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

GUIDANCE FOR HEALTHCARE PROFESSIONALS

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A project of the Colorado Advance Directives Consortium
www.coloradoadvancedirectives.com

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 healthcare professional and patient (individual) to determine preferences in key areas of life-sustaining medical treatment, including CPR, antibiotics, artificial nutrition & hydration.

The conversation may be guided by **any healthcare 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. Individuals may **refuse treatment, request full treatment, or specify limitations.**

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.

The *MOST* is primarily intended for **elderly, chronically, or seriously ill individuals** who are in frequent contact with the healthcare system. No one is required to complete a *MOST.*

The *MOST* must be **signed by the individual** or, if incapacitated, by the individual's authorized Healthcare 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 individuals, healthcare 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 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 original is brightly colored for easy identification, but **photocopies, faxes, and electronic scans are also valid.**

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

Healthcare providers who cannot follow the orders for moral or religious reasons may decline, but they must arrange prompt transfer of the individual to another provider who will comply with the orders.

A master *MOST* form can be downloaded from the Colorado Advance Directives Consortium Web site: www.coloradoadvancedirectives.com. For best results, photocopy onto Wausau Astrobrights® Vulcan Green Smooth Finish 65lb cover paper.

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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 in the documentation and communication of patient preferences for key life-sustaining treatments and to assist healthcare providers in following 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 healthcare professionals that ensures that patients understand the decisions they are making.
>
> The *POLST* Paradigm Program: (1) Assists healthcare professionals discuss and develop treatment plans that reflect patient wishes; (2) Results in the completion of the *POLST* form; (3) Helps physicians, nurses, healthcare facilities and emergency personnel to 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 individuals' 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: www.polst.org]

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 healthcare (hospital, hospice, long-term care, emergency services), 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), healthcare ethicists, elder law and health law attorneys, and others.

The Consortium has customized the *POLST* program and form for consistency with Colorado law, medical practice, and statewide healthcare 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 Colorado *MOST* can be signed by a physician or an advanced practice nurse or physician's assistant.

The Consortium provides administrative support to the *MOST* program: At our Web site, www.coloradoadvancedirectives.com, *MOST* master form and instructions are posted for easy electronic download or printing, education and training opportunities are listed, and over time, additional educational tools will be available.

In addition, the Consortium, 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 institutional-ization" (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 healthcare 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 end-of-life 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 healthcare decision makers. These include the "Living Will," the CPR Directive, Medical Durable Power of Attorney for Healthcare, and the healthcare Proxy process (see Appendix A for details). 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 healthcare 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 Federal Patient Self-Determination Act of 1990 requires any healthcare facility receiving Federal funds to ask patients whether they have advance directives and to provide information on the available options, if desired. Despite this requirement, 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.
- Documented 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 healthcare 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 healthcare 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 healthcare 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 choices.

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. 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 healthcare setting:** primary care practice, hospital, nursing facility, home health visit, hospice intake. The success of the *MOST* program, in fact, is often demonstrated in situations of transfer between medical settings. For instance:

> Mr. Smith collapses at home and is taken to the ER 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 Healthcare 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 healthcare services.** For this population, the form should be completed at the earliest opportunity in any setting:

- ***Nursing facilities:*** 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.
- ***Hospitals:*** 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.
- ***Hospice:*** The form should be incorporated into the hospice admission process.
- ***Primary care:*** For appropriate individuals (chronically or seriously ill, requiring intensive medical management, frail elderly, etc.), the form should be completed and reviewed in the context of a routine checkup in a medical practice office.

How to Complete and Follow a *MOST* Form

To begin, download the master MOST form from www.coloradoadvancedirectives.com and photocopy onto Wausau Astrobrights® Vulcan Green, 64lb paper. **The *MOST* form must be completed by a healthcare 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. He 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. The form must be signed by a physician (MD or DO), advanced practice nurse, or physician's assistant; the individual—if able—or the individual's Healthcare Agent or Guardian.

If the individual lacks capacity, a surrogate decision maker (Healthcare Agent, Proxy-by-statute, 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, see the box on page 17 on the Healthcare 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 Healthcare Professionals."

Appendix C provides a protocol for the *MOST* program and some tips for conducting the *MOST* conversation. Appendix D provides concise summaries for implementing the *MOST* program in various healthcare settings.

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*) • **FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA).** • These Medical Orders are based on the person's medical condition & wishes. • Any section not completed implies full treatment for that section. • 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.**	Last Name		
	First Name/Middle Name		
	Date of Birth		Sex
	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 for 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.***

Following the Form

When a *MOST* form is presented by an individual or his or her surrogate decision maker, healthcare professionals should check the upper right section and – if possible – the individual's identification to ensure that the form applies to the individual. In an emergency situation, checking identification may not be practical, but emergency personnel should check the individual's apparent age, sex, hair and eye color, and race/ethnicity against the form and be reasonably satisfied that the form and individual match up.

Section A: Cardiopulmonary Resuscitation (CPR)

A Check One Box Only	CARDIOPULMONARY RESUSCITATION (CPR) **Person has no pulse and is not breathing.** ☐ **No CPR** Do Not Resuscitate/DNR/Allow Natural Death ☐ **Yes CPR** Attempt Resuscitation/ CPR *When not 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 can apply 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 very shortly.

- 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 further treatment.
- ***Important:*** If the individual previously completed a CPR directive refusing resuscitation, a Healthcare Agent, Guardian, or Proxy-by-statute cannot check "Yes CPR" on the individual's behalf in this section. Only the individual him- or herself may revoke a CPR directive or make a different choice on the *MOST* form.

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 can apply 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** **Person has pulse and/or is breathing.**
	☐ **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.
- 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.
- Additional orders can be noted here: other interventions such as dialysis, invasive diagnostic tests or procedures, blood products, etc. may be refused or limited. 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 healthcare 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 "Comfort Measures Only," concentrate on relief of pain, distress, agitation, and the like. Transfer to the hospital only if comfort cannot be achieved in the current location.
- 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. Avoid invasive procedures as much as possible. 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 provide 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.

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**
- The discussion for this section should focus on antibiotics as a life-sustaining treatment, which in some cases might provide little or only temporary benefit and might 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 surrogate decision maker.

Section D: Artificially Administered Nutrition and Hydration

D Check One Box Only	**ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION** *****Always offer food & water by mouth if feasible****** ☐ No artificial nutrition/hydration by tube. **(NOTE: Special rules for *proxy by statute* on page 2)** ☐ Patient has executed a "Living Will" ☐ Patient has not executed a "Living Will" ☐ 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

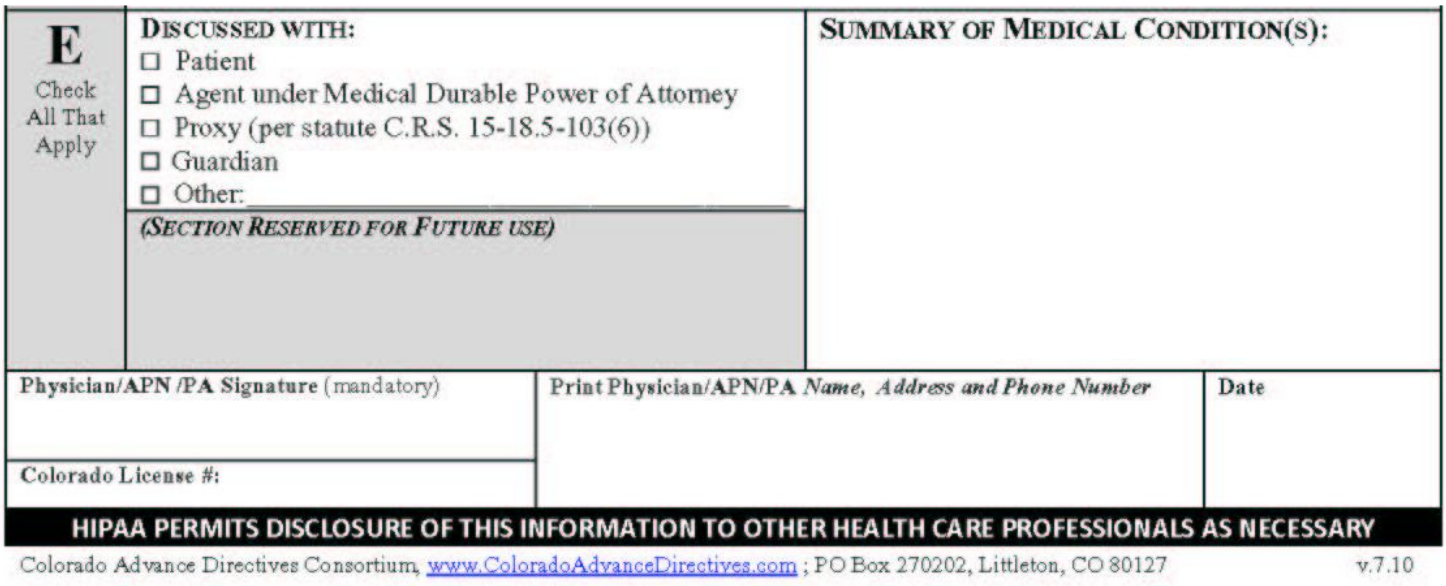
- **Check One Box Only.**
- Artificial nutrition and hydration (ANH) is any delivery of nutrients and fluids by tube: intravenous, nasogastric, or gastrointestinal. As ANH can be an appropriate, routine, and temporary measure in many contexts, any degree of refusal should be fully explored with reference 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.
- ***NOTE:*** Check the appropriate box regarding a Living Will. It is very important that the MOST form and a previously executed Living Will—if there is one—are consistent in the choices for ANH. 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 healthcare Proxy-by-statute (see box on page 17) may withhold or withdraw ANH only if two physicians, one trained in neurology, certify that the procedure is only prolonging the individual's dying.
- 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 following major medical event." Timeframes are dependent on the clinical condition and circumstances and the individual's goals. This section will require specific conversations between the individual and the healthcare 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 surrogate decision maker, 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.

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 under any circumstances.*
- 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 surrogate decision maker 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 surrogate decision maker. 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 surrogate decision maker, 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 healthcare Proxy-by-statute (see box on page 15) may withhold or withdraw ANH only if two physicians, one trained in neurology, certify that the procedure is only prolonging the individual's dying.

Section E: Summary and Medical Professional Signature



E Check All That Apply	**DISCUSSED WITH:** ☐ Patient ☐ Agent under Medical Durable Power of Attorney ☐ Proxy (per statute C.R.S. 15-18.5-103(6)) ☐ Guardian ☐ Other: ***(SECTION RESERVED FOR FUTURE USE)***	**SUMMARY OF MEDICAL CONDITION(S):**	
Physician/APN /PA Signature (mandatory) **Colorado License #:**	**Print Physician/APN/PA** ***Name, Address and Phone Number***	**Date**	

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. "Other" might be other consulting healthcare professionals, or additional family members, friends, or advisors 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 Section Reserved for Future Use*
- 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 healthcare professional 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. The time and date, along with the physician/APN/PA license number should be noted on the form. The

physician/APN/PA must countersign the notation of the verbal order within 30 days. The signature may be provided by photocopy, fax, or electronic means or in person.

- As indicated, the professional should provide, in print, his or her name, address, and phone number; the date; and professional license number. 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. The physician/APN/PA signature may be provided in person or by photocopy, fax, or electronic means.
- An original, bright-green colored *MOST* form is preferable, ***but photocopies, faxes, and electronic scans are also valid and should be honored.***
- This document complies with all regulations of the state health department with respect to portability of orders – ***any healthcare professional in receipt of these signed orders should follow them.***
- Receiving physicians must review the orders at once and follow them to the extent possible and appropriate to the individual's current condition. **If the physician has concerns about the medical appropriateness of the orders, he or she may suggest alternative treatments** to the individual or the individual's surrogate decision maker. If agreement is reached to change the orders, the changes must be noted and initialed on the form or a new form completed. If agreement is not reached, original orders should be followed or the individual transferred to the care of another provider.
- Healthcare providers and facilities may refuse to follow *MOST* orders on moral or religious grounds. In this case, the providers must inform the individual as soon as possible and arrange for prompt transfer to another's care.
- If a provider or facility chooses to refuse to accept all *MOST* orders as a matter of policy, this policy must be made known to other providers and potential patients through usual information sharing methods such as written notices in the facility, patient information packets, on facility Web site, etc.
- Prior to discharge from the facility or provider's care, the *MOST* form should be reviewed and updated according to the individual's current condition and treatment preferences.
- ***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 healthcare team.** The original form is the individual's personal property; copies may be made for the medical record. If the individual is at home, the original should stay with the individual and a copy placed in the supervising provider's chart.
- 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 healthcare providers may – and should – still adhere to the instructions.

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 do 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 and/or **MDPOA**, **Proxy***	*Phone Number/Contact Information*	
Health Care 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. The signature means that the individual has given thorough consideration to the issues and the choices indicated are consistent with his or her wishes and with other prior advance directives if any.
- If the individual does not have capacity to make these assertions and decisions, his or her surrogate decision maker – Healthcare Agent under Medical Durable Power of Attorney, Guardian, or Proxy-by-statute (see box on page 17) – must sign and indicate his or her status.
- Surrogate decision makers may complete a MOST on behalf of an incapacitated individual, but the *MOST* orders should reflect the individual's preferences and choices – as far as they are known – not the surrogate's. If the surrogate does not know and cannot determine with confidence the individual's preferences, choices should be made in the individual's best interests.
- Only valid surrogate decision makers (Medical Durable Powers of Attorney, Guardians, Proxy-by-statute, etc.) have authority to sign the *MOST* form; family members, financial powers of attorney, or other persons who are not valid healthcare decision makers 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 surrogate decision maker, but can be any close family member or friend. The primary contact person is a contact; not necessarily the authorized decision maker.
- The healthcare 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 surrogate decision maker, the orders are invalid.
- ***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 Healthcare Providers

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

Review and Replacement

REVIEWING THESE *MEDICAL ORDERS*

These *Medical Orders* should be reviewed regularly and when the person is transferred from one care setting or care level to another, there is a substantial change in the person's health status, the person's treatment preferences change, or when contact information changes.

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 healthcare provider should prompt appropriate reviews of the *MOST* instructions. Individuals, too, may initiate such a review with their healthcare providers.

Completing the Form

- Record date of review (very important in establishing precedence of forms).
- Provide name of reviewer (healthcare professional).
- Record location of review.
- Indicate outcome: No change, Form voided, New Form Completed.

- In some cases, the changes to the form are enough to require 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

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

HEALTHCARE PROXY-BY-STATUTE

- In Colorado, no one is given automatic authority in decision making for another adult, and healthcare providers cannot simply make decisions for individuals except in an emergency.
- If an individual does not have a Healthcare 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 the name and contact information for the Proxy in the medical chart. The individual must also be informed of the choice of Proxy.
- If the group can't agree on who the Proxy should be, then guardianship must be pursued through the courts.
- Like a Healthcare Agent, the Proxy should act according to the known wishes and values of the individual; so the Proxy know the individual well and, if possible, should have a clear understanding of what his or her wishes and values and how they might affect medical treatment decisions.
- ***Proxies selected in this way cannot withhold or 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.***

SUGGESTED 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 in any place that is easily accessed and obvious: 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.

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 an appropriate qualified healthcare or legal professional. More information about advance directive documents and the Colorado-specific forms can be found on the Colorado Advance Directives Consortium Web site: www.coloradoadvancedirectives.com or www.caringinfo.org.

Medical Durable Power of Attorney

- In Colorado, *no one is automatically authorized* to make healthcare decisions for another adult.
- The Medical Durable Power of Attorney (also called the "Power of Attorney for Healthcare") is a document an individual (the principal) signs to appoint someone else to make the principal's healthcare decisions in case of incapacity. The person appointed is called a "Healthcare 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 healthcare providers, and make all necessary healthcare 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 healthcare 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 healthcare decisions. A general POA covers legal and financial affairs. The authority of both types of Agent ends at the death of the principal.

Living Will

- In Colorado, the Living Will is called the "Declaration as to Medical or Surgical Treatment."
- It tells healthcare providers what to do about life-sustaining treatments if the individual is unable to make or express his or her healthcare decisions **and** is in a terminal condition **or** "persistent vegetative state."
- In Colorado, a Living Will does not go into effect until 48 hours after two doctors agree in writing that the individual has cannot make or express his or her own decisions, and has a terminal condition or is in persistent vegetative state.
- In these circumstances, a Living Will directs the physicians to continue or discontinue, as indicated, life-sustaining procedures, artificial nutrition, and artificial hydration.
- The Living Will can also provide other instructions for care following certification of terminal condition or persistent vegetative state.

- An individual does not need an attorney or healthcare professional to complete a Living Will, but two witnesses must sign. The witnesses cannot be the individual's healthcare providers, an employee of the healthcare provider, or anyone likely to inherit property from the individual.
- A notary's seal and 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.

CPR Directive

- A CPR (cardiopulmonary resuscitation) directive allows an individual to direct in advance that no one should administer CPR if the individual's heart or lungs stop working 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 healthcare 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. Faxes, photocopies, and electronic scans of CPR directives are just as valid as original forms.
- CPR directives must 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.

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 Advance Directives Consortium Web site: www.coloradoadvancedirectives.com.

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

Current Colorado law has some complexities around what Healthcare 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 must 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. Healthcare 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 section of the *MOST* form, when being completed by an Agent or other surrogate, 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 or MDPOA document. 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 not withhold or withdraw ANH 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.
  - → *What have your doctors told you about your [disease, condition, problems]?*
  - → *Have you talked about what can be done to help you get better?*
  - → *Is there anything you don't understand about your [disease, condition, problems] and the treatments you are receiving?*
- Determine the individual's views and values for life-sustaining treatment in light of the medical condition and likelihood of interventions.
  - → *When you think about the future, what is most important to you right now?*
  - → *If your heart or lungs stop, what do you want us to do?*
  - → *What are you afraid of/worried about?*
  - → *How do you feel about having a machine to help you breathe? Getting fluids and nutrients through a tube? Getting antibiotics to treat infections?*

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

- Provide information in small amounts.
- Allow plenty of time for responses or questions.
- Seek a common understanding.
- If asked, make recommendations based on clinical experience and individual's condition / values.

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

- Explore (rather than challenge or dismiss) choices you think are medically inappropriate.
- If individual and surrogate decision maker or other interested persons disagree, negotiate and try to reconcile differences; seek common ground/compromise.
- Use conflict resolution when necessary.

Respond empathetically.

- Acknowledge & legitimize.
  - → *I understand what you are saying.*
  - → *These are difficult issues.*
  - → *That's a very common concern.*
  - → *No question is silly.*
- Explore assumptions; correct misinformation.
  - → *You know, a lot of people have that idea, but research suggests . . .*
  - → *How do you think X will help/hurt you?*
  - → *Let's think of how this might apply in your case . . .*
- Reinforce commitment and nonabandonment.
  - → *We'll support you whatever decision you make.*
  - → *Even if you don't want a lot of treatment, we will always give you care.*
  - → *It's not what we want or think that matters, but what you want or think.*
  - → *If we can't do what you want us to, we'll be sure to find someone who will.*

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.

APPENDIX D: CONCISE IMPLEMENTATION GUIDELINES

Implementation in Nursing Facilities

- Offer/complete *MOST* promptly after admission; for current residents, at quarterly conference
- Include resident, Healthcare Agent, other family in conversations
- Incorporate prior advance directives; attention to ANH provisions
- Place original and backup photocopy in *"Advance Directives"* section of chart; inform staff
- If resident transferred, send ***original*** *MOST* with the patient
- Review/update as condition changes; at least quarterly.

Implementation by EMS

- Recognize form
- Review, and follow instructions: ***Look at Sections A and B, signatures***
- Must be signed by MD/DO, APN, PA to be "orders"; must be signed by patient or surrogate
- Without signature may still indicate preferences
- Contact Medical Control with treatment questions
- Obtain original form prior to transfer
- Present to receiving health care professionals
- Implementation by ERs

Implementation by ER/ED

- Recognize form
- Review, follow orders pending additional physician's orders
- Transcribe as appropriate
- Departure from orders/instructions possible only with consultation with patient or authorized surrogate
- Alert admitting physician
- Ensure *MOST* stays with patient if admitted

Implementation by Hospital Discharge

- Retrieve form and review choices
- Revise/replace as needed
- Send form with individual to next setting
    - If healthcare facility/agency, inform receiving professionals of MOST orders

Implementation in Hospice/Palliative Care

- Palliative Care consultations tool
- Review relative to change in condition precipitating referral to hospice
- Re-evaluate *goals of care* and consistency with *treatment wishes* relative to current diagnoses, condition and life-limiting prognosis

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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 HEALTHCARE PROFESSIONALS

Organizations & Web Sites

Colorado Advance Directives Consortium, www.coloradoadvancedirectives.com. Your "go-to" site for the latest information on the MOST program, forms and instructions, educational events and resources.

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. www.cha.com.

Colorado Health Care Association, www.cohca.org

Colorado Center for Hospice & Palliative Care. www.cochpc.org.

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.
Ambuel, B., & Weissman, D. E. (2005). Fast Fact and Concept #011: Delivering bad news Part II – Talking to patients and precepting trainees. Available online: www.eperc.mcw.edu/fastFact/ff_011.htm.
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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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