GETTING THE MOST OUT OF THE *MEDICAL ORDERS FOR SCOPE OF TREATMENT* PROCESS AND FORM

GUIDANCE FOR HEALTH CARE PROFESSIONALS

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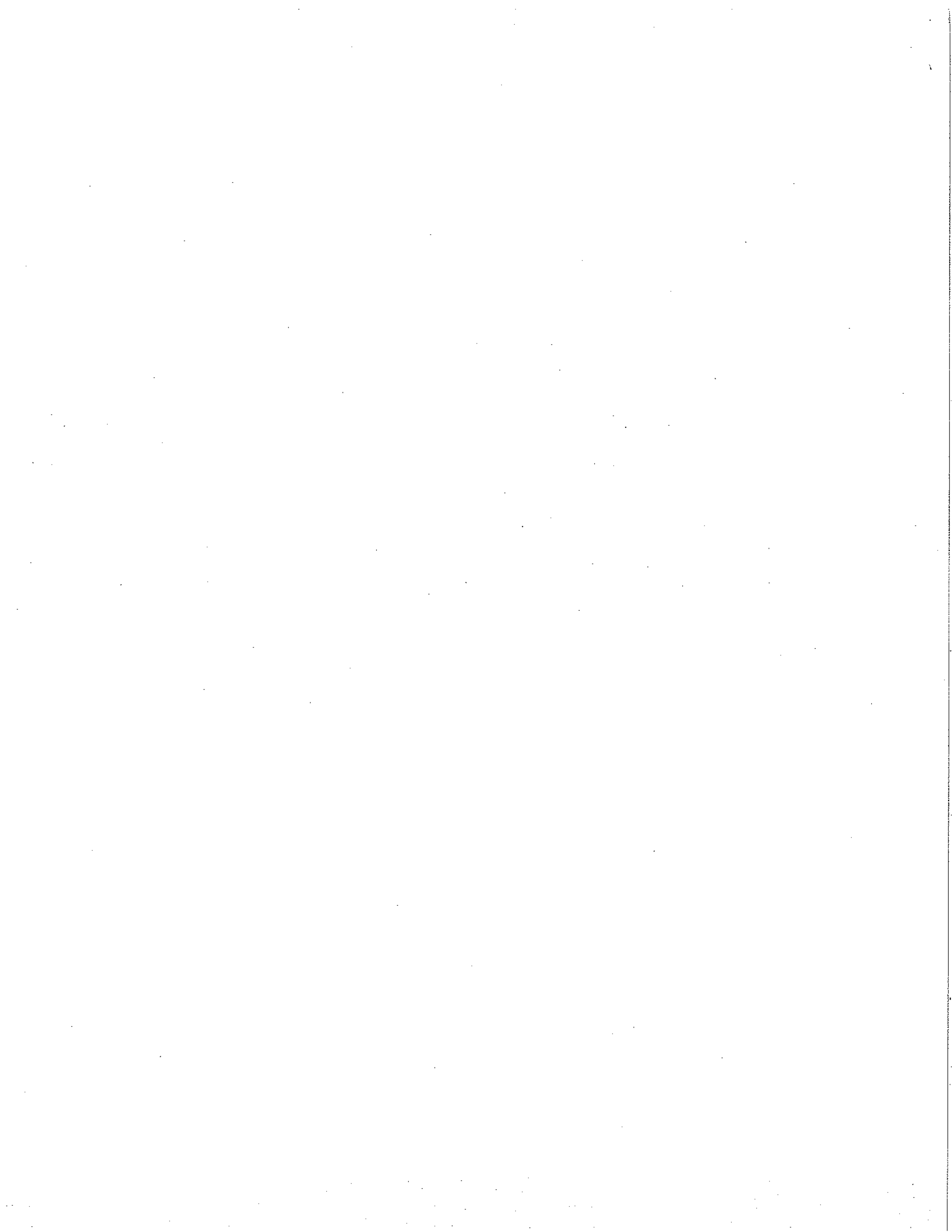

A Brief Overview of the Medical Orders for Scope of Treatment (MOST)

The Medical Orders for Scope of Treatment (*MOST*) program begins with a **conversation** between a health care provider and patient (individual) to determine preferences in key areas of life-sustaining medical treatment, including CPR, antibiotics, artificial nutrition & hydration.

The conversation may be undertaken by **any health care professional** with sufficient expertise to discuss the medical facts of the individual's situation and likely risks and benefits of the various treatments described.

The decisions are then documented on the *MOST* form, a 1-page, 2-sided document that **consolidates and summarizes** those individual preferences.

These preferences may be previously or more extensively documented in advance directives, such as a Living Will, CPR Directive, or medical power of attorney. **Completion of a *MOST* does not revoke** these instruments; all such other and earlier directives remain in effect. **The *MOST* overrules prior instructions only when they directly conflict.** Completion of a *MOST*, however, invalidates all previous *MOST* forms.

Individuals may **refuse treatment, request full treatment, or specify limitations.**

It is primarily intended for elderly, chronically or seriously ill individuals in frequent contact with the health care system, but it may be used by any adult.

The *MOST* must be **signed by the individual** or, if incapacitated, by the individual's authorized agent or guardian. It must also be signed by a physician, advanced practice nurse, or physician's assistant. This signature **translates patient preferences into medical orders.**

The standardized form can be **easily and quickly understood** by individual, health care providers, and emergency personnel.

The *MOST* "travels" with the individual and is **honored in any setting:** hospital, clinic, day surgery, long-term care or rehab facility, ALR, hospice, or at home. The original is brightly colored for easy identification, but **photocopies, faxes, and electronic scans are also valid.**

The portability of the form **allows seamless documentation of treatment preferences and closes gaps** as individuals transfer from setting to setting or experience delays in access to providers.

The latitude of authorized signers (physician/APN/PA) allows prompt documentation of preferences, especially in **rural regions or areas where physicians and health care services are limited.**

A section on the back **prompts individuals and providers to regularly review**, confirm, or update choices based on changing medical conditions and goals.

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MEDICAL ORDERS FOR SCOPE OF TREATMENT – THE *POLST* PARADIGM IN COLORADO

Medical Orders for Scope of Treatment (*MOST*) is a variant of a program first pioneered in Oregon in the early 1990s: Physician's Orders for Life-Sustaining Treatment (*POLST*). The *POLST* program, or "paradigm," was developed to address flaws and gaps in the expression and documentation of patient preferences for key life-sustaining treatments and health care providers' adherence to those preferences. Briefly,

> A Physician Orders for Life-Sustaining Treatment (*POLST*) Paradigm Program is designed to improve the quality of care people receive at the end of life by turning patient goals and preferences for care into medical orders.
>
> *POLST* is based on communication between the patient or other legally designated medical decision-maker and health care professionals that ensures that patients understand the decisions they are making.
>
> The *POLST* Paradigm Program: (1) Assists health care professionals discuss and develop treatment plans that reflect patient wishes; (2) Results in the completion of the *POLST* form; (3) Helps physicians, nurses, health care facilities and emergency personnel honor patient wishes regarding life-sustaining treatments. (*POLST* Web site: www.polst.org)

The program is intended to promote a competent adult individual's right to self-determination and autonomy with respect to treatment preferences; clarify treatment choices and goals; and reduce repetitive actions and inappropriate hospitalization/transfer. Numerous studies conducted by the *POLST* Paradigm pioneers have shown that the program and use of the *POLST* form has had a number of positive effects in various settings including

- Accurate reflection of individual's actual treatment decisions (90%)
- Higher rate of patient wishes being honored (90%)
- Greater clarity of decisions as perceived by emergency personnel (74%)
- Improved perceived usefulness of the instructions to guide treatment by emergency personnel for individuals without pulse or respiration (91%)
- Congruence between *POLST* form and previously executed advance directives in patient chart (100%) [*POLST* Web site]

In Colorado, the Colorado Advance Directives Consortium ("the Consortium") began developing a *POLST* program in 2007. The Consortium is a multidisciplinary volunteer group including representatives from health care (hospital, hospice, long-term care), professional associations and statewide organizations (Colorado Medical Society, Colorado Bar Association, Colorado Center for Hospice & Palliative Care, Colorado Health Care Association, Colorado Hospital Association), patient and consumer advocates (Guardianship Alliance, Compassion & Choices, and others), government and social services (Colorado Department of Public Health & Environment, ombudsman, Denver Regional Council of Governments, Colorado Department of Health Care Policy & Finance, legislators), health care ethicists, elder law attorneys, and others.

The Consortium has customized the *POLST* program and form for adherence to Colorado law, medical practice, and statewide health care system realities. Thus, the Consortium has adopted one of the *POLST* variant approaches: the Medical Orders for Scope of Treatment (*MOST*). The goal was to make use and

acceptance as broad as possible; for instance, the *MOST* can be signed by a physician or an advanced practice nurse or physician's assistant.

A member of the Consortium, the Colorado Center for Hospice & Palliative Care ("the Center") is well positioned to take the lead in administering the *MOST* program: The Center provides administrative and technical support to the Consortium, coordinates pilot programs, produces and distributes *MOST* forms and this guidelines booklet, and conducts ongoing education training programs for health care professionals and the lay community. In addition, the Center, in collaboration with the National *POLST* program, will be developing ongoing quality improvement efforts and directing quality processes and outcome measures.

Why Colorado Needs a *MOST* Program

According to the American Society on Aging, "84 percent of individuals 65 and older have at least one chronic illness, and 62 percent have two or more." Such illnesses include hypertension, congestive heart failure, coronary artery disease, pulmonary diseases, diabetes, stroke, neurological and neurodegenerative diseases, cancer, and AIDs (Warshaw, 2006).

A study conducted by the National Research Center for the Colorado Department of Human Services, Division of Aging & Adult Services in 2004 found that 28 percent of Coloradans over age 60 suffered from some condition(s) that substantially limited daily activities; 20 percent [or about 120,000] had been hospitalized at least once in the previous year; 5 percent [or about 30,000] had had a stay in a rehabilitation or skilled nursing facility; and 2 percent [or about 12,000] were "at risk for institutionalization" (NRC, 2004). In 2007, more than 16,000 Coloradans were living in 209 certified nursing facilities, and about 13,000 were admitted to hospice care (Kaiser, 2007; CCHPC, 2008). Approximately 30 percent of nursing home residents die within 6 months of admission (USDHHS, 2007), and the average length of stay in U.S. nursing homes is just under 2.5 years (Heiser, 2007). The average length of service for hospice patients in 2007 was just over 9 weeks, with a median of less than 3 weeks.

In Colorado, the 65+ population is expected to triple from 400,000 to 1.2 million between 2000 and 2030 (currently about 600,000). This is in large part due to the aging of the "baby boomers," termed by the State Demography Office to be "the largest single factor affecting the demographic trends in Colorado." By 2010, this group will have increased by 75 percent since 2000; by 2030, about 1 in 6 Coloradans will be over 65 (State Demography Office, 2008).

In short, the population of Coloradans who, due to advanced years and/or life-limiting illness, are in frequent contact with health care settings and services is large and growing exponentially. This population is also the one most in need of tools for considering, expressing, and documenting decisions about the desired extent of medical treatment, especially in emergency or "brink of death" situations.

Advance Directives in Colorado

Since 1985, the Colorado General Assembly has enacted a collection of laws and instruments governing individuals' ability to express advance medical directives and/or appoint surrogate health care decision makers. These include the "Living Will," the CPR Directive, Medical Durable Power of Attorney for Health Care, and the health care proxy process (see Appendix A for details and a comparison chart). The first two – the Living Will and CPR Directive – express refusals of certain life-support treatments under certain circumstances; the second two provide mechanisms by which legal representatives or surrogates may be appointed for the purpose of health care decision making. All four are empowered by the well-established, in law and medical practice, right of the adult individual to refuse any medical treatment at any time for any reason, even if the result is death.

The Patient Self-Determination Act of 1990 requires any health care facility receiving Federal funds to ask patients whether they have advance directives and to provide information on the available options, if desired. Despite this, and more than two decades of vigorous efforts to educate the public about their rights and responsibilities with respect to advance medical treatment decision making, it is estimated that only about 18 to 30 percent of Americans generally and only about 1 in 3 chronically ill individuals have executed advance directives. Among the critically or terminally ill, the rate does not exceed 1 in 2 (USDHHS, 2007). Furthermore, even when advance directives are completed, barriers and stumbling blocks can impede their use.

There are numerous explanations for the "failure" of advance directives, but some of the most often cited include:

- Opportunities for discussion of possible treatment preferences and documentation of decisions are limited by systemic gaps or constraints and personal issues.
- Treatment preferences/decisions are unclear, not specific, or not relevant to the individual's current health status.
- Documents – or surrogates – are not available at the time they are needed.
- Documents are incomplete, in a form that is not familiar to the health care professional or setting, or otherwise do not conform to legal or standard practice requirements. (USDHHS, 2007)

Responses to this troubling state of affairs have been varied and variously successful. Some intensively collaborative educational efforts focused on particular communities have achieved completion and adherence rates well above 70 percent (e.g., LaCrosse, WI [Hammes & Rooney, 1998]; Oklahoma [McAuley, 2008]). Other interventions have focused on particular factors, such as enhanced training of health care and social service professionals, community education, introducing setting-specific systems (e.g., automatic completion of ADs on nursing home admission), and improving particular documentation tools (USDHHS, 2007). No advance care planning instrument or effort to date, however, has been as effective as the *POLST* program and its variants.

HOW THE *MOST* PROGRAM WORKS

The heart of the Medical Orders for Scope of Treatment program is the interaction between health care providers and patients around treatment decisions in key areas of life-sustaining care. The program begins with a conversation and ends in a completed *MOST* form, which then provides guidance for care when the individual cannot express his or her own decisions.

The form provides the motivation and the structure for a conversation that otherwise might be difficult, vague, or unproductive. It allows for quick review and documentation of a set of essential decisions in a standardized format. And it prompts frequent review of decisions as the individual's health situation evolves.

This conversation and completion of the *MOST* form can occur in any health care setting: primary care practice, hospital, nursing facility, home health visit, hospice intake. The success of the *MOST* program, in fact, is most often demonstrated in situations of transfer between medical settings. For instance:

> Mr. Smith collapses at home and is taken to the emergency room and admitted to the hospital for treatment. While he is there, his physician enters a DNR order into his chart, based on Mr. Smith's medical condition and his preferences as expressed by his health care agent. Once stabilized, Mr. Smith is discharged to a nursing facility on Friday afternoon. The nursing facility attending physician is not scheduled to visit the facility until the following Monday. Mr. Smith

arrests on Sunday, is resuscitated by EMS, and transferred back to the hospital in a considerably worse condition.

Completion of a *MOST* form before Mr. Smith left the hospital could have extended his No-CPR preference to the nursing facility setting. The nursing facility staff would not have contacted EMS. Instead, Mr. Smith would have died peacefully, as he wished, without additional trauma, retransfer to the hospital, and extended maintenance care.

When to Complete a *MOST* Form

As noted above, the *MOST* is generally completed by individuals who already have a life-limiting condition and are in frequent contact with health care services. For this population, the form should be completed at the earliest opportunity in any setting:

- Nursing facilities should institute policies for scheduled completion of a *MOST* for new admissions before the first quarterly care plan meeting. Staff should complete *MOST* forms for all current residents before the next scheduled quarterly care plan meeting, and future quarterly assessments should trigger automatic review of the *MOST* for all nursing facility residents.
- The *MOST* should be incorporated into the hospital discharge process so that each qualifying individual (any individual at risk of cardiopulmonary arrest or ongoing or renewed life-sustaining treatment) leaves the hospital with the form completed.
- The form should be incorporated into the hospice admission process.
- The form should be completed in the context of a routine checkup in a medical practice office.

How to Complete a *MOST* Form

The *MOST* form must be completed by a health care professional with sufficient expertise to discuss medical conditions, treatments, risks and benefits with the individual. This professional should be competent and comfortable with conducting this kind of conversation. Her or she should also be able to make a determination of the individual's decision-making capacity or locate another professional to make that determination. The professional who conducts the conversation and completes the form, however, need not be the same professional who signs the form.

If the individual lacks capacity, a surrogate decision maker (health care agent or guardian) must be located and consulted. Even if the individual has capacity, if he or she has appointed an agent, that person should be included in the discussion, if at all possible, or at least briefed on the conclusions. Ideally, all involved family members should also be aware of the individual's decisions in order to avoid future conflicts. If there is no agent or guardian available, see the box on page 15 on the Health Care Proxy-by-Statute process.

Below, each section of the form is reviewed and details offered for explaining the options to individuals and completing the form and following the instructions. The most essential provisions are also recapped on the back of the *MOST* form in the section "Directions for Health Care Professionals."

Appendix B provides an 8-step protocol for the *MOST* program and some tips for conducting the *MOST* conversation.

Side 1: Preliminaries and Identification of Individual for Whom MOST Is Completed

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (*MOST*)	Last Name		
• **<u>FIRST</u> follow these orders, <u>THEN</u> contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA).**	First Name/Middle Name		
• These Medical Orders are based on the person's medical condition & wishes. • Any section not completed implies full treatment for that section.	Date of Birth		Sex
• May only be completed by, or on behalf of, a person 18 years of age or older. • **Everyone shall be treated with dignity and respect.**	Hair Color	Eye Color	Race/Ethnicity

General rules and provisions of the *MOST* program are given in the upper left. Note that *MOST* can only be used for individuals 18 years of age or older. Colorado does not currently have a *MOST* program applicable to minors.

Completing the Form

In the upper right of the *MOST* form, the individual's identifying information should be provided. Sex, hair color, eye color, and race/ethnicity are used primarily to ensure appropriate identification of the individual and to meet statutory requirements for the Colorado CPR directive. ***This section must be completely filled in.***

Section A: Cardiopulmonary Resuscitation (CPR)

A Check One Box Only	CARDIOPULMONARY RESUSCITATION (CPR) **<u>Person has no pulse and is not breathing.</u>** ☐ **No CPR** Do Not Resuscitate/DNR/Allow Natural Death ☐ **Yes CPR** Attempt Resuscitation/ CPR *When <u>not</u> in Cardiopulmonary arrest, follow orders B, C, and D*

Explaining the Options and Completing the Form

- **Check one box only:** "No CPR" or "Yes CPR."
- Note that this choice applies ***only*** when the individual has *no pulse and is not breathing*. This is a stricter standard than the Colorado CPR directive, which applies when the individual is experiencing a cardiopulmonary malfunction short of full arrest of both pulse and respiration.
- If "No CPR" is checked, death will be allowed to occur without any attempt at resuscitation. If the individual is in full cardiopulmonary arrest, he or she has expired, or will expire in a very short period of time.
- If "Yes CPR" is checked, emergency measures will be taken to restore pulse and respiration including but not limited to chest compression, intubation, mechanical ventilation, and electric shock.
- If "Yes CPR" is checked, the individual is likely to be transferred to the hospital for additional treatment.
- *Important:* An individual's legal representative (whether a health care power of attorney [or agent], guardian, or proxy-by-statute, or other type of legal representative) may not check "Yes CPR" on an

individual's behalf if the individual previously executed a CPR directive indicating refusal of resuscitation. If the individual previously completed a CPR directive, an agent, guardian, or proxy-by-statute cannot later change the choice in this section.

Following the Instructions

- Note that this choice applies *only* when the individual *has no pulse and is not breathing*. This is a stricter standard than for the Colorado CPR directive, which applies when the individual is experiencing a cardiopulmonary malfunction short of full arrest of pulse or respiration.
- ***If "No CPR" is checked, do not call 9-1-1; do not attempt resuscitation by any means.*** CPR is more than just chest compression—this applies to both basic and advanced therapies.
- Always provide comfort measures.
- *If the individual is not in full cardiopulmonary arrest, Section A does not apply*; orders in Sections B, C, and D should be followed.
- If "Yes CPR" is checked, call 9-1-1 and/or initiate emergency resuscitation.

Section B: Medical Interventions

B Check One Box Only	MEDICAL INTERVENTIONS <u>Person has pulse and/or is breathing.</u> ☐ **Comfort Measures Only:** Use medication by any route, positioning, and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Do not transfer* to hospital for life-sustaining treatment. *Transfer only* if comfort needs cannot be met in current location; EMS-Contact medical control ☐ **Limited Additional Interventions:** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. *Transfer to hospital if indicated. Avoid intensive care;* EMS-Contact medical control. ☐ **Full Treatment:** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.* EMS-Contact medical control. *Additional Orders:* ______________________ (EMS=*Emergency Medical Services*)

Explaining the Options and Completing the Form

- **Check One Box only.**
- Applies when the individual has a pulse *and/or* is breathing but may require life-sustaining or other medical interventions.
- Defines extent of medical interventions desired and instructions on transfer to hospital and admission to intensive care. EMS personnel are advised to contact medical control to clarify needs for transfer based on the circumstances.
- The individual should understand each level of intervention and express a preference based on his/her wishes and medical condition and goals.
- Note that *each level of care includes the measures in the preceding level* such that comfort measures are always included and full treatment may include limited treatment interventions.
- Diagnostic tests should continue or not, according to individual's condition and physician's discretion.
- Additional orders can be noted here, or, if other instructions and preferences are noted in other documents such as a Living Will or MDPOA, use this line to reference the appropriate materials.

Following the Instructions

- ***A note to family members, nonmedical caregivers, and nursing facility staff:*** if "Comfort Measures Only" box is checked, it is recommended that you do not call 9-1-1, but rather contact the individual's treating physician, hospice agency, or other health care provider for instructions.
- Responding emergency or other medical personnel should perform the level of intervention as indicated on the form.
- Examples of treatments given on the form are not an exhaustive list of possibilities. If questions arise, EMS should seek advice from medical control.
- EMS should also contact medical control for instructions on transfer based on indicated level of intervention and particular circumstances.
- Note that individuals who have indicated "Comfort Measures Only" or "Limited Additional Interventions" should *not* be entered into the Trauma System.
- For "Limited Additional Interventions," provide all appropriate comfort measures, IV fluids, and cardiac monitoring as indicated. Intubation, advanced airway intervention, and mechanical ventilation **are not** to be used. Transfer to the hospital only if comfort cannot be achieved in the current location. Intensive care should be avoided.
- "Full treatment" includes all appropriate comfort measures, and all available and indicated support measures to maintain and extend life.
- Note "Additional Orders" line. This may note other instructions contained in other advance directive documents such as a Living Will or MDPOA. If these documents are not attached to the *MOST*, request them.
- *Important:* If the individual is transferred to another provider facility or discharged, be sure the *MOST* form accompanies the individual and is presented to the receiving health care team. Direct communication about the individual's goals of care ensures that his or her wishes will be respected in moving between health care settings.

Transfer to the Hospital

- The *MOST* form must accompany the individual to the hospital.
- When the individual arrives in the ER, EMS will present the *MOST* form to the ER staff and provide clear communication about the individual's wishes.
- ER and hospital staff will follow the orders indicated by the *MOST*.
- The accepting physician will write an order on the physician's order sheet: "Follow *MOST* orders."
- A copy of the form will be placed in the front of the chart and the original will remain with the patient/family.
- The orders on the *MOST* sheet will be transcribed into the hospital order system, and the appropriate actions will be taken if the individual has indicated "No" to CPR (e.g., DNR wrist band placed on patient, sticker placed on outside of chart, etc.)
- Whenever the individual is transferred, the transferring staff member will include a review of the *MOST* form outlining the individual's wishes in the report to the accepting staff member.
- The *MOST* form will accompany the individual.

Section C: Antibiotics

C Check One Box Only	**ANTIBIOTICS** ☐ No antibiotics. Use other measures to relieve symptoms. ☐ Use antibiotics when comfort is the goal. ☐ Use antibiotics. *Additional Orders:* ______________________

Explaining the Options and Completing the Form

- **Check One Box Only**
- This section can stimulate discussion about antibiotics as life-sustaining treatments, which can be refused if the benefits are likely to be low or temporary or only serve to prolong dying.
- Three options are offered: complete refusal of antibiotics; use solely for comfort (e.g., to relieve pain); or open-ended use of antibiotics as appropriate. Check the box that best reflects the individual's preference.
- Additional orders may be included: for instance, a certain timeframe, route, or context for antibiotic administration can be specified.

Following the Instructions

- This order should be very straightforward, but if questions arise, further discussion to clarify goals or define comfort may be pursued with the individual or his or her legal representative.

Section D: Artificially Administered Nutrition and Hydration

D Check One Box Only	**ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION** <u>Offer food & water by mouth if feasible</u> ☐ No artificial nutrition/hydration by tube. (NOTE: **Special rules for *proxy by statute* on page 2**) ☐ Defined trial period of artificial nutrition/hydration by tube. (Length of trial: ______________ Goal: ______________________) ☐ Long-term artificial nutrition/hydration by tube. *Additional Orders:* ______________________

Explaining the Options and Completing the Form

- **Check One Box Only.**
- Artificial nutrition and hydration (ANH) is any delivery of nutrients and fluids by tube: intravenous, nasogastric, or gastrointestinal. As ANH can be an appropriate, routine, and temporary measure in many contexts, any degree of refusal should be fully explored with reference to goals of care. In other words, if an individual says, "No tube feeding!" an appropriate follow-up might be, "Do you mean that we shouldn't give you an IV if you become dehydrated or are unconscious for some time during surgery or after an accident?" If this type of ANH is acceptable, but the individual does not want long-term maintenance feeding by tube, the second option is more appropriate.
- The second option allows for a defined trial period or use of ANH for a specific purpose. This option could be completed as, for example, "Length of trial: max 6 months. Goal: opportunity to recover

cognitive or physical function following coma, stroke, surgery, or other major medical event." Timeframes are dependent on the clinical condition and circumstances and the individual's goals. This section will necessitate specific conversations between the individual and the health care professional. At the end of the trial period, ANH can be continued or discontinued based on the stated goals and the ongoing conversation.

- The third option should be selected only by individuals who intend truly long-term use of ANH under any circumstances, including terminal illness, minimally conscious or persistent vegetative state, traumatic brain injury, neurodegenerative disease, paralysis, etc. The individual should be cautioned, however, that "long-term" does not mean "forever." His or her legal representative, in consultation with medical professionals, may still withdraw ANH after a "long-term" administration if the individual is deriving no benefit, or indeed experiencing harm, from the procedure.
- Additional orders can be provided.
- The health care professional completing the form should determine whether the individual has previously completed a Living Will with an ANH provision. Preferences expressed there should be discussed and incorporated into the *MOST* instructions.
- ***Important:*** An individual's guardian or agent under medical durable power of attorney may refuse or withdraw ANH on an individual's behalf. However, if the individual has a previously executed Living Will, the guardian, agent, or proxy-by-statute must follow the instructions in the Living Will. A health care proxy-by-statute (see box on page 15) may refuse or withhold ANH before it is started, but cannot withdraw it after it is started unless two physicians, one trained in neurology, certify that the procedure is only prolonging the individual's dying.

Following the Instructions

- Food and water by mouth should always be offered, if feasible. This section only applies if the individual cannot take food or water by mouth.
- "By tube" includes intravenous, nasogastric, and gastrointestinal. Instructions apply to all forms of ANH delivery.
- The first option means ***no ANH by any tube form of delivery.***
- The second option should define a timeframe and a goal. If these specifications are not clear, further discussion with the individual or his or her legal representative should be initiated.
- If the time period elapses and the goal has not been achieved, further discussion and evaluation should be undertaken with the individual or his or her legal representative. At that point, ANH might be continued for another defined time period with a revised goal, or discontinued.
- "Long term" in the third option does not mean "forever." The individual's legal representative, in consultation with medical professionals, may still withdraw ANH after a "long-term" administration if the individual is deriving no benefit, or indeed experiencing harm, from the procedure.
- ***Important:*** An individual's guardian or agent under medical durable power of attorney may refuse or withdraw ANH on the individual's behalf. However, if the individual has a previously executed Living Will, the guardian, agent, or proxy-by-statute must follow the instructions in the Living Will. A health care proxy-by-statute (see box on page 15) may refuse or withhold ANH before it is started, but cannot withdraw it after it is started unless two physicians, one trained in neurology, certify that the procedure is only prolonging the individual's dying.

Section E: Summary and Medical Professional Signature

<table>
<tr><td rowspan="2">E
Check All That Apply</td><td>DISCUSSED WITH:
☐ Patient
☐ Agent under Medical Durable Power of Attorney
☐ Proxy (per statute C.R.S. 15-18.5-103(6))
☐ Guardian
☐ Other:________________</td><td rowspan="2" colspan="2">SUMMARY OF MEDICAL CONDITION(S):</td></tr>
<tr><td>(SECTION RESERVED FOR FUTURE USE)
PILOT PROGRAM FORM</td></tr>
<tr><td colspan="2">Physician/APN /PA Signature (mandatory)</td><td>Print Physician/APN/PA Name, Address and Phone Number</td><td>Date</td></tr>
</table>

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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Explaining the Options and Completing the Form

- **Check All That Apply.**
- Indicate in the "Discussed with" box all the persons consulted in the completion of this form: "Patient" if the individual has sufficient capacity to have contributed to the decision making; "Agent" or "Proxy (per statute)" (see box on page 15), or "Guardian." "Other" might be other consulting health care professionals, or additional family members or friends who are involved with the individual's care but not officially authorized as decision makers.
- In "Summary of Medical Condition(s)" box, indicate primary diagnosis and any other relevant physical or functional factors that support the treatment decisions indicated.
- *Do not write in screened box labeled Pilot Program Form.*
- The *MOST* form ***must be signed by a physician, advanced practice nurse, or physician assistant.*** If this signing professional is not the person who helped the individual complete the form, the signing professional should review it, making sure all sections are complete and clear and appear to be consistent with the individual's medical situation.
- A registered nurse may complete the *MOST* with an individual and then obtain verbal (i.e., phone) orders from a physician, APN, or PA until an original signature can be supplied. This should be indicated according to facility/agency protocol.
- In the second box, the professional should provide, in print, his or her name, address, and phone number; and in the third box, the date. The date of signature may be very important for determining precedence of orders and instructions.

Following the Instructions

- A signature by a physician, advanced practice nurse, or physician's assistant is required to translate the individual's preferences into medical orders and to ensure portability across settings. However, verbal orders taken by phone and appropriately indicated are also valid.
- An original, brightly colored (blue for pilot program) *MOST* form is preferable, ***but photocopies, faxes, and electronic scans are also valid and should be honored.***

- This document is in compliance with all regulations of the state health department with respect to portability of orders – ***any health care professional in receipt of these signed orders should follow them.***
- The absence of a physician/APN/PA signature does not nullify the instructions as expressions of the individual's choices for treatment. EMS and other health care providers may – and should – still adhere to the instructions.
- The health care facility caring for the individual should place the *MOST* form in the front of the individual's chart or in the Advance Directives section of the medical record for easy access during their stay.
- If the individual is transferred to another facility or discharged to home, the original form should go with the individual and a photocopy kept in the chart.
- If the individual's stay in the facility is due to a change in his or her medical condition – for instance, a new diagnosis or injury, exacerbation, or crisis – a review of the *MOST* form and its provisions is appropriate prior to transfer or discharge. See the section below on Review and Replacement.
- If the individual is at home, the original should stay with the individual and a copy placed in the supervising provider's chart.

Side 2: Signature of Patient, Agent, Guardian, or Proxy by Statute

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

SIGNATURE OF PATIENT, AGENT, GUARDIAN, OR PROXY BY STATUTE (MANDATORY)

Significant thought has been given to the desired scope of end-of-life treatment and these instructions. Preferences have been discussed and expressed to a health care professional. This document reflects those treatment preferences which may also be documented in a MDPOA, CPR Directive, Living Will, or other advance directive, (attached if available). To the extent that my prior advance directives does not conflict with these *Medical Orders for Scope of Treatment*, my prior advance directives shall remain in full force and effect.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature	*Name (Print)*	*Relationship/ Surrogate status (write "self" if patient)*	*Date Signed (Revokes all previous MOST forms)*
Primary Contact Person for the Patient	*Relationship; MDPOA, Proxy, Guardian*	*Phone Number/Contact Information*	
Healthcare Professional Preparing Form	*Preparer Title*	*Phone Number*	*Date Prepared*
Hospice Program (if applicable)	*Address*	*Phone Number*	*Date Enrolled*

Explaining the Options and Completing the Form

- The ***individual must also sign*** the form to indicate that the preferences expressed have been given thorough consideration and are consistent with his or her wishes; consistent with other prior advance directives if completed; and that only those provisions in the *MOST* that conflict with prior instructions overrule those prior instructions.
- If the individual does not have capacity to make these assertions and decisions, his or her legal representative – health care agent under medical durable power of attorney, guardian, or proxy-by-statute (see box on page 15) – must sign and indicate his or her status.
- Legal representatives should be reminded that *MOST* decisions should reflect the individual's preferences and decisions – as far as they are known – not the representative's. If the representative

does not know and cannot determine with confidence the individual's preferences, decisions should be made in the best interests of the individual.

- Only valid legal representatives (medical powers of attorney, guardians, proxy-by-statute decision-makers, etc.) have authority to sign the *MOST* form; family members or other persons who are not valid legal representatives do not have authority to sign.
- The form must be dated. A *revised* MOST *form automatically supersedes all previously completed* MOST *forms.* See the section on Review and Replacement for other instructions.
- *Completing a* MOST *form does not revoke or replace previously completed advance directives such as a Living Will, MDPOA, CPR directive, etc.* Efforts should be made to locate any previously executed advance directives and review them in the process of completing a *MOST*. Provisions in previous advance directives, if still appropriate and desired, should be transferred to the *MOST*. If previous advance directives are no longer appropriate, they should be revoked and destroyed. In cases of direct conflict, the *MOST* overrules previously completed instructions. *Please review instructions under Section D for interactions between the* MOST *and the Living Will.*
- The primary contact person for the individual is most appropriately his or her legal representative, but can be any close family member or friend. The primary contact person is a contact; not necessarily the authorized decision maker.
- The health care professional who helped complete the *MOST* form should provide his or her name, title, phone number, and date of preparation. This is helpful information in case any questions arise about the preparation of the form.
- If the individual is enrolled in a hospice program, the agency's contact information and date of enrollment should also be noted.

Following the Instructions

- If there is no signature by the individual or his or her legal representative, the orders are invalid.
- If the individual or legal representative had previously completed a *MOST* form, the form dated most recently should be honored. *A revised* MOST *form automatically supersedes all previously completed* MOST *forms.*
- *If provisions of the* MOST *conflict with provisions in previously completed advance directives, the* MOST *orders should be followed.* Please review instructions under Section D, however, for interactions between the *MOST* and the Living Will.

Directions for Health Care Providers

This section recaps key instructions – all of which are covered above in this booklet.

Review and Replacement

REVIEW OF THIS *MOST* FORM			
Review Date	Reviewer	Location of Review	Review Outcome
			☐No Change ☐Form Voided ☐New Form Completed
			☐No Change ☐Form Voided ☐New Form Completed
			☐No Change ☐Form Voided ☐New Form Completed
			☐No Change ☐Form Voided ☐New Form Completed
HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			

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The final section on the back of the *MOST* form provides for documentation of reviews of the *MOST*. The *MOST* should be reviewed periodically (quarterly for nursing facility residents), especially on transfer to another care setting, any change in condition, change of preferences or choices, change in contact information of individual; physician, APN, PA; agent or guardian.

If the individual resides in a nursing facility, the facility staff are responsible for keeping the *MOST* updated. If the individual lives independently, his or her primary care provider, attending physician, or other health care provider should prompt appropriate reviews of the *MOST* instructions. Individuals, too, may initiate such a review with their health care providers.

Completing the Form

- Record date of review (very important in establishing precedence of forms).
- Provide name of reviewer (health care professional).
- Record location of review.
- Indicate outcome: No change, Form voided, New Form Completed.
- In most cases, any change to the form will necessitate completion of a new form. "Form Voided" and "New Form Completed" should be checked.
- As an extra assurance, write the word "VOID" prominently on both faces of the form. Voided forms may remain in the individual's chart or personal files; any copies of superseded forms should be destroyed.

Following the Instructions

Health care professionals and EMS personnel should check this area to make sure the form is not voided.

****

Placement of the MOST Form

Once the *MOST* form is completed, the original stays with the individual.

In a facility: The original should be kept in the very front of the individual's chart or in the Advance Directives section. When the individual is transferred between care settings, a copy should stay in that same location in the chart, but the original should go with the individual to the new setting.

At home: When the individual is at home, the *MOST* form should be kept on the refrigerator, by the phone in the kitchen, or by the individual's bed. These are the locations that emergency personnel are trained to look for important medical directive documents.

In the community: If the individual is not homebound, he or she should carry a copy of the form in wallet or purse for easy location by emergency personnel. For the Pilot Program, wallet cards or bracelet/necklace *MOST* indicators are not available.

Health Care Proxy-by-Statute

- In Colorado, no one is given automatic authority in decision making for another adult, and health care providers cannot simply make decisions for individuals except in an emergency.
- If an individual does not have a health care agent / medical power of attorney or guardian, and if that individual is unable to make or express decisions, a "proxy-by-statute" is needed.
- First, the individual's physician "certifies" that the individual does not have capacity to make his or her own decisions. As of January 1, 2009, Advanced Practice Nurses may also make this determination about an individual in collaboration with the attending physician. Such collaboration may be done in person, by phone, or electronically. The nurse must document the name of the physician with whom she or he collaborated.
- Next, the physician, advanced practice nurse, or someone designated by the physician or nurse must make a good faith effort to locate and assemble (physically or by telecommunications) people who have an interest in the care of the individual who is ill.
- These "interested parties" – which can be family members, life partners, close friends, pastoral or other advisors – determine by consensus which one of their group will serve as the "proxy" for the individual. Once the proxy is selected, the physician or advanced practice nurse documents this and the contact information for the proxy in the medical chart.
- If the group can't agree on who the proxy should be, then guardianship must be pursued through the courts.
- Like a health care agent, the proxy should act according to the known wishes and values of the individual; so the proxy should have a clear understanding of what those wishes and values are and how they might affect treatment decisions.
- ***Proxies selected in this way cannot withdraw artificial nutrition and hydration for the individual, unless two physicians (one trained in neurology) determine that the treatment is only serving to prolong the individual's death.***

APPENDIX A: A GUIDE TO COLORADO ADVANCE DIRECTIVE DOCUMENTS

Please be aware that what follows is just information, not advice. Every situation is different. If individuals have questions about their particular situations, please direct them to the appropriate qualified professional: health care practitioner, attorney, or estate planner. Although none of these documents require a lawyer to assist in the process, many individuals complete health care documents in the context of other end-of-life planning such as making a will or setting up financial trusts. Low-cost legal assistance is sometimes available. Consult the Colorado Bar Association Web site at www.cobar.org (click on "For the Public" and "Legal Assistance Programs"). More information about advance directive documents and the Colorado-specific forms can be found on the Colorado Health and Hospital Association Web site, www.cha.com (click on "Publications," select "Your Right to Make Health Care Decisions") or www.caringinfo.org.

Medical Durable Power of Attorney

- In Colorado, *no one is automatically authorized* to make health care decisions for another adult.
- The Medical Durable Power of Attorney (also called the "Power of Attorney for Health Care") is a document an individual (the principal) signs to appoint someone else to make the principal's health care decisions in case of incapacity. The person appointed is called a "health care agent."
- In most cases, the agent only makes decisions for the principal when he or she cannot. This may be temporary, following an accident or injury, or long term, if the principal is permanently incapacitated.
- The agent is authorized to request and review medical records, consult with the principal's doctors and other health care providers, and make all necessary health care decisions.
- The agent is supposed to act according to *the principal's* wishes and values, so whoever is appointed agent must have a clear idea of the principal's life values, goals, and preferences for treatment. The agent must be able to devote the time and energy to handling complex health care needs.
- A Medical Durable Power of Attorney (MDPOA) is not the same as a general Power of Attorney (POA). The MDPOA agent is only authorized to make health care decisions. A general POA covers legal and financial affairs. The authority of both types of agent ends at the death of the principal.
- For more information, and to obtain the Colorado Medical Durable Power of Attorney document, visit the Colorado Health and Hospital Association Web site, www.cha.com.

Living Will

- In Colorado, the Living Will is called the "Declaration as to Medical or Surgical Treatment."
- It tells health care providers what to do about artificial life support measures if the individual has an injury, disease, or illness that is *not curable or reversible and is terminal.*
- In Colorado, a Living Will does not go into effect until 48 hours after two doctors agree in writing that the individual has a terminal condition and is unconscious or otherwise unable to make or make known his or her medical decisions.
- In these circumstances, a Living Will directs the physicians to continue or discontinue, as indicated, life-sustaining procedures, artificial nutrition, and artificial hydration.
- An attorney or health care professional is not needed for an individual to complete a Living Will, but two witnesses must sign. The witnesses cannot be the individual's health care providers, an employee of the health care provider, or anyone likely to inherit property from the individual.
- A notary's signature is a good idea but not required.

- A Living Will is not the same as a regular will ("Last Will and Testament") or a Living Trust, which refer to possessions and property. A Living Will only provides instructions on medical treatment, not the distribution or disposal of property.
- For more information, and to obtain the Colorado Declaration document, visit the Colorado Health and Hospital Association Web site, www.cha.com.

CPR Directive

- A CPR (cardiopulmonary resuscitation) directive allows an individual to direct in advance that no one should administer CPR if that individual experiences any problem that causes cardiopulmonary arrest or malfunction.
- CPR directives are almost always used by individuals who are severely or terminally ill or elderly. In these situations, the trauma involved in CPR is likely to do more harm than good, but emergency personnel are trained to perform CPR unless a CPR directive tells them not to.
- A CPR directive is not the same as a DNR order. A DNR order is a doctor's order made for severely or terminally ill individual in health care facilities, including nursing homes. The DNR does not require the individual's consent, and it does not remain in effect if the individual leaves the facility.
- A CPR directive must be signed by both the individual (or the individual's MDPOA agent or proxy-by-statute) and his/her physician.
- CPR directives must also be immediately visible to emergency personnel. For more active folks with CPR directives, a wallet card or special CPR directive bracelet or necklace can be obtained.
- For more information on CPR directives, visit the Colorado Health and Hospital Association Web site www.cha.com.

NOTE: A helpful chart summarizing these advance directives, the Five Wishes form, the *MOST*, and processes for proxy selection and guardianship can be found on the Colorado Center for Hospice & Palliative Care Web site, under "For Healthcare Professionals/Medical Orders for Scope of Treatment."

APPENDIX B: THE RESPONSIBILITIES AND RIGHTS OF AGENTS, GUARDIANS, AND PROXIES-BY-STATUTE

Current Colorado law has some complexities around what health care agents under medical durable power of attorney ("agents"), guardians, and proxies-by-statute can and cannot do on behalf of individuals. One point is absolutely clear and cannot be emphasized enough: ***All surrogate decision makers must always make decisions according to the wishes of the individual, in the way that the individual would, to the best of the surrogates' ability and knowledge.*** Agents and others may need to set aside their own desires, values, and preferences in order to honor the wishes of the individual for whom they are speaking. They should also, as much as possible, consult with the individual about those preferences. Health care professionals should not refrain from reminding agents and others of this requirement, or from supporting sincere efforts to uphold this duty, recognizing how difficult it can be.

There are limits, however, to what agents and others can do when an individual has already expressed his or her own wishes. To recap:

CPR

If an individual has executed a CPR directive on his or her own behalf, in any manner or on any form including a *MOST*, an agent, guardian, or proxy-by-statute ***may not*** revoke or change it under any circumstances. This means that this section of the *MOST* form, when being completed by an agent or other, must conform to any *MOST* or other CPR directive previously completed by the individual.

Artificial Nutrition and Hydration

If an individual has executed a Living Will, an agent, guardian, or proxy-by-statute ***may not*** revoke it unless that power is specifically granted in the Living Will. The provisions of a Living Will are not exactly mirrored in the *MOST* form, but the Living Will does include a section on artificial nutrition and hydration that should be taken into account in the completion of a *MOST*. Again, this section of the *MOST*, when being completed by an agent, guardian, or proxy-by-statute, must conform to any previously executed Living Will.

If the individual has not previously executed a Living Will that includes instructions as to artificial nutrition and hydration, an agent or guardian – but ***not*** a proxy-by-statute – may withhold or withdraw ANH according to the known wishes or best interests of the individual. A proxy-by-statute may withhold or refuse ANH, but if it has already begun, a proxy may ***not*** withdraw it unless two physicians, one trained in neurology, certify that continuing ANH is simply prolonging death and not providing any benefit to the individual.

APPENDIX C: *MOST* PROTOCOL AND COMMUNICATION TIPS*

Prepare for discussion

- Review what is known about the individual and family goals and values
- Understand the medical facts about the individual's medical condition and prognosis
- Review what is known about the individual's capacity to consent
- Request, retrieve, and review completed Advance Directive and MDPOA appointment documents (if applicable)
- Determine who key family members are, and if the individual has not appointed an agent and lacks capacity to do so, initiate the Proxy-by-Statute process
- Find uninterrupted time for the discussion

Begin with what the individual and family knows

- Determine what the individual and family know regarding condition and prognosis.
- Determine the individual's views and values for life-sustaining treatment in light of the medical condition and likelihood of interventions.

Provide any new information about the individual's medical condition and values from the medical team's perspective

- Provide information in small amounts, giving time for response
- Seek a common understanding; understand areas of agreement and disagreement
- Make recommendations based on clinical experience in light of individual's condition / values

Try to reconcile differences in terms of prognosis, goals, hopes, and expectations

- Negotiate and try to reconcile differences; seek common ground; be creative
- Use conflict resolution when necessary

Respond empathetically
- Acknowledge
- Legitimize
- Explore (rather than prematurely reassuring)
- Reinforce commitment and nonabandonment

Use *MOST* to guide choices and finalize individual/family wishes
- Review the key elements with the individual and/or family
- Apply shared medical decision making
- Manage conflict resolution

Complete and sign *MOST* from (or provide to physician, APN, PA for review and signature)
- Review for any internal contradictions between choices
- Review for consistency with previously executed advance directives, if applicable.
- Make sure individual or agent/guardian/proxy signs the *MOST* form too (on the back)

Periodically review and revise
- When individual transfers to another setting
- When condition changes
- When choices change
- When contact information changes

*Adapted [WITH PERMISSION] from New York State "Medical Orders for Life Sustaining Treatment Guidebook," 2006.

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State Demography Office. (2008). Demographic fact sheet. http://www.dola.state.co.us/demog/presentations/demographic_fact_sheet.pdf. Accessed 9/16/08.

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RESOURCES FOR HEALTH CARE PROFESSIONALS

Organizations & Web Sites

Colorado Center for Hospice & Palliative Care. www.cochpc.org. 719-594-9233 or 303-756-1360. For original copies of *MOST* form, guidelines booklet. Visit our Web site for more helpful information for patients, families, and health care professionals on advance care planning and hospice & palliative care.

Oregon POLST Task Force. Center for Ethics in Health Care, Oregon Health & Science University. www.polst.org. For background information on the national POLST paradigm, research findings and news, educational materials.

Caring Connections. www.caringinfo.org. A consumer-based Web site offering support to patients and families. Information on advance care planning, including downloadable state-specific advance directives.

Colorado Health and Hospital Association. "Your Right to Make Health Care Decisions," a booklet containing completion information and forms for Colorado Living Will and Medical Durable Power of Attorney. Also explains proxy-by-statute process.720-489-1630. Multiple copies available from Stockless Form Management, 303-923-0000.

Resources for Conducting Difficult Conversations

Ambuel, B., & Weissman, D. E. (2005). Fast Fact and Concept #066: Delivering bad news Part I. Available online: www.eperc.mcw.edu/fastFact/ff_011.htm.

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Balaban, R. B. (2000). A physician's guide to talking about end-of-life care. *Journal of General Internal Medicine* 15: 195-200.

Casarett, D. J., & Quill, T. E. (2007) « I'm not Ready for Hospice » : Strategies for timely and effective hospice discussions. *Annals of Internal Medicine 146*(6): 443-449.

Duggleby, W., & Popkin, D. (2006). Effective patient-physician communication at the end of life: What patients want to hear and how to say it. *Geriatrics & Aging* 9(2): 129-132.

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TO COME: GLOSSARY AND FAQs, pending input from Pilot Program participants.