

LIFE QUALITY INSTITUTE

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Advance Directive and Medical Orders for Scope of Treatment Frequently Asked Questions

Note: This list is in progress—Keep checking back, and if you don't see your question here, please email us: jballentine@lifequalityinstitute.org. Updated 2/11/11

1. Are healthcare providers/facilities required to complete a MOST for every patient/resident?
2. **NEW** What staff member of a facility or medical practice should be the one to complete the form with the patient?
3. What changes do we have to make to our facility's forms or processes to comply with the recent changes in advance directive laws and the MOST program? Do we have to redo advance directives that are already in our charts?
4. **NEW** If the facility has not yet developed a policy with regard to the MOST, are the staff legally able to initiate or comply with MOST orders?
5. Does a MOST replace or revoke advance directives?
6. **NEW** What if the MOST orders conflict with the patient's other advance directives?
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12. **NEW** What should hospitals do with the MOST before the patient leaves the hospital?
13. **NEW** Should changes to MOST orders be made as annotations on an existing form or should a new form be created?
14. How and where should staff document a telephone order for the MOST? Would this be written in some way on the form itself, and dated, or would this be on the TO form usually used and attached to the MOST form? If the doctor isn't going to visit the facility soon, would you then mail the original for signature, keeping a copy in the chart until it returns?
15. If the MDPOA is out of town, and consent to the MOST must be gathered by phone, is there a process suggested? [Our] facility has two witnesses to any phone call requiring a verbal consent from an MDPOA, and that's documented. Would this be a good process for getting the MOST consent witnessed? Would we then mail the original MOST to the MDPOA for a signature or is the verbal sufficient? What if the patient is in the home? How would you document this so that it was considered sufficiently witnessed?
16. If a person [completing the MOST] has capacity, but is physically unable to write a legible signature, how is that handled? Is an "X" adequate if it's been witness by the facility staff?
17. An ALR administrator said that because they are not a skilled facility, if someone falls and has bleeding or head injury, the facility is required to send the person to the ER for evaluation. Their question is how to address this if the person has filled out option 1 in section B (Comfort measures only; do not transfer).

18. Why isn't there a signature line for the healthcare professional helping to prepare the form?
19. In the review section on the back of the form, why is there a "form voided" option? Wouldn't you just destroy a voided form?
20. If the CPR directive triplicate form is not being used anymore, or if the MOST is being used as a CPR directive, how does someone get the bracelet or necklace?
21. Is there a way for a healthcare provider to bill for the time it takes to complete the MOST form with a patient? Some providers might be reluctant to take the time if they cannot be reimbursed.
22. Is the MOST form or any of the instructional/informational materials available in Spanish?
23. Can we make multiple copies of the MOST Instruction booklet for our staff and provider partners?

1. Are healthcare providers/facilities required to complete a MOST for every patient/resident?

No—use of the MOST by providers, facilities, or individuals is not required. It is strongly recommended for persons with serious, chronic, or life-limiting illness in frequent contact with healthcare settings and providers or already residing in a nursing facility.

2. NEW Which staff member of a facility or medical practice should be the one to complete the MOST with a patient?

Any staff member with sufficient knowledge to be able to explain the procedural and medical implications of the various treatment choices can complete the form with the patient. This could be a physician, physician assistant, nurse, medical social worker, possibly even a chaplain; although facilities may have their own specific policies on this. The completion of the MOST is not just a "check-the-box" exercise—it requires thorough and thoughtful conversation. Once the form is completed, the physician, PA, or NP who signs the form is responsible for reviewing and approving the choices. The choices should be clear, consistent with the patient's medical condition and prognosis, and values. If there is any question, the person signing the form should follow up with the patient or the professional who helped complete the form.

3. What changes do we have to make to our facility's forms or processes to comply with the recent changes in advance directive laws and the MOST program? Do we have to redo advance directives that are already in our charts?

No advance directives *must* be redone to comply with recent updates to laws or regulations. Here are some specific suggestions for incorporating changes:

Medical Durable Power of Attorney—no changes to the law, so no changes to forms or processes needed. We strongly recommend, however, that you follow up with patients who have not appointed an MDPOA and be sure they and their family members understand that no one has automatic decision-making authority for another person—an MDPOA must be appointed ahead of time, or a Proxy-by-Statute selection process must be initiated if the patient is incapacitated, has no Agent under MDPOA and a medical decision must be made. (*NOTE:* See "Summary and Comparison of Advance Directive

Laws and Tools” on the CADC Links and Resources page for the difference between an Agent under MDPOA and Proxy-by-Statute).

Living Will—forms complying with the old Living Will law are completely legal and don’t have to be replaced. However, the new law does include PVS (persistent vegetative state) as a qualifying condition and allows several additions of information and instruction to the Living Will document, which patients may wish to be aware of. A Living Will form including all the innovations can be found on The Iris Project Web site (www.irisproject.net, Links & Resources page). The Colorado Bar Association has also revised their standard form, however it is not yet posted on their Web site.

CPR Directive—the current Colorado Directive for CPR (triplicate “blue form”) is still valid and may be used but will eventually be phased out. A template CPR directive form is available from the Colorado Department of Public Health & Environment Web site (<http://www.cdphe.state.co.us/em/Operations/CPRDirectives/index.html>). This form may be used “as is” or customized for your facility. **Until the MOST is well recognized and accepted statewide, it is a good idea to continue to use the CPR Directive form in addition to the MOST to ensure refusal of CPR. [NEW Only the CPR directive can be used to refuse CPR for minors.]** NOTE: Other forms, such as provider- or facility-specific forms, the Medical Orders for Scope of Treatment, or any other manner of clearly communicating a refusal of CPR (jewelry, wallet card, hand-written note) are valid and should be honored.

Medical Orders for Scope of Treatment program—the MOST program is in the process of being rolled out statewide through “train-the-trainer” sessions offered by the Colorado Advance Directives Consortium. We strongly recommend that facilities send representatives to the next training (information can be found on the CADC Web site, www.coloroadvancedirectives.com). The standard, official MOST form is available at the CADC Web site. At minimum, every facility and provider of healthcare services to persons who have serious, chronic, or life-limiting illness, as well as the frail elderly, **must develop policies and procedures for accepting* MOST orders and integrating the MOST into their systems and practice.** This includes nursing facilities, EMS services, Emergency departments, acute care hospitals, home health, rehab and long-term care, hospice and palliative care. **Use of the MOST is not required** for any patient or provider, but providers must be prepared. An instruction booklet with details on the program, completing and following the form, and implementation guidelines is available from the Colorado Advance Directives Consortium.

*Individual providers and facilities are not compelled to follow MOST orders which they believe are medically inappropriate for the patient or are contrary to moral or religious convictions. Patients and/or surrogate decision makers must be consulted before orders are changed and must be informed—and transferred to another’s care—if orders will not be honored.

4. NEW If the facility has not yet developed a specific policy with regard to the MOST, are the staff legally able to initiate or comply with MOST orders?

Yes, the MOST statute provides all the necessary protections.

5. Does a MOST replace or revoke advance directives?

No. The **MOST is a medical order set, not an advance directive**. The treatment types and choices on a MOST are only a few of the possible issues that advance directives can address. If a person has advance directives in place (Living Will, MDPOA, etc.), the person completing the MOST with the patient/resident should review the advance directives so that the MOST orders match the advance directives—or the advance directives are revised or revoked to match current choices documented on the MOST. The advance directives remain in effect and valid. If the MOST orders conflict with choices made in an advance directive (for instance, the person had executed a CPR directive, but the MOST says “Yes CPR”), then the most recent document prevails. If a person completing a MOST does not have any other advance directives, the MOST covers the key life-sustaining treatment choices, and there is room to add additional orders. However, it cannot be used to appoint a healthcare agent, nor does it address personal care or nonmedical matters.

The MOST will likely eventually replace the CPR “blue form” but the blue forms are still valid and, until all EMS services and ED/ERs are familiar with the MOST, it’s a good idea for a patient/resident to have both. **NEW** Some long-term care facility policies require a facility-specific CPR directive form. There is no problem with using those forms along with a MOST.

6. NEW What if MOST orders conflict with the patient’s other advance directives?

As noted in Question 3, the general rule of thumb is that in cases of conflict between a MOST and other advance directives, the most recent document rules. However, there are some nuances to this, depending on who has completed which document when:

The MOST and CPR directives: If a person completed a CPR directive (refusing CPR) before completing a MOST, but then on the MOST says “Yes” to CPR; the most recent document prevails. If the person completed a CPR directive (refusing CPR), and later is incapacitated and the person’s Healthcare Agent is unaware of the earlier CPR and completes a MOST for the patient saying “Yes” to CPR, the prior CPR directive prevails—because no one but the person him- or herself can revoke a CPR directive he or she completed.

The MOST and Living Wills: A Healthcare Agent cannot complete a Living Will for an incapacitated patient. Likewise, a Healthcare Agent cannot override or revoke the person’s Living Will unless specific authority to do is stated in the Living Will or the MDPOA document. If the Healthcare Agent completes a MOST for the person and a previously completed Living Will contradicts any of the MOST provisions, the Living Will prevails. If the person completes a MOST and a previously completed Living Will contradicts the MOST, the MOST prevails.

IMPORTANT: This is why it is essential, before completing a MOST, to ask about previously completed advance directives to make sure the documents do not conflict.

7. Can a Healthcare Agent (MDPOA), Proxy, or Designated Beneficiary (DB) complete, revise, or revoke a MOST for an incapacitated person?

Yes. However, changes to the MOST form should only be made if there are good reasons to make changes—such as a change in the condition, prognosis, or goals of the person. Agents and other proxies should not just wait for “Granny to conk out” and then redo the MOST. Any changes to a MOST form should also take in to account the input and advice of the healthcare professional who will sign the form.

Also, an Agent must abide by the person’s choices documented in a previously executed CPR directive or a Living Will, unless the Living Will or MDPOA document specifically grants an override right to the Agent. A Proxy or DB must abide by the person’s choices in a CPR directive or Living Will, period. If, for instance, the person completed a Living Will some years ago and indicated there a preference to continue ANH even when other life-sustaining procedures are withdrawn, the Agent cannot execute or revise a MOST that refuses all ANH, or vice versa. As well, a Proxy or DB cannot withhold or withdraw artificial nutrition/hydration from a patient unless and until two physicians, one of whom is trained in neurology, certify that the provision of ANH will not contribute to the patient’s recovery and will only prolong dying.

8. What if a patient brings in a MOST or other POLST/POST/MOLST form from another state that doesn’t exactly comply with Colorado requirements for the MOST?

The MOST statute says that MOST/POLST/POST/MOLST forms from other states must be honored, subject to the exceptions/limitations in Colorado’s law.

9. Will my patient’s MOST form be honored in other states?

Whether a Colorado MOST form will be honored in another state is entirely up to the laws of that state. A valid Colorado MOST form presented to a healthcare provider in another state will likely carry a great deal of weight as a strong indication of patient preferences with the endorsement of the healthcare professional who signed the form; however, providers in other states may not be obliged to follow the orders.

10. What can be done to help ensure that the form actually stays with the patient into and out of the hospital and returns to the facility or home with the patient?

First, although the form belongs to and should stay with the patient, facilities/hospice agencies should always keep a copy in the patient’s chart. If the resident/patient leaves the facility with a MOST but comes back without one, contact the hospital and ask for it back. Hospitals should list the form as “personal property” and have procedures in place to review/update/replace the form during discharge process to make sure orders are current and form leaves with patient.

11. Should/can hospitals initiate the MOST process for patients who do not come into the hospital with a MOST?

Yes, for the target patient population (seriously or chronically ill, being discharged to a facility or to home with hospice or home health). The goal of the MOST program is to make sure that vulnerable patients have orders in place re life-sustaining treatments as they transfer across healthcare settings. NOTE: Some hospitals are balking at initiating advance directive forms. Remember, **the MOST is NOT an advance directive!** It is a medical order set that communicates patients' desires for particular treatments.

12. NEW What should hospitals do with the MOST before the patient leaves the hospital?

If the patient already has a MOST, it should be reviewed and (likely) revised prior to discharge by the hospitalist or attending. He or she should review the choices on the form in light of the course of the patient's hospitalization, current condition, and prognosis. If substantive changes are called for, a new form should be initiated. The old form should be voided out (by writing VOID clearly across both sides of the form), but returned to the patient.

13. NEW Should changes to MOST orders be made as annotations on an existing form or should a new form be created?

General ruling principle: do whatever is MOST likely to be clear and authoritative. If annotations to change orders might create confusion or doubt about the validity or clarity of the order, then do up a new form. If annotations are used to indicate changes or additions/deletions, they should be initialed by signing professional (MD/DO, APN, or PA) and patient or agent.

14. How and where should staff document a telephone order for the MOST? Would this be written in some way on the form itself, and dated, or would this be on the TO form usually used and attached to the MOST form? If the doctor isn't going to visit the facility soon, would you then mail the original for signature, keeping a copy in the chart until it returns?

Here is how the legislation addresses verbal orders:

An adult's physician, advanced practice nurse, or if under the supervision of the physician, physician's assistant may provide a verbal confirmation to a health care provider who shall annotate on the MOST form the time and date of the verbal confirmation and the name and license number of the physician, advanced practice nurse, or physician's assistant. The physician, advanced practice nurse or physician's assistant shall countersign the annotation of the verbal confirmation of the MOST form within a time period that satisfies any applicable state law or within 30 days, whichever period is less, after providing the verbal confirmation. (Section 15-18.7-104)

Documentation of verbal/telephone orders should follow these guidelines and any other existing facility procedures for verbal or telephone orders. If the physician/APN/PA is not

going to visit the facility (or the patient if the patient is at home) within 30 days, the form may be faxed for countersignature.

15.If the MDPOA is out of town, and consent to the MOST must be gathered by phone, is there a process suggested? [Our] facility has two witnesses to any phone call requiring a verbal consent from an MDPOA, and that's documented. Would this be a good process for getting the MOST consent witnessed? Would we then mail the original MOST to the MDPOA for a signature or is the verbal sufficient? What if the patient is in the home? How would you document this so that it was considered sufficiently witnessed?

There is no legal requirement for "witnessing" the MOST. The signatures of the physician/APN/PA and patient/agent are sufficient. However, the process described for confirming a verbal consent from an agent sounds perfectly fine. The MOST form can then be faxed to the agent for signature and faxed back.

16.If a person [completing the MOST] has capacity, but is physically unable to write a legible signature, how is that handled? Is an "X" adequate if it's been witnessed by the facility staff?

This is not directly addressed in the legislation. This situation should be handled according to policies the facility/provider has in place for any signature of important documents, for instance MDPOA, Living Will, etc. The facility/provider should consult with their legal advisors as to what would be the best method if they do not have policies in place covering other similar situations. NOTE: Facility staff are probably not the best witnesses in this or similar cases as they are specifically forbidden to witness Living Wills.

17.An ALR administrator said that because they are not a skilled facility, if someone falls and has bleeding or head injury, the facility is required to send the person to the ER for evaluation. Their question is how to address this if the person has filled out option 1 in section B (Comfort measures only; do not transfer).

Option 1 says "do not transfer to hospital for life-sustaining treatment/transfer only if comfort cannot be met in current location." If head injury is possible or if bleeding cannot be controlled by EMS, this would be a completely appropriate reason to transfer the resident, even under the "comfort care only" option. Also, a request for transfer under certain circumstances can always be included on the "additional orders" line.

18.Why isn't there a signature line for the healthcare professional helping to prepare the form?

The purpose of the physician/PA/APN signature is to "translate" the patient choices into medical orders. A medical social worker or RN could help the patient complete the form but cannot sign medical orders; which is why we specifically *did not* include a signature line for any healthcare professional other than the MD/DO/PA/APN. There is a place for the person helping to complete the form (if not the same as the person signing it) to provide their name and contact information, however.

19. In the review section on the back of the form, why is there a “form voided” option? Wouldn’t you just destroy a voided form?

Some medical records departments do not allow destruction of orders or documents. Also, a person might void their MOST form and not replace it with a new one, so the voided form is the most recent version.

20. If the CPR directive triplicate form is not being used anymore, or if the MOST is being used as a CPR directive, how does someone get the bracelet or necklace?

The Colorado Department of Public Health & Environment was in touch with Award and Sign (providers of the No-CPR bracelets/necklaces) right after the new CPR rules took effect. Award and Sign are aware that there is no one required CPR form anymore. CDPHE suggests folks call them or other companies that make similar jewelry to see what the companies' requirements are. www.awardandsign.com or (303) 799-8979.

21. Is there a way for a healthcare provider to bill for the time it takes to complete the MOST form with a patient? Some providers might be reluctant to take the time if they cannot be reimbursed.

There is no billing code specifically for advance care planning conversations (yet!). However, there is a mechanism within Medicare to bill for “prolonged services,” and this is often used to bill for counseling or visits that exceed the Medicare time definitions per guidelines.

22. Is the MOST form or any of the instructional/informational materials available in Spanish?

Not yet – and the Consortium would welcome assistance in translating our materials and performing outreach to the Latino community as well as other non-English-speaking groups. Please contact us if you have skills that you would be willing to offer!

23. Can we make multiple copies of the MOST Instruction booklet for our staff and provider partners?

Yes! And we encourage you to do so. You may even add your facility or organization’s logo to the cover. What you CAN’T do is edit, add to, or alter the content. If you have suggestions for additions or edits, please direct them to Jennifer Ballentine, jballentine@lifequalityinstitute.org.