

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

GUIDANCE FOR HEALTHCARE 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 healthcare professional and patient (individual) to determine preferences in key areas of life-sustaining medical treatment, including CPR, scope of treatment, and artificial nutrition.

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 directives remain in effect. In general, the MOST overrules prior instructions only when they directly conflict (see Appendix B for details and exceptions). A more recently completed MOST, however, invalidates all previous MOST forms. The MOST form was significantly revised in 2015; earlier forms remain valid unless and until they are superseded by a newer version.

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

The MOST must be signed by the individual or, if incapacitated, by the individual's authorized Healthcare Agent, Proxy, 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, which must be followed regardless of the provider's privileges at the admitting facility.

The standardized form can be easily and quickly understood by individuals, healthcare providers, and emergency personnel. The original is brightly colored for easy identification, but photocopies, faxes, and electronic scans are also valid.

The MOST form belongs to and "travels" with the individual; it must be 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.

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.civhc.org.

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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. At this writing, 16 states have established POLST paradigm programs by legislation or regulation, and another 29 have programs in development. Briefly,

- A Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program is designed to improve the quality of care people receive during serious, chronic, or life-limiting illness by turning patient goals and preferences for care into portable medical orders.
- POLST is based on communication between the patient or other legally designated medical decision-maker and healthcare professionals, which ensures that patients understand the decisions they are making.
- The POLST Paradigm Program: (1) Assists healthcare professionals to 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 participants have shown that the program 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 (CADC) began developing a POLST program in 2007. The CADC is a multidisciplinary volunteer group including representatives from healthcare, professional associations and statewide organizations, patient and consumer advocates, government and social services, healthcare ethicists, elder law and health law attorneys, and others.

The CADC has customized the POLST program and form for consistency with Colorado law, medical practice, and statewide healthcare system realities. Thus, the CADC adopted one of the POLST variant approaches: the Medical Orders for Scope of Treatment (MOST) with the goal of making 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 MOST program was established by legislation in Colorado in 2010 (C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment). Revisions to the form undertaken in 2013 and adopted in 2015 reflect emerging national standards and feedback from stakeholders since the program's establishment in 2010. In addition, the CADC, in collaboration with the National POLST program, will be developing ongoing quality improvement efforts and directing quality processes and outcome measures.

CIVHC provides administrative support to the MOST program: At our website, www.civhc.org, 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.

ADVANCE DIRECTIVES IN COLORADO

Since 1985, the Colorado General Assembly has authorized several methods for individuals to document advance medical directives and/or appoint surrogate healthcare decision makers:

- Colorado Directive as to Medical Treatment (aka “living will,”)
- CPR Directive
- Medical Durable Power of Attorney for Healthcare
- Healthcare Proxy process (see Appendix A for details)

The first two – the living will and CPR Directive – document refusals of certain life-support treatments under certain circumstances; the second two provide mechanisms by which legal representatives or surrogates may be identified for the purpose of healthcare decision making. (For more information on these advance directives and appropriate forms, please refer to Your Right to Make Health Care Decisions [CHA, 2012]). All four tools are empowered by the well-established, in law and medical practice, right of a competent adult 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)

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 medical director 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 DNR 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 or on behalf of 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, not necessarily at admission but within the first two or three days of the resident's stay. Staff should complete MOST forms for all current residents before the next scheduled quarterly care plan meeting and review the form automatically before each resident's quarterly assessment
- **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 lifesustaining treatment) leaves the hospital with the form completed.
- **Home Health:** If persons receiving home health services do not already have a MOST form, completion should be included as part of the advance care planning process.
- **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.civhc.org and photocopy onto Wausau Astrobrights Vulcan Green, 64lb paper. (Astrobrights® Terra Green is also acceptable, as is any equivalently bright green paper that photocopies “clean,” meaning that the color of the paper does not result in a muddy or darkened image.) Note that the green paper is strongly recommended for easy identification and retrieval, but is not required. Photocopies, faxes, and electronic scans of MOST forms are just as valid as an original.

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 (see Appendix C for discussion guidelines and tips). Ideally, this would be the attending physician, physician’s assistant, or advanced practice nurse. Registered nurses and even experienced medical social workers may complete the form and present it to the supervising provider for signature. Whoever completes the form must be able to answer questions about the medical treatments addressed, in light of the individual’s condition and goals, and should also be able to make a determination of the individual’s decision-making capacity or locate another professional to make that determination. The form must be signed by a physician (MD or DO), advanced practice nurse, or physician’s assistant and the individual, assuming the individual has decisional capacity.

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 a Healthcare 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 Healthcare 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 ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED				
Colorado Medical Orders for Scope of Treatment (MOST)		Last Name		
<ul style="list-style-type: none"> • FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA), for further orders if indicated. • These Medical Orders are based on the person's medical condition & wishes. • If Section A or B is not completed, full treatment for that section is implied. • 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. 		First Name/Middle Name		
		Date of Birth	Sex	
		Hair Color	Eye Color	Race/Ethnicity
		<p><i>In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. (See additional instructions on page 2.)</i></p>		

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.

Before proceeding to instruction sections, ask the individual if he/she has completed any other advance directives, such as a living will, CPR directive, or medical durable power of attorney. If yes, ask to review the documents so that instructions can be made consistent. Instructions on previously completed documents can be changed to align with the individual's current values and goals, but the MOST should not contradict previous instructions. If the documents are not available, proceed on the recollection of the individual, but make a note to follow up with family members or other providers to obtain copies of the documents if at all possible. If previous advance directives are no longer appropriate, they should be revised or revoked and destroyed.

Surrogate decision makers including a Healthcare Agent under Medical Durable Power of Attorney, Guardian, or Proxy-by-statute (see page 17) 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.

Important: If the MOST is being completed for an incapacitated individual by a Healthcare Agent, Proxy-by-statute, or Guardian, advance directives previously completed by the individual when competent should be followed and reflected in the MOST. This is especially important for any provisions contained in a living will (Colorado Declaration as to Medical Treatment), which cannot be revoked or revised by a healthcare agent unless specifically authorized.

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)	<i>Person has no pulse and is not breathing.</i>
	<input type="checkbox"/> Yes CPR: Attempt Resuscitation	<input type="checkbox"/> No CPR: Do Not Attempt Resuscitation
<i>NOTE: Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B. When <u>not</u> in cardiopulmonary arrest, follow orders in Section B.</i>		

Explaining the Options and Completing the Form

- Check one box only: “Yes CPR” or “No 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 “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.
- 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.
- 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.
- Important: If “Yes CPR” is checked, the only possible selection in Section B is “Full Treatment.” If “No CPR” is checked, the individual may select any option in the Section B.

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 the individual is not in full cardiopulmonary arrest, Section A does not apply; orders in Section B should be followed.
- If “Yes CPR” is checked, call 9-1-1 and/or initiate emergency resuscitation.

- 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.

SECTION B: MEDICAL INTERVENTIONS

B Check one box only	MEDICAL INTERVENTIONS	<i><u>Person has pulse and/or is breathing.</u></i>
	<input type="checkbox"/> Full Treatment—primary goal to prolong life by all medically effective means: In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care. <input type="checkbox"/> Selective Treatment—goal to treat medical conditions while avoiding burdensome measures: In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. <u>Do not intubate.</u> May use noninvasive positive airway pressure. Transfer to hospital if indicated. <u>Avoid intensive care.</u> <input type="checkbox"/> Comfort-focused Treatment—primary goal to maximize comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. <u>Do not transfer to hospital for life-sustaining treatment.</u> <u>Transfer only if comfort needs cannot be met in current location.</u>	
	Additional Orders: _____	

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 goals, extent of medical interventions desired, and instructions on transfer to hospital and admission to intensive care.
- Each option should be explained to the individual should in light of his/her medical condition and goals. If questions arise that person completing the form cannot answer, refer to the physician.
- Comfort-focused Treatment is always included. If Comfort-focused Treatment is selected and the person has not been admitted to hospice care, a hospice evaluation and referral or palliative care consult is strongly recommended.
- 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-focused Treatment” 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. Comfort-focused treatment is always included.
- 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-focused Treatment” or “Selective Interventions” should not be entered into the Trauma System.
- For “Comfort-focused Treatment,” concentrate on relief of pain, distress, agitation, and the like. Transfer to the hospital only if comfort cannot be achieved in the current location.
- Note “Additional Orders” line for 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: ARTIFICIALLY ADMINISTERED NUTRITION

Note: The original Colorado MOST form Section C addressed the use of antibiotics. If you are a healthcare provider caring for a person with an older MOST form, follow the instructions regarding antibiotics as written. The original form Section D addressed Artificial Nutrition and Hydration. Follow the orders as written or ask the individual or his/her healthcare agent to clarify preferences in light of the current forms choices.

C Check one box only	ARTIFICIALLY ADMINISTERED NUTRITION <i>Always offer food & water by mouth if feasible.</i>
	<p>Any surrogate legal decision maker (MDPOA, Proxy-by-Statute, guardian, or other) must follow directions in living will, if any. Not completing this section does not imply any one of the choices—further discussion is required. NOTE: <i>Special rules for Proxy-by-Statute apply; see reverse side (“Completing the MOST form”) for details.</i></p> <p> <input type="checkbox"/> Artificial nutrition by tube long term/permanent if indicated. <input type="checkbox"/> Artificial nutrition by tube short term/temporary only. (May state term & goal in “Additional Orders”) <input type="checkbox"/> No artificial nutrition by tube. </p> <p>Additional Orders:</p>

Explaining the Options and Completing the Form

- Check One Box Only.
- Artificially administered nutrition (AN) is any delivery of nutrients by tube: intravenous, nasogastric, or gastrointestinal. As AN 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.
- Choices offered are “long-term/permanent,” which is used to supply nutrition to a person who can no longer ingest or digest “normal” food due to physical or cognitive impairment (e.g., persistent vegetative state, permanent coma, advanced dementia, ALS, etc.); or “short-term/temporary,” which might be an appropriate supportive measure following surgery, during an acute illness, or after an accident; or none.
- Important: The MOST form and a previously executed living will—if there is one—must be consistent in the choices for AN. An individual’s Guardian or Healthcare Agent under Medical Durable Power of Attorney may refuse or withdraw AN on an individual’s behalf. However, if the individual has a previously executed living will, the Guardian, Healthcare 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 AN only if two physicians, one trained in neurology, certify that the procedure is only prolonging the individual’s dying.
- Additional orders can be provided, including a timeframe during which to provide AN, at the end of which, if no improvement has occurred, it may be discontinued.

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.
- The instructions in this section do not apply to routine or therapeutic provision of IV fluids.
- “By tube” includes intravenous, nasogastric, and gastrointestinal. Instructions apply to all forms of AN delivery.
- The first option, “Artificial nutrition by tube long-term/permanent” indicates a life-sustaining measure for persons otherwise unable to ingest or digest “normal” food due to physical or cognitive impairment (e.g., persistent vegetative state, permanent coma, advanced dementia, ALS, etc.). Selection of this option does not sanction or mandate long-term use of AN if it results in disproportionate harm to benefit. Healthcare providers with concerns about the benefit-to-harm ratio in provision of long-term AN are encouraged to review goals of care and preferences with individuals and/or their healthcare decision makers.
- The second option, “Artificial nutrition by tube short-term/temporary” refers to nutritional support following surgery, during an acute illness, or after an accident, with the goal of sustaining the individual until he/she recovers the ability to eat normally.
- Important: An individual’s Guardian or Healthcare Agent under Medical Durable Power of Attorney may refuse or withdraw AN 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 17) may withhold or withdraw AN only if two physicians, one trained in neurology, certify that the procedure is only prolonging the individual’s dying.

SECTION D: DISCUSSED WITH . . .

D	DISCUSSED WITH (check all that apply):	<input type="checkbox"/> Proxy (per statute C.R.S. 15-18.5-103(6))
	<input type="checkbox"/> Patient	<input type="checkbox"/> Legal guardian
	<input type="checkbox"/> Agent under Medical Durable Power of Attorney	<input type="checkbox"/> Other: _____

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.

SIGNATURES

SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (MANDATORY)			
Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare 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 previously completed advance directives do not conflict with these <i>Medical Orders for Scope of Treatment</i> , they shall remain in full force and effect.			
<i>If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.</i>			
<i>Patient/Legal Decision Maker Signature (mandatory)</i>	<i>Name (Print)</i>	<i>Relationship/ Decision maker status (Write "self" if patient)</i>	<i>Date Signed (Revokes all previous MOST forms)</i>
<i>Physician / APN / PA Signature (mandatory)</i>	<i>Print Physician / APN / PA Name, Address, and Phone Number</i>		<i>Date Signed</i>
Colorado License #:			
HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY			
<small>Authority for this form and process is granted by C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment, enacted 2010.</small>			

Completing the Form

- The MOST form must be signed by a physician, advanced practice nurse, or physician assistant.
- Ideally, the signing healthcare provider is the person who has discussed the choices and options with the individual and/or healthcare decision maker, but at least should be the attending physician of record or facility provider.
- If the 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 or sooner per facility policy. The signature may be provided by fax, or electronic means, or in person.
- As indicated, the signing healthcare professional should print his or her name, address, and phone number; the date; and professional license number, and then sign the form. The date of signature may be very important for determining precedence of orders and instructions.
- 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.
- 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. However, as noted above, efforts should be made to ensure the documents are consistent.

Following the Instructions

- A signature by a physician, advanced practice nurse, or physician’s assistant translates patient preferences into valid, portable medical orders. 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 consent is given to change the orders, the changes must be noted and initialed on the form or a new form completed. If consent is not given, 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.
- 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. However, if there is no signature by the individual or his or her surrogate decision maker, the form is not valid as orders or patient preferences.

SIDE 2: ADDITIONAL INFORMATION

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED			
ADDITIONAL INFORMATION: <i>Please provide contact information below, in case follow up or more information needed.</i>			
<i>Patient Last Name</i>	<i>Patient First Name</i>	<i>Patient Middle Name (if any)</i>	<i>Patient Date of Birth</i>
<i>Healthcare Professional Preparing Form</i>	<i>Preparer Title</i>	<i>Phone Number/Email</i>	<i>Date Prepared</i>
<i>Patient Primary Diagnosis</i>	<i>Hospice Program (if applicable) /Address</i>		<i>Hospice Phone Number</i>

Completing the Form

- Repeat individual’s name and date of birth.
- Provide contact information for the healthcare professional who helped complete the MOST form. This is not a signature—just 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, along with the patient’s primary diagnosis.

DIRECTIONS FOR HEALTHCARE PROVIDERS

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

REVIEW, REVOCATION, AND REPLACEMENT

<u>Reviewing the Medical Orders:</u>			
<ul style="list-style-type: none"> • These medical orders should be reviewed <ul style="list-style-type: none"> ○ regularly by the person’s attending physician or facility staff with the patient and/or patient’s legal decision maker; ○ on admission to or discharge from any facility or on transfer between care settings or levels; ○ at any substantial change in the person’s health status or treatment preferences; and ○ when authorized decision maker or contact information changes. • If substantive changes are made, please complete a new form and void the replaced one. • To void the form, draw a line across Sections A through C and write “VOID” in large letters. Sign and date. 			
REVIEW OF THIS COLORADO MOST FORM			
Review Date	Reviewer	Location of Review	Review Outcome
			<input type="checkbox"/> No Change <input type="checkbox"/> New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> New Form Completed
HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY			

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 or New Form Completed.
- If changes are desired/required, it is best to complete a new form. Check “New Form Completed,” but also write “VOID” or “REVOKED” prominently on both faces of the form.

- Voided original 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.

Handling and Suggested Placement of the MOST Form

Once the MOST form is completed, the original belongs to and 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. A MOST medical alert bracelet or necklace may also be obtained; contact Award & Sign Connection, www.AwardandSign.com, 303-799-8979.

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.

“Next of kin,” spouses, adult children, or other relatives are not authorized decision makers unless duly appointed as a Healthcare Agent or Guardian.

If an individual does not have a Healthcare Agent under Medical Durable 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 (APN) 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, APN, or someone designated by the physician or APN must make a good faith effort to locate and assemble (physically or via communication technology) people who have an interest in the care of the individual who is ill.

These “interested parties” – which can be family members by blood, marriage, or adoption; 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 APN 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 should know the individual well and, if possible, have a clear understanding of 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.

The Proxy-by-statute process is intended as a stop-gap in unexpected circumstances or for a particular episode of care. Proxy-by-statute decision makers are not intended to remain in the role indefinitely. If the individual requires long-term medical decision making, an interested person should seek Guardianship through the courts.

IMPORTANT UPDATE. In 2016, the Colorado Legislature approved amendments to the Proxy Decision Maker Statute to provide a process for proxy decision making on behalf of incapacitated patients without any “interested persons.” In this revised process, the attending physician may designate another “willing” physician to serve as the patient’s proxy; the designation must be approved by the facility’s ethics committee. The attending physician may make routine medical decisions for the patient, but any decision requiring informed consent or concerning end-of-life treatment or care must be made by the physician proxy with consensus of the ethics committee. The proxy designation ends on discharge or death of the patient, or if the patient regains decisional capacity. Details can be found on the CADC website in the handout “Summary of House Bill 161101”: <https://www.civhc.org/wp-content/uploads/2018/10/Summary-of-2016-Amendments-to-Proxy-Decision-Maker-Statute-revised.pdf>.

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 CIVHC website: www.civhc.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 Healthcare 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 Healthcare 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 Healthcare Agent is supposed to act according to the principal's wishes and values, so whoever is appointed as agent must have a clear idea of the principal's life values, goals, and preferences for treatment. The Healthcare Agent must be able to devote the time and energy to handling complex healthcare needs, perhaps over many years.
- 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 Healthcare Agent ends at the death of the principal.

LIVING WILL

- In Colorado, the living will is called the "Declaration as to Medical 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 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 seriously 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 obliged 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 seriously or terminally ill individuals 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 Healthcare 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. Contact Award & Sign Connection, www.AwardandSign.com, 303-799-8979, or the MedicAlert Foundation, www.MedicAlert.org, 888-633-4298.

Appendix B: The Responsibilities and Rights of Healthcare Agents, Guardians, and Proxies-by-Statute

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. Healthcare 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 Healthcare 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 Healthcare 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, a Healthcare Agent, Guardian, or Proxy-by-statute may not revoke it under any circumstances. This section of the MOST form, when being completed by a Healthcare Agent or other surrogate, must conform to any MOST or other CPR directive previously completed by the individual.

ARTIFICIAL NUTRITION

If an individual has executed a living will, a Healthcare Agent, Guardian, or Proxy-by-statute may not revoke or modify 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 choices regarding artificial nutrition. This section of the MOST, when being completed by a Healthcare Agent, Guardian, or Proxy-by-statute, must conform to any previously executed living will. In the absence of a living will, a Healthcare Agent or Guardian – but not a Proxy-by-statute – may withhold or withdraw AN according to the known wishes or best interests of the individual. A Proxy-by-statute may not withhold or withdraw AN unless two physicians, one trained in neurology, certify that continuing AN 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 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 a Healthcare 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?
 - Do you have a clear picture as to how we might expect your [disease, condition, problems] to progress?
 - 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 nutrients through a tube?

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

- Provide information in small amounts.
- Gently and respectfully correct misunderstandings or inaccurate information (e.g., about likelihood of successful CPR)
- Allow plenty of time for responses or questions.
- Seek a common understanding.
- If asked and qualified to answer, 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 Healthcare Agent/Guardian/Proxy signs the MOST form too.

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, but not necessarily “at” admission. Individuals and families are exhausted, perhaps disoriented, and overwhelmed. The MOST conversation takes time. Schedule the conversation with the resident and family members within the first couple of days of admission. For current residents, complete or review at quarterly conference.
- Include resident, Healthcare Agent, other family in conversations.
- Incorporate prior advance directives; attention to AN 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 healthcare professionals.

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 (or store as personal property)

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

- Review relative to change in condition precipitating referral to palliative care or hospice.
- Re-evaluate goals of care and consistency with treatment wishes relative to current diagnoses, condition and life-limiting prognosis.

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- McAuley, W.J. (2008). Advance directives for healthcare among older community residents. *Journal of Health & Human Services Division*. Online: FindArticles.com. 16 Sep. 2008. http://findarticles.com/p/articles/mi_m1YLZ/is_4_30/ai_n25014477
- U.S. Department of Health & Human Services. (2007). Literature review on advance directives. Online: <http://aspe.hhs.gov/daltcp/reports/2007/advdir.htm>. Accessed 9/16/08.

Resources for Healthcare Professionals

ORGANIZATIONS & WEB SITES

Center for Improving Value in Health Care, www.civhc.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

Hospice Analytics (National Hospice Locator). www.hospiceanalytics.com

The Conversation Project, www.theconversationproject.org/

Tomorrow's Choices, www.tomorrowschoices.org

Colorado Care Planning, www.coloradocareplanning.org

RESOURCES FOR CONDUCTING DIFFICULT CONVERSATIONS

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.

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.

Huggins, M. A., & Brooks, L. (2007). Discussing end-of-life care with older patients: What are you waiting for? *Geriatrics & Aging* 10(7): 461-464.

Von Gunten, C. F. (2002). Discussing hospice care. *Journal of Clinical Oncology* 20(5): 1419-1424.

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