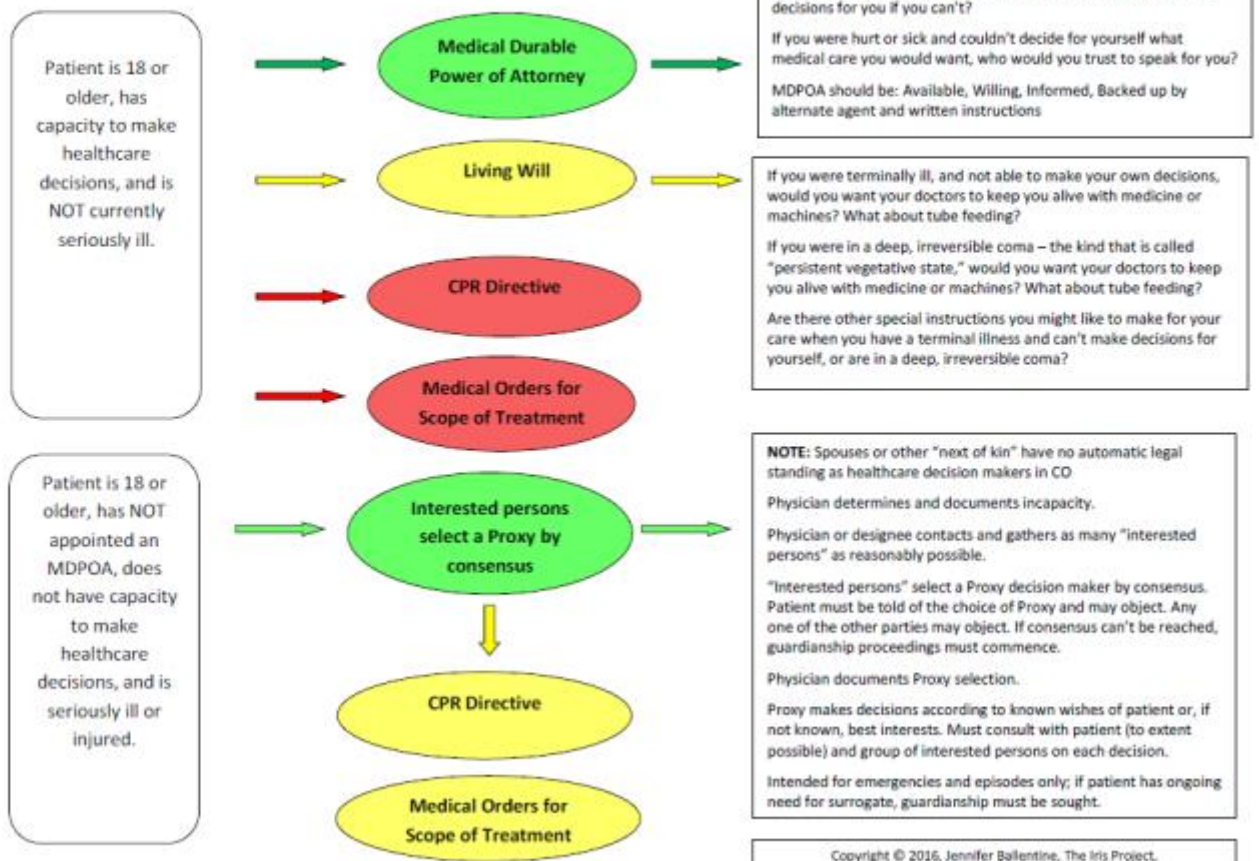
Legend: = Strongly recommended Use this form or process now | = Optional/at patient's or agent's discretion | = Not appropriate at this time/for this pt

Advance Care Planning Flowchart



Have you thought about who you would want to make healthcare decisions for you if you can't?

If you were hurt or sick and couldn't decide for yourself what medical care you would want, who would you trust to speak for you?

MDPOA should be: Available, Willing, Informed, Backed up by alternate agent and written instructions

If you were terminally ill, and not able to make your own decisions, would you want your doctors to keep you alive with medicine or machines? What about tube feeding?

If you were in a deep, irreversible coma – the kind that is called "persistent vegetative state," would you want your doctors to keep you alive with medicine or machines? What about tube feeding?

Are there other special instructions you might like to make for your care when you have a terminal illness and can't make decisions for yourself, or are in a deep, irreversible coma?

NOTE: Spouses or other "next of kin" have no automatic legal standing as healthcare decision makers in CO

Physician determines and documents incapacity.

Physician or designee contacts and gathers as many "interested persons" as reasonably possible.

"Interested persons" select a Proxy decision maker by consensus. Patient must be told of the choice of Proxy and may object. Any one of the other parties may object. If consensus can't be reached, guardianship proceedings must commence.

Physician documents Proxy selection.

Proxy makes decisions according to known wishes of patient or, if not known, best interests. Must consult with patient (to extent possible) and group of interested persons on each decision.

Intended for emergencies and episodes only; if patient has ongoing need for surrogate, guardianship must be sought.

THINK

PAIR

SHARE

What is the MOST form?

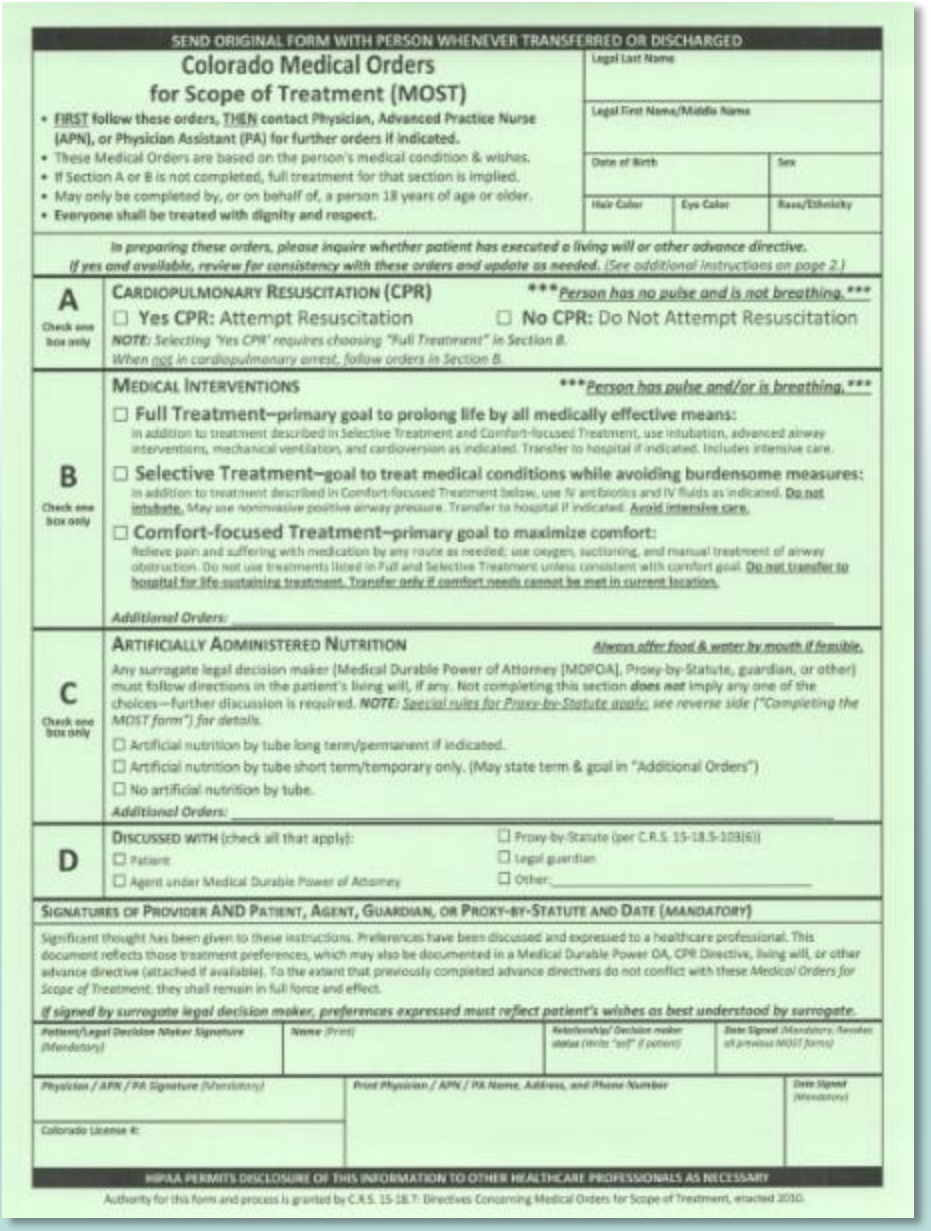
How MOST works:

- For people with serious and/or chronic illness
- Requires **robust** conversation
- Addresses current healthcare condition and wishes
- Makes clear choices into orders
- Belongs to and stays with the patient
- Portable across settings
- Copies, faxes, and scans are valid

Nuts and bolts of MOST Form

- **Section A:** CPR (Cardiopulmonary Resuscitation)
- **Section B:** Choose type of medical intervention
  - Full, limited or comfort interventions
- **Section C:** Artificially Administered Nutrition
- **Section D:** With whom this has been discussed
- **Signatures**

MOST Form



SEND ORIGINAL 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) 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.

Legal Last Name | Legal First Name/Middle Name | Date of Birth | Sex | Hair Color | Eye Color | Race/Ethnicity

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.)

A — Check one box only

CARDIOPULMONARY RESUSCITATION (CPR) ***Person has no pulse and is not breathing.***

☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation

NOTE: Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B.
When not in cardiopulmonary arrest, follow orders in Section B.

B — Check one box only

MEDICAL INTERVENTIONS ***Person has pulse and/or is breathing.***

☐ **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.

☐ **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. Do not intubate. May use noninvasive positive airway pressure. Transfer to hospital if indicated. Avoid intensive care.

☐ **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. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

Additional Orders: _____

C — Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION *Always offer food & water by mouth if feasible.*

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section **does not** imply any one of the choices—further discussion is required. ***NOTE:*** *Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

Additional Orders: _____

D

DISCUSSED WITH (check all that apply):
☐ Patient
☐ Agent under Medical Durable Power of Attorney
☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6))
☐ Legal guardian
☐ Other: _____

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 Medical Durable Power OA, CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these *Medical Orders for Scope of Treatment*, they shall remain in full force and effect.

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.

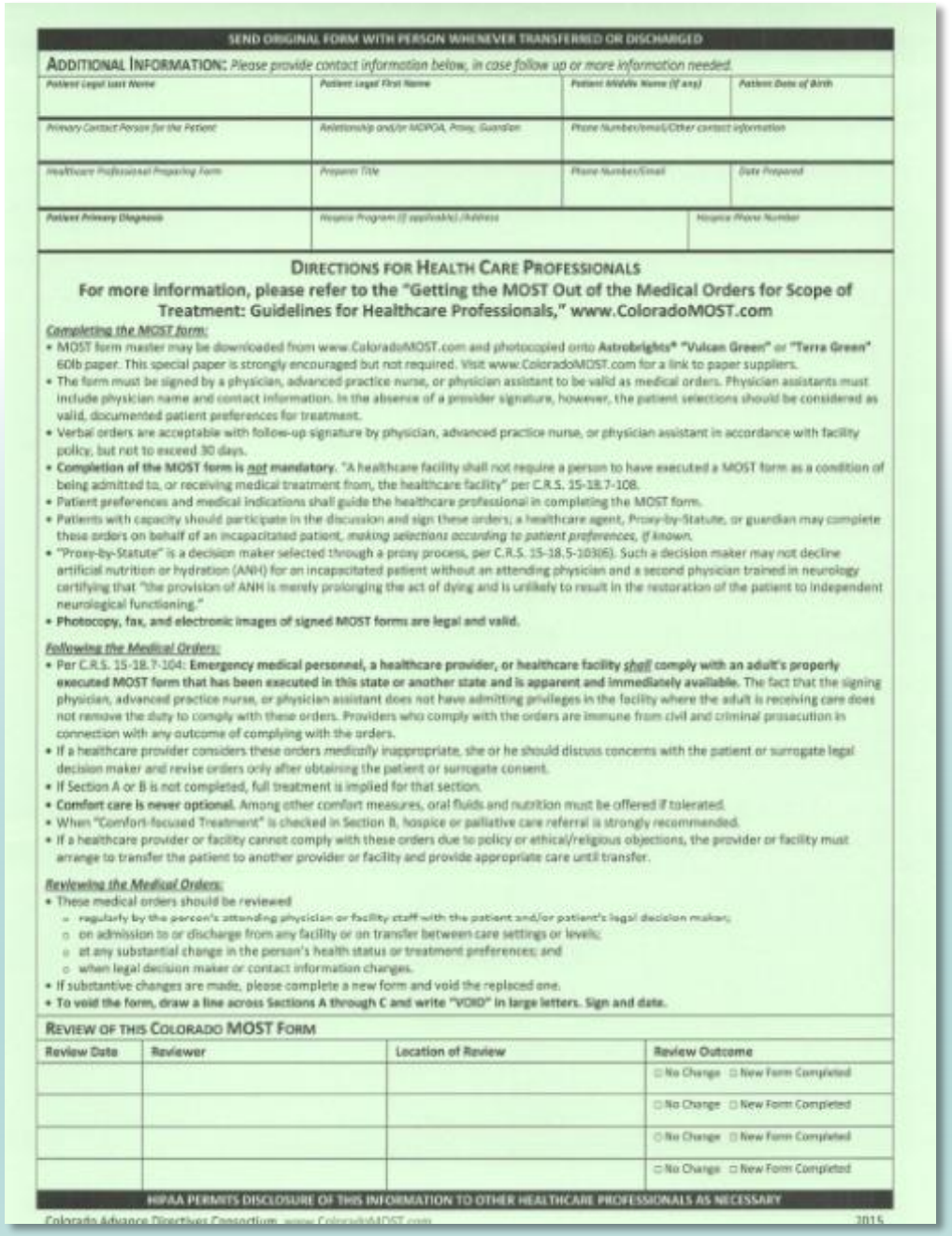
Patient/Legal Decision Maker Signature (Mandatory) | *Name (Print)* | *Relationship/ Decision maker status (Write "self" if patient)* | *Date Signed (Mandatory; Revokes all previous MOST forms)*

Physician / APN / PA Signature (Mandatory) | *Print Physician / APN / PA Name, Address, and Phone Number* | *Date Signed (Mandatory)*

Colorado License #:

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

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.



SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

ADDITIONAL INFORMATION: *Please provide contact information below, in case follow up or more information needed.*

Patient Legal Last Name	Patient Legal First Name	Patient Middle Name (if any)	Patient Date of Birth

Primary Contact Person for the Patient	Relationship and/or MDPOA, Proxy, Guardian	Phone Number/email/Other contact information

Healthcare Professional Preparing Form	Preparer Title	Phone Number/Email	Date Prepared

Patient Primary Diagnosis	Hospice Program (if applicable)/Address	Hospice Phone Number

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

For more information, please refer to the "Getting the MOST Out of the Medical Orders for Scope of Treatment: Guidelines for Healthcare Professionals," www.ColoradoMOST.com

Completing the MOST form:

- MOST form master may be downloaded from www.ColoradoMOST.com and photocopied onto **Astrobrights® "Vulcan Green"** or **"Terra Green"** 60lb paper. This special paper is strongly encouraged but not required. Visit www.ColoradoMOST.com for a link to paper suppliers.
- The form must be signed by a physician, advanced practice nurse, or physician assistant to be valid as medical orders. Physician assistants must include physician name and contact information. In the absence of a provider signature, however, the patient selections should be considered as valid, documented patient preferences for treatment.
- Verbal orders are acceptable with follow-up signature by physician, advanced practice nurse, or physician assistant in accordance with facility policy, but not to exceed 30 days.
- **Completion of the MOST form is *not* mandatory.** "A healthcare facility shall not require a person to have executed a MOST form as a condition of being admitted to, or receiving medical treatment from, the healthcare facility" per C.R.S. 15-18.7-108.
- Patient preferences and medical indications shall guide the healthcare professional in completing the MOST form.
- Patients with capacity should participate in the discussion and sign these orders; a healthcare agent, Proxy-by-Statute, or guardian may complete these orders on behalf of an incapacitated patient, *making selections according to patient preferences, if known.*
- "Proxy-by-Statute" is a decision maker selected through a proxy process, per C.R.S. 15-18.5-103(6). Such a decision maker may not decline artificial nutrition or hydration (ANH) for an incapacitated patient without an attending physician and a second physician trained in neurology certifying that "the provision of ANH is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning."
- **Photocopy, fax, and electronic images of signed MOST forms are legal and valid.**

Following the Medical Orders:

- Per C.R.S. 15-18.7-104: **Emergency medical personnel, a healthcare provider, or healthcare facility *shall* comply with an adult's properly executed MOST form that has been executed in this state or another state and is apparent and immediately available.** The fact that the signing physician, advanced practice nurse, or physician assistant does not have admitting privileges in the facility where the adult is receiving care does not remove the duty to comply with these orders. Providers who comply with the orders are immune from civil and criminal prosecution in connection with any outcome of complying with the orders.
- If a healthcare provider considers these orders medically inappropriate, she or he should discuss concerns with the patient or surrogate legal decision maker and revise orders only after obtaining the patient or surrogate consent.
- If Section A or B is not completed, full treatment is implied for that section.
- **Comfort care is never optional.** Among other comfort measures, oral fluids and nutrition must be offered if tolerated.
- When "Comfort-focused Treatment" is checked in Section B, hospice or palliative care referral is strongly recommended.
- If a healthcare provider or facility cannot comply with these orders due to policy or ethical/religious objections, the provider or facility must arrange to transfer the patient to another provider or facility and provide appropriate care until transfer.

Reviewing the Medical Orders:

- These medical orders should be reviewed
  - 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 legal 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
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Staff Competency with MOST form

- Gain sufficient expertise to discuss medical conditions, treatments, risks and benefits
- Become competent and comfortable with conducting this kind of conversation
- Be able to answer questions about the medical treatments addressed, in light of the individual's condition and goals
- Be able to assess decision-making capacity

When to complete a MOST form

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.

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: Incorporate this form into the 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.

When to Complete a MOST Form – Skilled Nursing

- Should be completed at the earliest opportunity in any setting for those that are **appropriate**.
- Skilled Nursing Facility: should complete MOST for new admissions within the first two or three days of the resident's stay.
- Complete and/or review MOST forms for all **appropriate** residents before the quarterly care plan meeting
- ***Do not sacrifice quality of process for timeliness***

Preparation & Building the Foundation

Before completing MOST form

- Obtain and review previous Advance Directives
- Review the patients medical condition, prognosis, likely course and call provider with questions and for guidance
- Assess decisional capacity
- Contact Durable Medical Power of Attorney and schedule time with patient and DM POA to have MOST Conversation



Determining Decisional Capacity

Advance Care Planning and Decisional Capacity

1. Advance Directives must be completed **only** after decisional capacity has been determined
2. Medical Durable Power of Attorney documents generally take effect when a patient does not have decisional capacity
3. A nurse or other healthcare provider may determine decisional capacity
4. Decisional capacity is different from Competency which is a legal term. We often use the terms "competence" and "capacity" (short for "decision-making capacity") interchangeably. However, they are not exactly the same. Competence is a legal term. Competence is presumed unless a court has determined that an individual is incompetent. A judicial declaration of incompetence may be global, or it may be limited (e.g., to financial matters, personal care, or medical decisions).
5. Decision-making capacity, on the other hand, is a clinical term that is task-specific. A physician or nurse may determine that a patient does not have the capacity to make a decision for or against surgery for a hip fracture, but she may have the capacity to decide if she wants a sleeping pill or a laxative.

Decision-Making Capacity

- Must be able to make a determination of the individual's decision-making capacity or locate another professional to make that determination *before* completing MOST

- All clinicians who are responsible for the care of patients should be able to perform routine capacity assessments.

Decision-Making Capacity

- Understanding
- Expressing a choice
- Appreciation
- Reasoning

Decision-Making Capacity

Understanding - The ability to state the meaning of the relevant information (eg, diagnosis, risks and benefits of a treatment or procedure, indications, and options of care).	After disclosing a piece of information, pause and ask the patient: "Can you tell me in your own words what I just said about [fill in the topic disclosed]?"
Expressing a choice - The ability to state a decision.	"Based on what we've just discussed about [insert the topic], what would you chose?" To assess appreciation of diagnosis: "Can you tell me in your own words what you see as your medical problem?“
Appreciation - The ability to explain how information applies to oneself.	To assess appreciation of benefit: "Regardless of what your choice is, do you think that it is possible the medication can benefit you?" To assess appreciation of risk: "Regardless of what your choice is, do you think it is possible the medication can harm you?"
Reasoning - The ability to compare information and infer consequences of choices.	To assess comparative reasoning: "How is X better than Y?" To assess consequential reasoning: "How could X affect your daily activities?"

Assessment of decision-making capacity in adults. UpToDate 12.5.2106 Jason Karlawish, MD

Decision-Making Capacity

- **If the individual lacks capacity,** a surrogate decision maker 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 must complete the Healthcare Proxy-by-statute process.

Prepare the Family

- Provide The Conversation Project Starter Kit to patients and their families in advance of the MOST form discussion
- If patient has dementia, provide Alzheimer's Disease ACP Forms and Dementia Conversation Project Starter Kit see the website www.conversationproject.org for free materials.
- Ask them to bring all Advance Directive documents for review
- Provide Simple Decision-Support Tools (CPR, Tube Feeding and Intubation) at ACP Facilitator's discretion.