form. It is important to speak to your physician or nurse practitioner and other health care professionals ahead of time about what is important to you. At that time, ask them questions about the kind of support you think you may need and whether they think that they could provide this support to you.

You have a right to participate in the planning of your care even if you lose the capacity to make decisions. An advance directive gives you the ability to exercise this right. Physicians and nurse practitioners have a legal, moral, and professional responsibility to ensure this right is honored.

Questions individuals have asked their physician or nurse practitioner and other health care professionals:

1. Will you acquaint yourself with the social norms of my culture and religion and respect these?
2. Will you talk openly with me and/or my family about my illness?
3. What will you do if I have a lot of pain or other uncomfortable symptoms?
4. Will you let me know if treatment stops working so that my family and I can make appropriate medical decisions?
5. Will you support me in having my pain properly managed and in getting hospice care?
6. What will you do to make sure that you always listen to me and/or my family?
7. If I reach a point where I can't speak for myself, how will you make decisions about my care?
8. Will you still be available to me even when I'm sick and close to the end of my life?

Step 5: Review and Update

Review and update your forms periodically.

- Review after major life events like divorce, birth of a child or death of a spouse, as you may wish or need to choose a new Health Care Agent
- Reevaluate your wishes if new life-threatening or chronic illnesses develop, as these chronic illnesses progress, and after complicated life-sustaining treatment. Your wishes and desires may change after these events
- If your wishes change after your documents have been completed, an entirely new set of documents reflecting your new wishes must be written, signed, dated and witnessed. Give a new set of the documents to your Health Care Agent and alternate Health Care Agent, your primary care physician or nurse practitioner, all specialist physicians or nurse practitioners who participate in your care and the primary hospital where you receive care. These will replace the old version

Medical Orders for Life-Sustaining Treatment (MOLST)

Surveys have shown that people are not dying in the setting of their choice, most do not have advance directives in place, the majority of those being referred to hospice arrive too late to fully benefit, and most fear dying in pain and without dignity or control.



What is the MOLST Program?

The MOLST program is designed to improve the quality of care seriously ill people receive at the end of life. MOLST is based on the patient's current health status, prognosis, and goals for care. The discussion emphasizes shared medical decision-making that helps the patient understand what can and cannot be accomplished. The result is a set of medical orders that must be honored by all health care professionals in all settings. MOLST is New York's endorsed National POLST Paradigm Program.

What is the MOLST form?

The MOLST form is a bright pink medical order form that tells others the patient's wishes for life-sustaining treatment. A physician or nurse practitioner must complete or change the MOLST form, based on the patient's current medical condition, values, wishes and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the Health Care Agent or Surrogate. Completion of the MOLST is voluntary.

MOLST includes medical orders based on patient preferences regarding cardiopulmonary resuscitation, intubation and mechanical ventilation, artificially administered fluids and nutrition, future hospitalization and transfer, antibiotics, treatment guidelines and other instructions. The MOLST is approved by the New York State Department of Health for use in all settings statewide.

Must all health care professionals follow the medical orders on the MOLST form?

All health care professionals must follow these orders as the patient moves from one location to another, unless a physician or nurse practitioner examines the patient, reviews the orders and changes them.

Who should have a MOLST form?

MOLST is generally for patients with serious health conditions (advanced progressive chronic illness or terminal illness) and others who are interested in further defining their care wishes as they are facing the end of life. The patient or other decision-maker should work with the physician or nurse practitioner and consider asking the physician or nurse practitioner to fill out a MOLST form if the patient:

- Patients whose physician or nurse practitioner would not be surprised if they die in the next year
- Patients who live in a nursing home or receive long-term care services at home or assisted living
- Patients who want to avoid or receive any or all life-sustaining treatment today
- Patients who have one or more advanced chronic conditions or a new diagnosis with a poor prognosis
- Patients who have had two or more unplanned hospital admissions in the last 12 months coupled with increasing frailty, decreasing functionality, progressive weight loss or lack of social support

How is the MOLST form completed?

Completion of the MOLST begins with a conversation or a series of conversations between the patient, the Health Care Agent or the Surrogate, and the physician or nurse practitioner that defines the patient's goals for care, reviews possible treatment options on the MOLST form, and ensures the decision-maker understands the decisions made about life-sustaining treatment. If a

patient is not ready to discuss or make a decision regarding a specific life-sustaining treatment, full treatment will be provided.

Who signs the MOLST form?

A licensed physician or nurse practitioner must always sign the MOLST form. If the physician is licensed in a border state, the physician must insert the abbreviation for the state in which he/she is licensed, along with the license number.

Who makes medical decisions on the MOLST form?

Patients are presumed to have the ability to make medical decisions about life-sustaining treatment unless a physician or nurse practitioner and another health or social service practitioner determines the patient is unable to make such decisions, in accordance with the Family Health Care Decisions Act (FHCDA).

If the patient has the ability to make medical decisions, the patient makes the decision. If the patient loses the ability to make medical decisions and has a health care proxy, the Health Care Agent makes medical decisions. If the patient does not have a health care proxy, a Public Health Law Surrogate makes medical decisions. The FHCDA defines the Surrogate list and their authority. Surrogates under the FHCDA must meet higher standards in making these medical decisions because the patient did not have a prior discussion. Thus, completing a health care proxy and having a discussion with your family and physician or nurse practitioner is very important. For further information on the FHCDA, visit [MOLST.org](https://www.molst.org) and health.ny.gov.

Can the MOLST be used for patients with mental illness or developmental disabilities?

The MOLST is approved by the Office of Mental Health and the Office for People with Developmental Disabilities (OPWDD). Thus, the MOLST can be used for patients with mental illness and patients with developmental disabilities. If the patient has a developmental disability and does not have the ability to decide, the physician (not a nurse practitioner) must follow special procedures and attach the appropriate legal requirements checklist. Learn more at [MOLST.org](https://www.molst.org).

What is the difference between a Health Care Proxy/Living Will and the MOLST?

A Health Care Proxy and a Living Will are traditional advance directives for all adults 18 years of age and older. These advance directives are completed ahead of time and only apply when decision-making capacity is lost. A properly completed MOLST form contains valid medical orders. MOLST is **not** intended to replace traditional advance directives like the Health Care Proxy and Living Will. In contrast to a Health Care Proxy, the MOLST applies right now and is **not** conditional on the patient losing the capacity to make complex medical decisions.

What are the benefits of the MOLST Program?

MOLST orders are followed by Emergency Medical Services (EMS) personnel in the pre-hospital setting. Medical orders carry more weight in the field because they are precise and can be easily interpreted in an emergency. MOLST expands on the DNR order and provides additional orders for life-sustaining treatment and future hospitalization. The MOLST can be used in the community instead of the New York State Nonhospital Do Not Resuscitate (DNR) form. For more information regarding MOLST in New York State, please visit [MOLST.org](https://www.molst.org) and health.ny.gov.

Can MOLST be used in other states?

MOLST is New York State's approved National POLST Paradigm Program. For further information on other states with approved or developing programs, please visit [POLST.org](https://www.polst.org).

Checklist for Action

Using the simple checklist provided below will ensure that you do not miss a step while creating a comprehensive Advance Care Plan.

- ☐ I have thought about what is important to me and shared that with my family and loved ones
- ☐ I have chosen my Health Care Agent and alternate Health Care Agent
 - I have discussed my wishes with my:
 - ☐ Health Care Agent
 - ☐ Alternate Health Care Agent
 - ☐ Family members, close friends
 - ☐ Physician or Nurse Practitioner
 - ☐ Spiritual Advisor
 - ☐ Attorney
- ☐ I have discussed my wishes regarding artificially administered fluids and nutrition with my Health Care Agent and alternate Health Care Agent
- ☐ I have completed my New York Health Care Proxy or my state's Advance Directive
- ☐ I have documented on my Health Care Proxy or my state's Advance Directive, that my Health Care Agent knows my wishes regarding artificially administered fluids and nutrition
- ☐ I have documented my wishes about organ donation on my Health Care Proxy, New York State driver's license (or other New York State issued identification), and/or official organ donor card.
- ☐ I have registered my intent to be an organ donor and enrolled in the [New York State Donate Life Registry](#) (registration online at health.ny.gov), or other state registry, if available
- ☐ I have completed my New York Living Will
 - I have given copies of both my New York Health Care Proxy and Living Will to my:
 - ☐ Health Care Agent
 - ☐ Alternate Health Care Agent
 - ☐ Family members, close friends
 - ☐ Physicians or Nurse Practitioners
 - ☐ Hospital
 - ☐ Nursing Home or Assisted Living
 - ☐ Attorney
- ☐ I have filled out the wallet card enclosed in this booklet according to the directions, and I carry the wallet card with my state-issued identification and insurance card
- ☐ I have added my Health Care Proxy and Living Will, or my state's Advance Directive to the electronic registry, if available.
- ☐ I have reviewed and updated my advance directives, as needed
- ☐ I have thought about the MOLST or similar approved or developing program in my state.
- ☐ I have worked with my physician or nurse practitioner and asked the physician or nurse practitioner to fill out a MOLST form.

Appendix

- New York State Health Care Proxy Form
- New York State Living Will Form
- Medical Orders for Life-Sustaining Treatment (MOLST) DOH-5003 Form
- Nonhospital Do Not Resuscitate (DNR) Form

INSTRUCTIONS

PRINT YOUR
NAME

PRINT NAME,
HOME ADDRESS
AND
TELEPHONE
NUMBER OF
YOUR AGENT

ADD PERSONAL
INSTRUCTIONS
(If Any)

PRINT NAME,
AND
TELEPHONE
NUMBER OF
YOUR
ALTERNATE
AGENT

ORGAN
DONATION
(OPTIONAL)

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CARING, INC.

NEW YORK HEALTH CARE PROXY

(1) I, _____, hereby appoint:
(name)

(name, home address and telephone number of agent)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. **My agent does know my wishes regarding artificial nutrition and hydration.**

This Health Care Proxy shall take effect in the event I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows.

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

(name, home address and telephone number of alternate agent)

(4) Donation of Organs at
Death:

Upon my
death:

☐ I **do not** wish to donate my organs, tissues or parts.

☐ I **do** wish to be an organ donor and upon my death I wish to donate:

**ORGAN
DONATION
(OPTIONAL)
CONTINUED**

☐ (a) Any needed organs, tissues, or parts; **OR**

☐ (b) The following organs, tissues, or parts

☐ (c) My gift is for the following purposes:
(put a line through any of the following you do not want)

(i) Transplant

(ii) Therapy

(iii) Research

(iv) Education

**ENTER A
DURATION OR A
CONDITION
(IF ANY)**

(5) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

**SIGN AND DATE
THE DOCUMENT
AND PRINT
YOUR ADDRESS**

(6) Signature _____ Date _____

Address _____

**WITNESSING
PROCEDURE**

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document appeared to execute the proxy willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence. I am not the person appointed as proxy by this document

Witness 1 _____

Address _____

Witness 2 _____

Address _____

**YOUR
WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES**

NEW YORK LIVING WILL

This Living Will has been prepared to conform to the law in the State of New York, as set forth in the case In re Westchester County Medical Center, 72 N.Y.2d 517 (1988). In that case the Court established the need for "clear and convincing" evidence of a patient's wishes and stated that the "ideal situation is one in which the patient's wishes were expressed in some form of writing, perhaps a 'living will.'"

**PRINT YOUR
NAME**

I, _____, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, if I should be in an **incurable or irreversible mental or physical condition with no reasonable expectation of recovery**, including but not limited to: (a) **a terminal condition**; (b) **a permanently unconscious condition**; or (c) **a minimally conscious condition in which I am permanently unable to make decisions or express my wishes**.

I direct that my treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

While I understand that I am not legally required to be specific about future treatments **if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:**

- I do not want cardiac resuscitation.
- I do not want mechanical respiration.
- I do not want artificial nutrition and hydration.
- I do not want antibiotics.

However, I **do want** maximum pain relief, even if it may hasten my death.

**CROSS OUT
ANY
STATEMENTS
THAT DO NOT
REFLECT YOUR
WISHES**

**ADD PERSONAL
INSTRUCTIONS
(IF ANY)**

Other directions:

**SIGN AND DATE
THE DOCUMENT
AND PRINT
YOUR ADDRESS**

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signed _____ Date _____

Address _____

**WITNESSING
PROCEDURE**

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

**YOUR
WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES**

Witness 1 _____

Address _____

Witness 2 _____

Address _____

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN OR NURSE PRACTITIONER KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY)

☐ Male ☐ Female

eMOLST NUMBER (THIS IS NOT AN eMOLST FORM)

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)

This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form based on the patient's current medical condition, values, wishes, and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician or nurse practitioner must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician or nurse practitioner examines the patient, reviews the orders, and changes them.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician or nurse practitioner and consider asking the physician or nurse practitioner to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has an intellectual or developmental disability (I/DD) and lacks the capacity to decide, the doctor (not a nurse practitioner) must follow special procedures and attach the completed Office for People with Developmental Disabilities (OPWDD) legal requirements checklist before signing the MOLST. See page 4.

SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check **one**:

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**

CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**

This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law. Individuals with I/DD who do not have capacity and do not have a health care proxy must follow SCPA 1750-b.

SIGNATURE _____ ☐ Check if verbal consent (Leave signature line blank) DATE/TIME _____

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME

PRINT SECOND WITNESS NAME

Who made the decisions? ☐ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate*

SECTION C Physician or Nurse Practitioner Signature for Sections A and B

PHYSICIAN OR NURSE PRACTITIONER SIGNATURE*

PRINT PHYSICIAN OR NURSE PRACTITIONER NAME

DATE/TIME

PHYSICIAN OR NURSE PRACTITIONER LICENSE NUMBER

PHYSICIAN OR NURSE PRACTITIONER PHONE/PAGER NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:

☐ Health Care Proxy ☐ Living Will ☐ Organ Donation ☐ Documentation of Oral Advance Directive

***If this decision is being made by a 1750-b surrogate, a physician must sign the MOLST.**

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

DATE OF BIRTH (MM/DD/YYYY)

SECTION E

Orders For Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Breathing

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. **If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped. Before stopping treatment, additional procedures may be needed as indicated on page 4.**

Treatment Guidelines No matter what else is chosen, the patient will be treated with dignity and respect, and health care providers will offer comfort measures. *Check one:*

- ☐ **Comfort measures only** Comfort measures are medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort.
- ☐ **Limited medical interventions** The patient will receive medication by mouth or through a vein, heart monitoring and all other necessary treatment, based on MOLST orders.
- ☐ **No limitations on medical interventions** The patient will receive all needed treatments.

Instructions for Intubation and Mechanical Ventilation *Check one:*

- ☐ **Do not intubate (DNI)** Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as oxygen and morphine. (This box should not be checked if full CPR is checked in Section A.)
- ☐ **A trial period** *Check one or both:*
- ☐ **Intubation and mechanical ventilation**
- ☐ **Noninvasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate**
- ☐ **Intubation and long-term mechanical ventilation, if needed** Place a tube down the patient's throat and connect to a breathing machine as long as it is medically needed.

Future Hospitalization/Transfer *Check one:*

- ☐ **Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled.**
- ☐ **Send to the hospital, if necessary, based on MOLST orders.**

Artificially Administered Fluids and Nutrition When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have either a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. **Additional procedures may be needed as indicated on page 4.**

Check one each for feeding tube and IV fluids:

- ☐ **No feeding tube** ☐ **No IV fluids**
- ☐ **A trial period of feeding tube** ☐ **A trial period of IV fluids**
- ☐ **Long-term feeding tube, if needed**

Antibiotics *Check one:*

- ☐ **Do not use antibiotics.** Use other comfort measures to relieve symptoms.
- ☐ **Determine use or limitation of antibiotics when infection occurs.**
- ☐ **Use antibiotics** to treat infections, if medically indicated.

Other Instructions about starting or stopping treatments discussed with the doctor or nurse practitioner or about other treatments not listed above (dialysis, transfusions, etc.).

Consent for Life-Sustaining Treatment Orders (Section E) (Same as Section B, which is the consent for Section A)

SIGNATURE _____ ☐ Check if verbal consent (Leave signature line blank) DATE/TIME _____

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME

PRINT SECOND WITNESS NAME

Who made the decisions? ☐ Patient ☐ Health Care Agent ☐ Based on clear and convincing evidence of patient's wishes
☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate*

Physician or Nurse Practitioner Signature for Section E

PHYSICIAN OR NURSE PRACTITIONER SIGNATURE* _____ PRINT PHYSICIAN OR NURSE PRACTITIONER NAME _____ DATE/TIME _____

***If this decision is being made by a 1750-b surrogate, a physician must sign the MOLST.**

**Nonhospital Order Not to Resuscitate
(DNR Order)**

Person's Name: _____

Date of Birth: _____

Do not resuscitate the person named above.

*Physician's or Nurse Practitioner's Signature: _____

Print Name: _____

License Number: _____

Date: _____

It is the responsibility of the physician or nurse practitioner 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.

*For individuals with an Intellectual or Developmental Disability (I/DD), the non-hospital DNR **must** be signed by a physician.

For individuals with an I/DD who do not have capacity and do not have a health care proxy, the physician must ensure compliance with SCPA Section 1750-b.

Instructions for Wallet Card:

In case of emergency, this wallet card alerts medical personnel to the presence of a Health Care Proxy and directs them to your Health Care Agent.

To be most effective, the wallet card should be carried on you along with your state-issued identification and insurance card.

To use this Wallet Card:

- 1. Simply remove the card by cutting along the dotted line.
- 2. Fill out the card so that the card includes the identical information contained within your New York Health Care Proxy form.
- 3. Follow the same witnessing procedures as the New York Health Care Proxy form by having the card properly witnessed by two individuals.
- 4. Carry this wallet card along with your state issued identification and insurance card.
- 5. Enjoy the peace of mind knowing that your Health Care Agent can be contacted and your wishes discussed even if something happens to you while you are not near any copies of your completed New York Health Care Proxy form.

HEALTH CARE PROXY

I, _____, of _____

STREET

CITY

STATE

DAYTIME PHONE

EVENING PHONE

here by appoint _____ of _____

NAME AGENT

STREET

CITY

STATE

ZIP

DAYTIME PHONE

EVENING PHONE

as my health care agent to make all health care decisions for me if I become unable to decide for myself, including decisions about artificial nutrition and hydration.

SIGNATURE (PROXY INITIATOR)

DATE

This proxy was signed in my presence. The signer is known to me and appears to be of sound mind and to act of his/her own free will.

WITNESS

DATE

WITNESS

DATE

SPECIAL INSTRUCTIONS

HEALTH CARE PROXY
for

NAME

distributed by



FOR MORE INFORMATION
visit CompassionAndSupport.org

Community Conversations on Compassionate Care (CCCC) Program is an Advance Care Planning Program developed by the Community-wide End-of-life/Palliative Care Initiative. As leader of the initiative, we are pleased to produce this updated Advance Care Planning Booklet to support the CCCC program.

For further information about this initiative or to order additional copies, visit CompassionAndSupport.org