



# Getting the Most out of MOST: A Win-Win for All

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HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY		
<b>Medical Orders for Scope of Treatment (MOST)</b> This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. When the need occurs, first follow these orders, then contact physicians.		Patient's Last Name: _____ Patient's First Name, Middle Initial: _____ Patient's Date of Birth: _____ <small>Form must be renewed or last annually.</small>
<b>Section A</b> Check One Box Only	<b>CARDIOPULMONARY RESUSCITATION (CPR):</b> Person has no pulse and is not breathing. <input type="checkbox"/> Attempt Resuscitation (CPR) <input type="checkbox"/> Do Not Attempt Resuscitation (DNR/no CPR) <small>When not in cardiopulmonary arrest, follow orders in B, C, and D.</small>	
<b>Section B</b> Check One Box Only	<b>MEDICAL INTERVENTIONS:</b> Person has pulse and/or is breathing. <input type="checkbox"/> Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, cardiopulmonary resuscitation, medical treatment, IV fluids, etc.; also provide comfort measures. <b>Transfer to hospital if indicated.</b> <input type="checkbox"/> Limited Additional Interventions: Use medical treatment, IV fluids and cardiac resuscitation as indicated. Do not use intubation or mechanical ventilation; also provide comfort measures. <b>Transfer to hospital if indicated. Avoid intensive care.</b> <input type="checkbox"/> Comfort Measures: Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual removal of airway obstruction as needed for comfort. <b>Do not transfer to hospital unless comfort needs cannot be met in current location.</b> <i>Other Instructions:</i> _____	
<b>Section C</b> Check One Box Only	<b>ANTIBIOTICS</b> <input type="checkbox"/> Antibiotics if life can be prolonged. <input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs. <input type="checkbox"/> No Antibiotics (use other measures to relieve symptoms). <i>Other Instructions:</i> _____	
<b>Section D</b> Check One Box Only in Each Column	<b>MEDICALLY ADMINISTERED FLUIDS AND NUTRITION:</b> Offer oral fluids and nutrition if physically feasible. <input type="checkbox"/> IV fluids long-term if indicated <input type="checkbox"/> Feeding tube long-term if indicated <input type="checkbox"/> IV fluids for a defined trial period <input type="checkbox"/> Feeding tube for a defined trial period <input type="checkbox"/> No IV fluids (provide other measures to ensure comfort) <input type="checkbox"/> No feeding tube <i>Other Instructions:</i> _____	
<b>Section E</b> Check The Appropriate Box	<b>DISCUSSED WITH AND AGREED TO BY:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Parent or guardian if patient is a minor <input type="checkbox"/> Health care agent <input type="checkbox"/> Legal guardian of the person <input type="checkbox"/> Attorney-in-fact with power to make health care decisions <input type="checkbox"/> Spouse  <input type="checkbox"/> Majority of patient's reasonably available persons and adult children <input type="checkbox"/> Majority of patient's reasonably available adult siblings <input type="checkbox"/> An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient	
MD/DO, PA, or NP Name (Print): _____ MD/DO, PA, or NP Signature (Required): _____ Phone #: _____		
<b>Signature of Person, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative</b> (Signature is required and must either be on this form or on file) I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent. <i>If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.</i> <b>You are not required to sign this form to receive treatment.</b>		
Patient or Representative Name (print): _____ Patient or Representative Signature _____ Relationship (write "self" if patient)		
<b>SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED</b>		

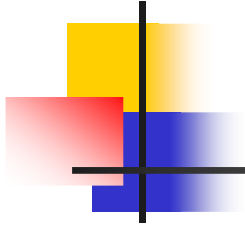
Anthony J. Caprio, MD  
Assistant Professor of Medicine  
Division of Geriatric Medicine  
Center for Aging and Health  
University of North Carolina-  
Chapel Hill



# Objectives

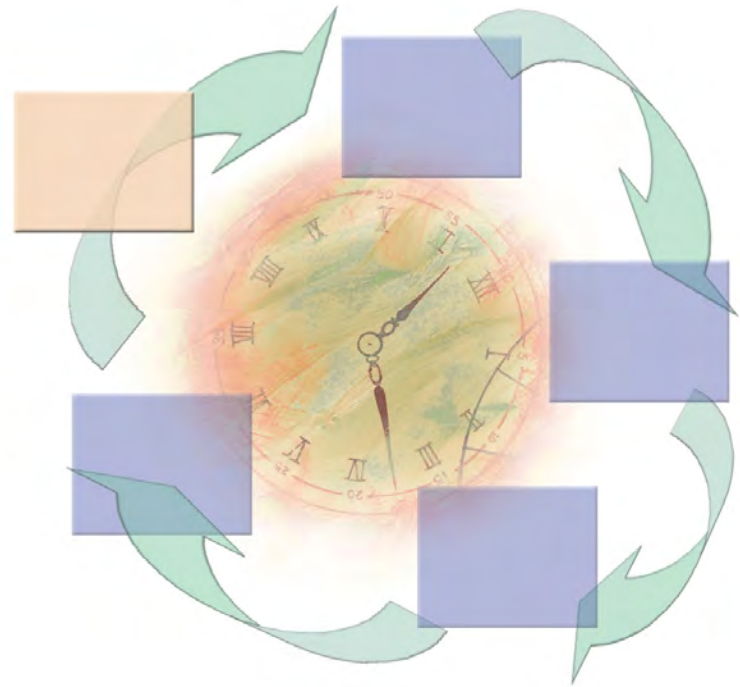
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- ✓ Describe failure of PSDA & DNR
- ✓ Discuss benefits of connecting advance directives to physician orders
- ✓ Review the MOST form
- ✓ Identify barriers to implementation and ways to overcome barriers



“The Future  
depends on  
what we do in  
the present.”

Mahatma Gandhi





# Win-Win for ???

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- Patients
- Physicians
- Families
- Nurses
- ER personnel
- EMS personnel
- Risk managers
- LTC & ALF staff
- ICU staff
- Primary Care MDs
- Hospice med staff
- Palliative care staff
- Social workers
- CFOs
- Ethics committees
- Administrators

# The way we die has changed



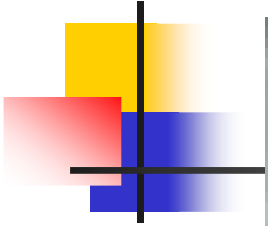
- Early 1900's life expectancy = 50 years
- Prior to antibiotics people died quickly
- MDs focused on caring, comfort, listening
- Sick were cared for at home
- Focus on technology, life expectancy increased after WWII
- Shift in values – death denying culture
- Aggressive/life prolonging tx at any cost
- Death is the enemy – “Do everything”
- Demand for ICU beds has increased



# CAUSE OF DEATH AND SOCIAL TRENDS – Pendulum swing

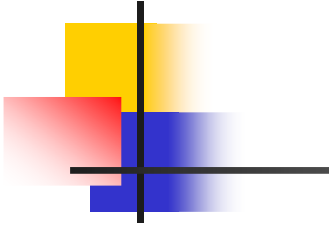
	<b>Early 1900s</b>	<b>Current</b>
<b>Medicine's Focus</b>	Comfort	Cure
<b>Cause of Death</b>	Infectious Diseases/ Communicable Diseases	Chronic Illnesses
<b>Average Life Expectancy</b>	50	76
<b>Site of Death</b>	Home	Institutions
<b>Caregiver</b>	Family	Strangers/ Medical
<b>Disease/Dying Trajectory</b>	Relatively Short	Prolonged

The way it was.....1900, Franklin Co, VA





More house calls than hospital admissions



# Transportation



# What we want isn't what we get



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- ~80% wish to die at home
- Over 85% say they want spiritual needs met
- Over 90% want well-managed pain
- ~25% die at home
- ~6% have talked to their minister
- ~11% have talked to their MD

An aerial photograph of a large ocean wave, showing the deep blue water of the trough and the white, foamy crest of the wave. The wave is moving from the top right towards the bottom left of the frame.

**1<sup>st</sup> Wave of Common Law Cases  
and the Development of  
Medical Advance Directives**

# 1975 - Quinlan Case (New Jersey)

- Karen Ann Quinlan (1975-1985)
  - First “Right to Die” case
  - 21 yrs. collapsed after alcohol and Valium April 14, 1975 (New Jersey)
  - Suffered brain damage and remained in a “persistent vegetative state.”
  - Karen kept breathing for almost 10 yrs. after the respirator was unplugged





# 1979 NC Establishes Declaration of Right to Die a Natural Death Act

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- **Response to the Quinlan Case:**
- **NC established the Living Will Statute:**
  - **Article 23 of G.S.90 (1979)**
  - **Specifying procedures for withholding medical treatment in end-of-life situations**

1991 - 2nd Wave  
NC Develops  
Health Care POA





# Nancy Cruzan (Missouri)

- Cruzan Case (1983-1990) - U.S. Supreme Court affirmed the "right to die" and the right to forgo treatment (Missouri)
- Article 3 of GS 32A enacted in 1991, authorizes designation of a "health care agent" in a HCPOA







3rd Wave  
Terri Schiavo Case

## 3<sup>rd</sup> Wave


# Terri Schiavo Case (Florida)

### ■ Terri Schiavo (1990-2005)

- 26 yrs. heart stopped for 5 min.  
Feb.25, 1990
- 1998 husband/legal guardian petitioned to have feeding tube removed
- After 2 wks w/o food or water, Terri died on March 31, 2005
- Autopsy showed brain had shrunk to half normal size and Terri was blind



## Terri's Legacy



# The End of Life **WHO DECIDES?**

- LESSONS OF THE SCHIAVO BATTLE
- **PLUS:** LIVING WILL RESOURCE GUIDE

Is there a 'bad guy' in this case?





## PSDA outcome: focus on paper

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- 20 years post-PSDA only +/- 30% have an AD – most of those are Living Wills
- Charts with AD but no corresponding DNR order
- Charts with DNR but no corresponding AD
- Documentation has NOT meant good conversation
- Saying the right thing to the right people at the right time has not been the norm
- Finding/taking time has been a problem



# Poor Communication

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- Patients, family members and MDs seem reluctant to initiate the conversation
- Healthy myth: these conversations are difficult to have – but they are easy to avoid
- Comfort and skill levels are low
- Even if discussed with primary care MD, when these decisions are made another MD is usually in attendance
- Wrong place, wrong time, wrong message



# Fragmented healthcare system

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- Specialist, ER & ICU MDs don't know pt.
- Decisions sometimes made based on risk-avoidance rather than patient's best interest
- Critical communication often occurs in the midst of crisis with too little info available
- **Advance directives are not a substitute for an MD order**
- LW's have little actual impact in most clinical settings



## Why the Patient Self-Determination Act (1991) has failed:

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- Only 25% of Americans have documents
- Family unaware of documents or wishes
- Not available when needed
- May not be applicable to a patient's current condition
- Advance Directives do not immediately direct care
- Emphasis on paperwork instead of conversations



When should 'everything' be done?



Knowledge

Wisdom



# Advance Directives

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- Documents completed in advance, in order to guide future medical decision-making
- Living Will (express preferences )
- Health Care Power of Attorney (appoint a future surrogate decision maker)
- Hypothetical
  - Based on a potential, future health state
  - Must be interpreted or appoint an interpreter



# Isn't It Time We Talk?

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Yes, but....

- What to say?
- Who to say it to?
- When to say it?
- What words do I use?
- What do I need to know before I talk?

*A Guide to  
Advance Care  
Planning*

*how to plan  
for your care at  
the end of life*

*Isn't It  
Time  
We Talk?*

*Peace of mind is a wonderful gift  
We can help  
336-768-6157, ext. 622  
A Program of Hospice & Palliative CareCenter*

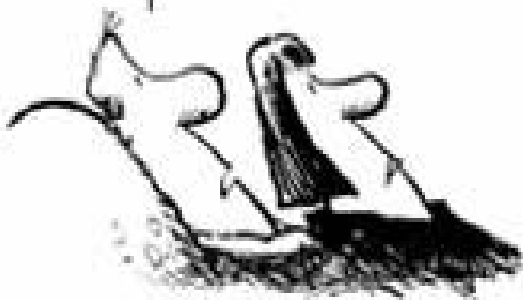
Community  
Partnership  
for End of Life Care

1. Definition of advance care planning
2. Why and how to plan ahead for uncertainty
3. Description of treatment setting options
4. Definition of various treatment options
5. Worksheets on beliefs, values and options
6. Having the conversation – who, when, where, what and how?
7. Living Will & HCPOA documents

JUST SO YOU KNOW...

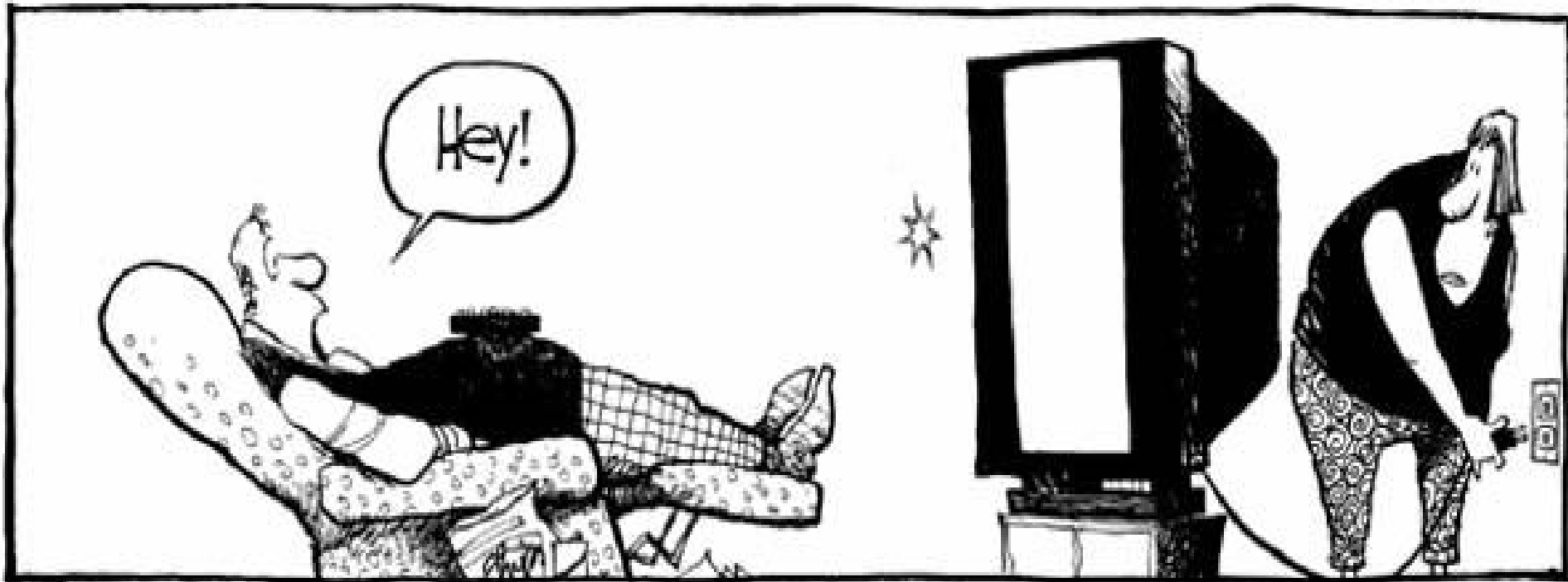
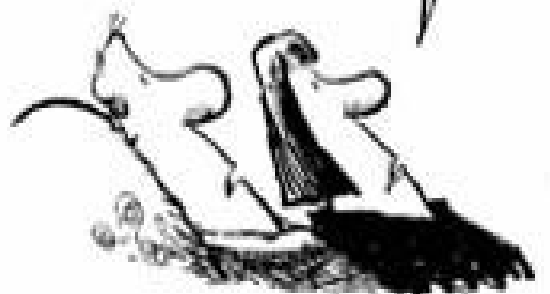


I NEVER WANT TO LIVE IN A VEGETATIVE STATE, DEPENDENT ON SOME MACHINE.



IF THAT EVER HAPPENS, JUST UNPLUG ME, OK?

OK.





# Changes in NC laws – Oct '07

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- Informed consent
- New Living Will form
- New Health Care Power of Attorney form
- New MOST form – a physician order set
- Old ADs are still, and will remain valid

# Advance Directive Limitations

May not be available when needed

May not be specific enough

Does not translate immediately into medical order



Literature Review on Advance Directives, June 2007  
<http://aspe.hhs.gov/daltcp/reports/2007/advdirlr.htm>

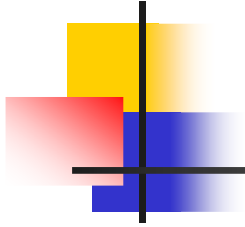


# From PSDA to POLST to MOST

- 1991 - Patient Self Determination Act
- 1991 - POLST form developed in Oregon
- 2002 - POST in West Virginia
- 2007 - MOST in North Carolina







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It's not about the documents!

It's about the conversation.

Are we asking, "Do you want to live?" instead of "What kind of care do you want?"



# It's about choice, values and principles

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- The patient's right to choose
- The clash of values, beliefs and attitudes
- Principles of medical ethics:
  - Autonomy
  - Beneficence
  - Distributive Justice
  - Knowledge vs. Wisdom
- Stick to "What are the goals of care?"







# Technology of Critical Care



[www.icu-usa.com/tour](http://www.icu-usa.com/tour)





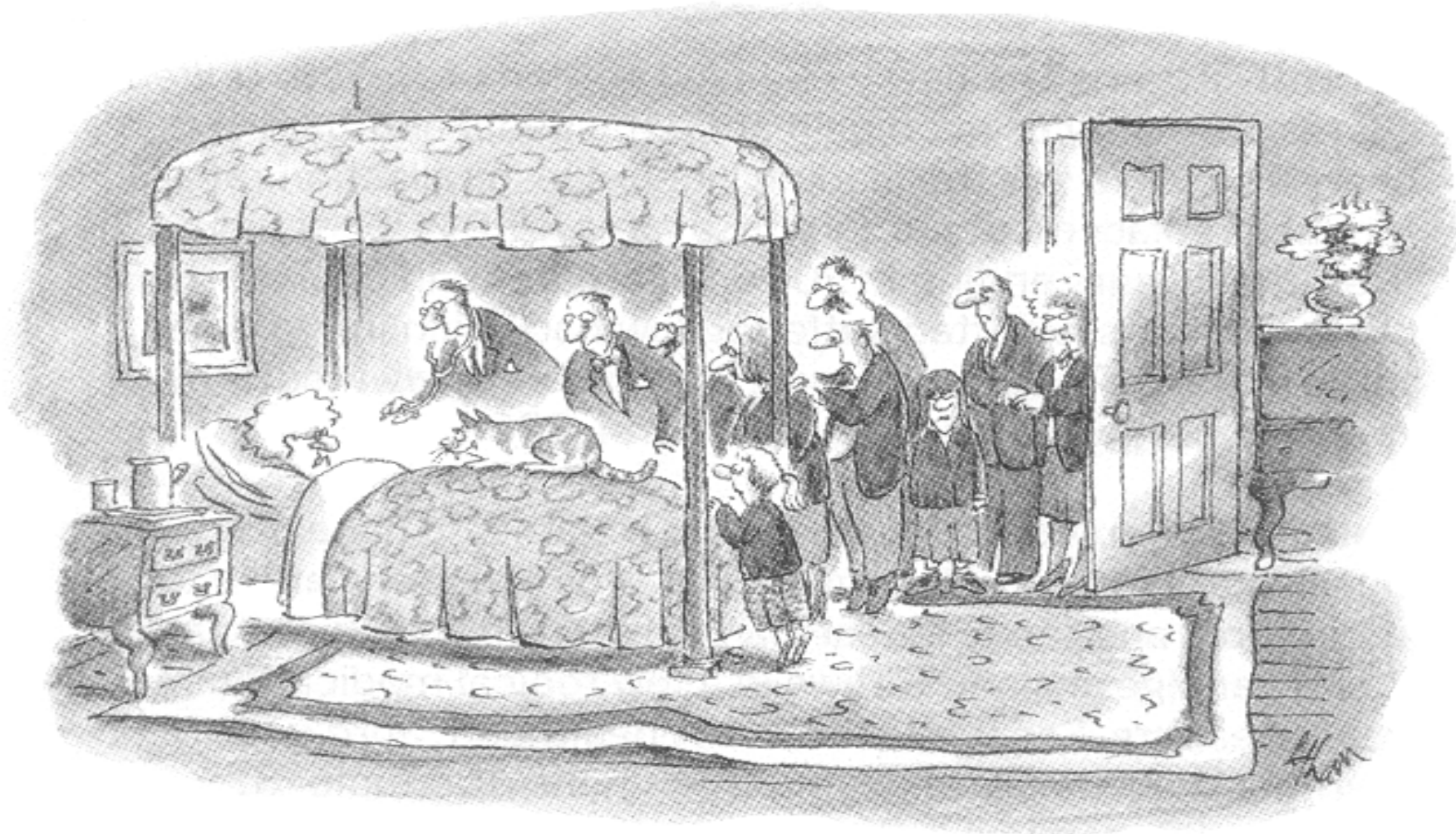




# It's the people, not the paper

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- Advance Directives are no substitute for **Advance Care Planning**.
- It's not a hard conversation to have. It's easy to avoid, but once started, people want to talk.
- It's about giving the gift of peace of mind that patients will be comfortable and have their wishes honored.



*"I want everyone to leave the room, except for the cat."*





# Facilitating the conversation

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- Move ACP upstream – out of acute care
- Change organizational and community culture to accommodate ACP, hospice & palliative care, use of MOST form
- Normalize the topics and the process
- Promote HCPOA, not Living Will
- Educate the public and the professional



# Check list for success

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- Knowledge of benefits and burdens of each treatment option
- Timing & length of discussion
- Appropriate place
- Individual-specific content
- Understandable language
- Relationships & facilitator skills
- Connect Advance Directives to MD orders



# Introducing the forms

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Set the stage with the right language.

“Do you have an advance directive?” vs. “What kind of care do you want?”

“We have some important papers for you to sign” vs.  
“We want to provide the best possible care for your mother.”

“This MOST form lets us know if you want us to start your heart again if it stops” vs. “We have a tool designed to help honor your wishes.”

Encourage conversations about end of life care wishes in a new, different and better way.

# A step in the right direction: Do Not Resuscitate (DNR) order

**STOP  
DO NOT  
Resuscitate**

Effective Date: \_\_\_\_\_  
Expiration Date, if any \_\_\_\_\_  
 Check box if no expiration

**DO NOT RESUSCITATE ORDER**

Patient's full name \_\_\_\_\_

In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.

Signature of Attending Physician/Physician Assistant/Nurse Practitioner \_\_\_\_\_  
Printed Name of Attending Physician \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone Number (office) \_\_\_\_\_  
Telephone Number (emergency) \_\_\_\_\_

**Do Not Copy Do Not Alter**

**DHS**  
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Medical Order
- Issued by a physician (NP or PA)
- Not hypothetical; immediately “in effect”
- No interpretation, immediately directs care in the event of a cardiac arrest

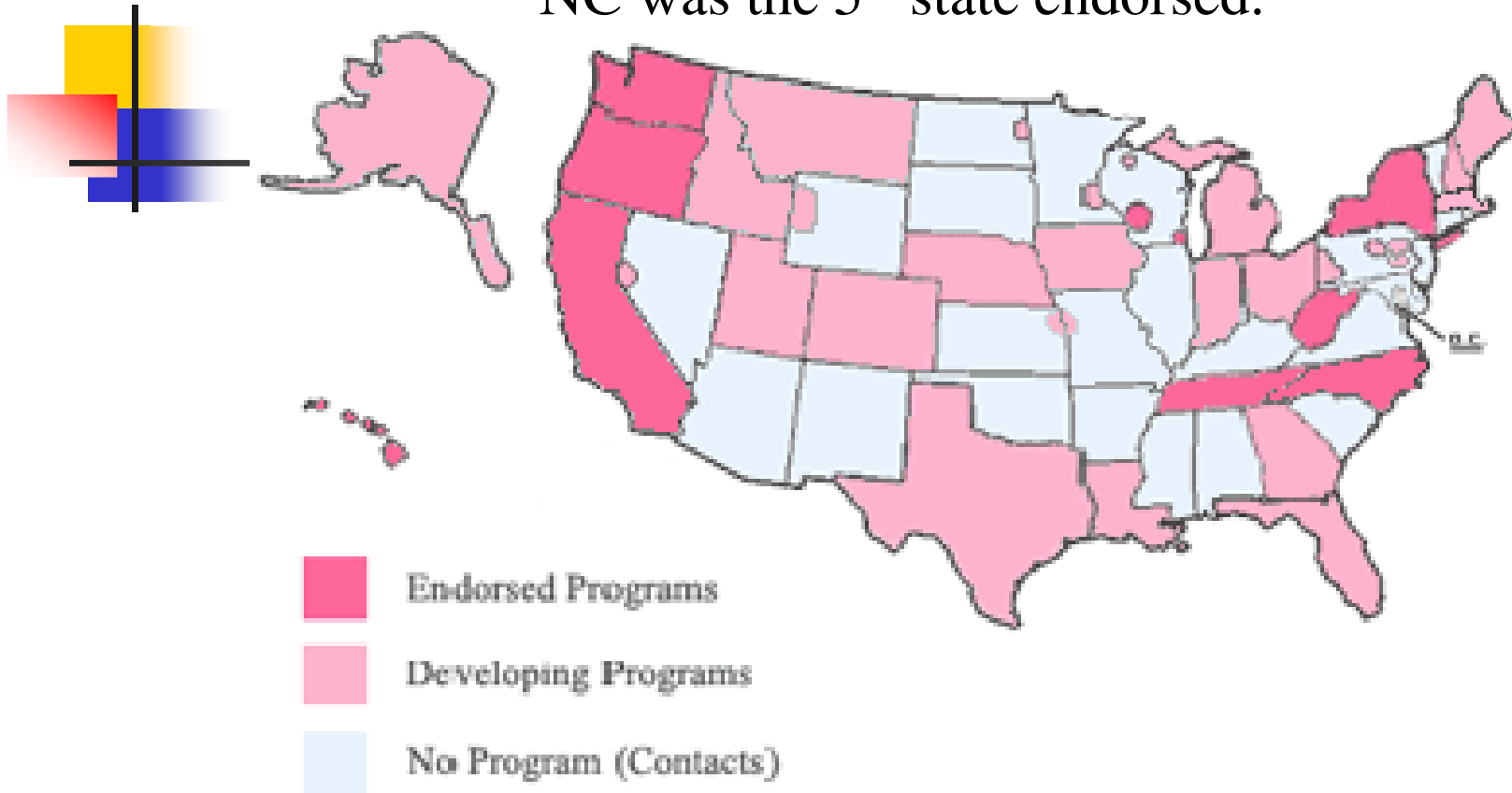
# DNR DOES NOT MEAN DO NOT TREAT

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- 78 % of long term care residents with DNR wanted other treatment options
- 20% of hospice patients want limited additional interventions

## Endorsed States as of 10-2010

NC was the 5<sup>th</sup> state endorsed.



**Idaho & Colorado** were endorsed on 1-27-2011  
(PA, MT, MA, MD, LA, SC, VA coming soon)

# The POLST Paradigm



[www.polst.org](http://www.polst.org)

[www.ncmedsoc.org](http://www.ncmedsoc.org) (search for EOL resources)

[www.caringinfo.org](http://www.caringinfo.org)

[www.kidneyeol.org](http://www.kidneyeol.org)

[www.carolinasendoflifecare.org](http://www.carolinasendoflifecare.org)

[www.compassionandsupport.org](http://www.compassionandsupport.org)

[www.hospicecarecenter.org](http://www.hospicecarecenter.org)

[www.seriousillness.org/piedmont](http://www.seriousillness.org/piedmont)



# What is the **MOST** form?

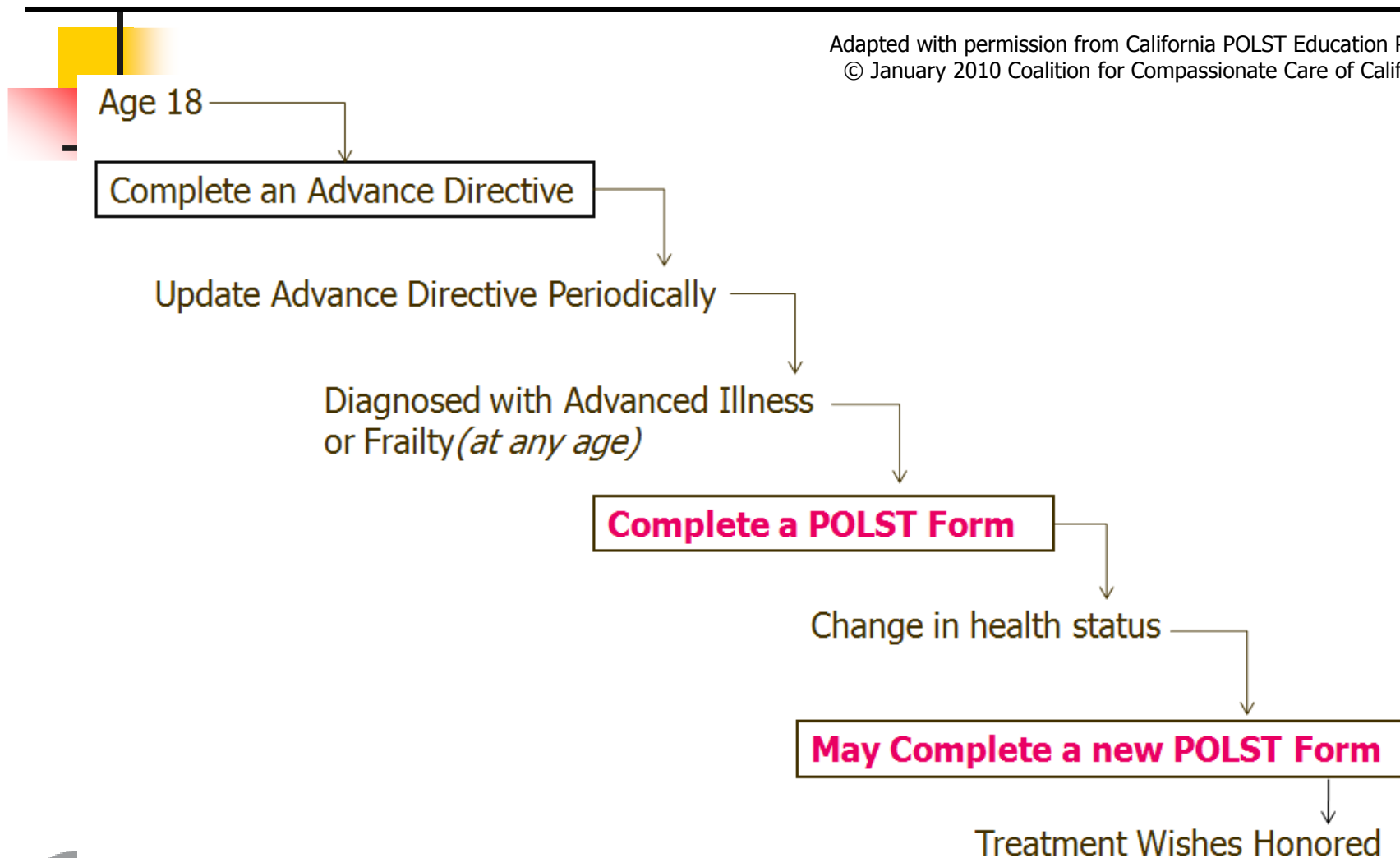
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- A physician order
- Completed by **any** qualified provider, signed by MD, PA or NP
- Complements **but does not replace** advance directives
- Voluntary; can be revoked at any time



# How Advance Directives and POLST Work Together

Adapted with permission from California POLST Education Program  
© January 2010 Coalition for Compassionate Care of California





# Rationale

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- AD may not be readily available
- AD may not have prompted needed conversation or been specific enough
  - No provision for tx in LTC or home
  - May not cover topics of most immediate need
- AD may be overridden by a treating MD
- AD does not automatically translate into an MD order



# Honoring Patient Preferences Across Care Settings

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- Portable medical order
  - Travels with patient (hospital, home, nursing home)
  - Available when needed (point of care)
- Standardized and easily identified
  - Bright color (find it among other paperwork)
  - Same form for all settings
- More than a DNR order
  - Accept or reject other types of treatment
- Issued by physician, PA, or NP
  - Discuss prognosis, risks, and benefits of treatments
  - Opportunity to answer questions and make recommendations

# The MOST Form up close

- Top left: Physician order sheet based on:
  - Patient's medical condition
  - Patient's wishes
- Like the (Yellow) Portable DNR:
  - MOST travels with PT

## **EXCEPT:**

- Includes more detail and direction
- Must be signed by MD, PA or ANP **and** Pt or Pt's Agent
- Must be updated at least once a year



# Medical Orders for Scope of Treatment (MOST) form

**HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

**Medical Orders for Scope of Treatment (MOST)**  
 This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name:		Effective Date of Form: <i>Form must be re-evaluated at least annually.</i>
Patient's First Name, Middle Initial:		Patient's Date of Birth:

**Section A**  
 Check One Box Only  
**CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.  
 Attempt Resuscitation (CPR)       Do Not Attempt Resuscitation (DNR/no CPR)  
 When not in cardiopulmonary arrest, follow orders in B, C, and D.

**Section B**  
 Check One Box Only  
**MEDICAL INTERVENTIONS:** Person has pulse and/or is breathing.  
 Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, cardiopulmonary as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**  
 Limited Additional Interventions: Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation; also provide comfort measures. **Transfer to hospital if indicated.**  
 Avoid intensive care.  
 Comfort Measures: Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**  
 Other Instructions: \_\_\_\_\_

**Section C**  
 Check One Box Only  
**ANTIBIOTICS**  
 Antibiotics if life can be prolonged.  
 Determine use or limitation of antibiotics when infection occurs.  
 No Antibiotics (use other measures to relieve symptoms).  
 Other Instructions: \_\_\_\_\_

**Section D**  
 Check One Box Only in Each Column  
**MEDICALLY ADMINISTERED FLUIDS AND NUTRITION:** Offer oral fluids and nutrition if physically feasible.  
 IV fluids long-term if indicated       Feeding tube long-term if indicated  
 IV fluids for a defined trial period       Feeding tube for a defined trial period  
 No IV fluids (provide other measures to ensure comfort)       No feeding tube  
 Other Instructions: \_\_\_\_\_

**Section E**  
 Check The Appropriate Box  
**DISCUSSED WITH AND AGREED TO BY:**  
 Patient       Majority of patient's reasonably available parents and adult children  
 Health care agent       Majority of patient's reasonably available adult siblings  
 Legal guardian of the person       An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient  
 Attorney-at-law with power to make health care decisions  
 Spouse  
*Consent for order must be documented in medical record.*

MD/DO, PA, or NP Name (Print): \_\_\_\_\_ MD/DO, PA, or NP Signature (Required): \_\_\_\_\_ Phone #: \_\_\_\_\_

**Signature of Person, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative**  
 (Signature is required and must either be on this form or on file)  
 I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.  
*If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.*  
**You are not required to sign this form to receive treatment.**

Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)
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**SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED**

- More than a DNR order
- Guide care even when patient has not arrested
- Options to receive or withhold treatments
- Avoid inappropriately limiting or providing other types of treatments



# Sections A and B

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- Section A: patient has no pulse and is not breathing
  - Options include “Do” and “Do Not” resuscitate
- Section B: patient has a pulse and/or is breathing
  - Three options are available:
    - Full scope of treatment
    - Limited Additional treatment
    - Comfort measures

# Section A: CARDIOPULMONARY RESUSCITATION

Medical Orders for Scope of Treatment (MOST)

Section A: CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

Attempt Resuscitation (CPR)       Do Not Attempt Resuscitation (DNR/no CPR)

Section B: MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, cardiovascular indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

Limited Additional Interventions: Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation; also provide comfort measures. **Transfer to hospital if indicated.**

Comfort Measures: Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Section C: ANTIBIOTICS

Antibiotics if life can be prolonged.

Determine use or limitation of antibiotics when infection occurs.

No Antibiotics (use other measures to relieve symptoms).

Section D: MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

IV fluids long-term if indicated       Feeding tube long-term if indicated

IV fluids for a defined trial period       Feeding tube for a defined trial period

No IV fluids (provide other measures to ensure comfort)       No feeding tube

Section E: DISCUSSED WITH AND AGREED TO BY:

Patient       Majority of patient's reasonably available parents and adult children

Patient's guardian if patient is a minor       Majority of patient's reasonably available health care agents       Legal guardian of the patient, which sibling

Health care agent       Attorney-in-fact with power to make health care decisions

Legal guardian of the patient       An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Spouse       An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Signature of Person, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form. You are not required to sign this form to receive treatment.

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

- Attempt Resuscitation (CPR)
- Do Not Attempt Resuscitation (DNR/no CPR)
- Only one option should be selected.
- Only applies if there is no pulse and the patient has stopped breathing
- (cardiopulmonary arrest)



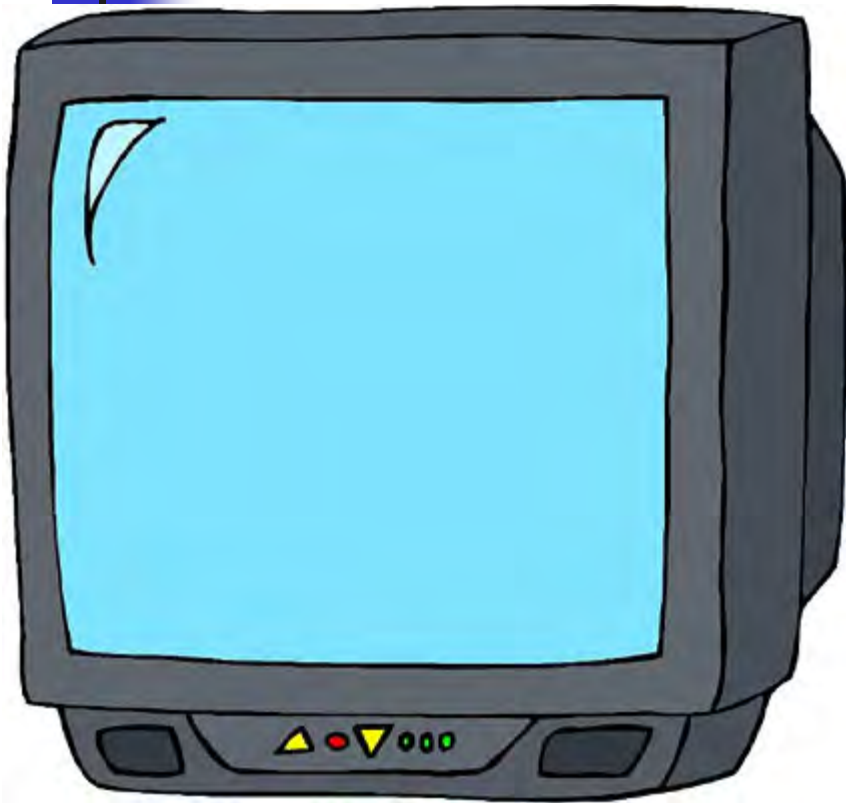
# CPR Survival Rate

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- Generally, only 10-15% survive to hospital discharge; many with impairments
- Lower rates of survival (<5%)
  - Unwitnessed arrest
  - Certain types of heart rhythms
  - Multiple chronic diseases
- Survival for LTC patients 0-3%



# Inaccurate Perceptions of Survival



- General belief of 65% survival after CPR
- 67% of resuscitations successful on TV
- Probability of survival influences choices
  - Nearly one-half of older adults changed their mind about wanting CPR after hearing about the true probability of survival

*NEJM* 1996; 334:1578-1582

*NEJM* 1994; 330:545-549

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GIVEN AN  
OPPORTUNITY  
ONLY 12% OF  
LONG TERM  
SKILLED  
NURSING  
FACILITY  
RESIDENTS  
WANT ICU CARE





## EMS arrives at home of pt.

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- Living will clearly states no life prolonging measures desired
- HCPOA is present and says 'do not resuscitate' – desire to die at home
- No pulse, not breathing, no DNR form
- Yellow DNR is prominently posted
- What if....they're breathing and have a pulse? What then?

# Section B: MEDICAL INTERVENTIONS

- Full Scope of Treatment
- Limited Additional Interventions
- Comfort Measures
- Guidance about the intensity of care and the patient's goals
- Patient is not experiencing cardiopulmonary arrest (No indication for CPR)

**HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

**Medical Orders for Scope of Treatment (MOST)**  
 This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: \_\_\_\_\_ Effective Date of Form: \_\_\_\_\_  
Form must be reviewed at least annually.

Patient's First Name, Middle Initial: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

---

**Section A**  
 Check One Box Only  
**CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.**  
 Attempt Resuscitation (CPR)       Do Not Attempt Resuscitation (DNR/No CPR)  
 When not in cardiopulmonary arrest, follow orders in B, C, and D.

**Section B**  
 Check One Box Only  
**MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.**  
 Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**  
 Limited Additional Interventions: Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation; also provide comfort measures. **Transfer to hospital if indicated.** Avoid intensive care.  
 Comfort Measures: Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to reduce pain and suffering. Use oxygen, suction and removal of secretions if patient chooses not to receive them. **Do not transfer to hospital unless comfort needs cannot be met in current location.**  
 Other Instructions: \_\_\_\_\_

**Section C**  
 Check One Box Only  
**ANTIBIOTICS**  
 Antibiotics if life can be prolonged.  
 Determine use or limitation of antibiotics when infection occurs.  
 No Antibiotics (use other measures to relieve symptoms).  
 Other Instructions: \_\_\_\_\_

**Section D**  
 Check One Box Only in Each Column  
**MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.**  
 IV fluids long-term if indicated       Feeding tube long-term if indicated  
 IV fluids for a defined trial period       Feeding tube for a defined trial period  
 No IV fluids (provide other measures to ensure comfort)       No feeding tube  
 Other Instructions: \_\_\_\_\_

**Section E**  
 Check The Appropriate Box  
**DISCUSSED WITH AND AGREED TO BY:**  
 Patient       Majority of patient's reasonably available parents and adult children  
 Patient's guardian if patient is a minor       Majority of patient's reasonably available adult siblings  
 Health care agent       Legal guardian of the person  
 Attorney-in-fact with power to make health care decisions       An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient  
 Spouse

MD/DO, PA, or NP Name (Print): \_\_\_\_\_ MD/DO, PA, or NP Signature (Required): \_\_\_\_\_ Phone #: \_\_\_\_\_

**Signature of Person, Parent or Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative**  
 (Signature is required and must either be on this form or on file.)  
 I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.  
 If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.  
**You are not required to sign this form to receive treatment.**

Patient or Representative Name (print): \_\_\_\_\_ Patient or Representative Signature: \_\_\_\_\_ Relationship (write "self" if patient): \_\_\_\_\_

**SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED**



# Prioritize Goals of Care

---

- 1) Longevity
- 2) Function (maintain/restore)
- 3) Comfort



# Full Scope of Treatment

---

- Intubation/mechanical ventilation
- Cardioversion
- ICU admission
- Transport to the hospital if indicated
- All other appropriate treatments
- Patients electing “Full Scope” usually express longevity as the primary goal of care



# Limited Additional Interventions

---

- No intubation/mechanical ventilation
- No cardioversion
- Would likely not be admitted to the ICU
- Transport to the hospital if indicated
- “Other instructions” can be used for clarifications
- Goals of Care
  - Usually do not prioritize longevity as their major goal
  - May express other goals like maintaining or restoring function
  - May opt for therapeutic trials and withdraw therapies if they are ineffective or become burdensome



# Comfort Measures

---

- These patients prioritize comfort as their most important goal of care
- Care is focused exclusively on relieving distressing symptoms
- No intubation/mechanical ventilation
- No cardioversion
- No ICU admissions
- Transport to the hospital ONLY if comfort needs can not be met in the current location



## Effectiveness Data

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# POLST USE IN SNF 1996

- 0/180 NH residents with POLST orders of DNR/comfort measures only received CPR/ICU
- 5% died in acute care hospital

## SECTION B

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# POLST USERS WITH COMFORT MEASURES ONLY

67% less likely to receive life  
sustaining medical interventions  
compared to POLST full treatment.

$P < 0.004$



# Consistency of Orders

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- Full Scope of Treatment order should follow an order to Attempt Resuscitation (CPR)
  - CPR often results in intubation (ABC protocol)
- DNR (no CPR) with Full Scope of Treatment
  - Some patients may still desire ICU care for serious illness or elective intubation for respiratory failure without cardiac arrest
- DNR (no CPR) with Limited Additional Interventions
  - Provide all other medical treatments as indicated, but no resuscitation attempts or intubation in the event of cardiac or respiratory arrest
- DNR (no CPR) with Comfort Measures
  - Comfort measures should be provided for all patients



# Interpreting Section B

---

- Doesn't cover all possible treatments
- Provides additional guidance beyond CPR or DNR orders
- Clear directions to EMS about intubation, cardioversion, and hospital transportation
- Other treatment decisions are clarified in sections C and D

# Section C: ANTI-BIOTICS

- To receive antibiotics if life can be prolonged
- To determine use or limitation of antibiotics when infection occurs
- No antibiotics, in which case other measures would be used to relieve symptoms

**HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

**Medical Orders for Scope of Treatment (MOST)**  
 This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. When the need occurs, first follow these orders, then contact physician.

Patient's Last Name: \_\_\_\_\_ Effective Date of Form: \_\_\_\_\_  
 Form must be reviewed at least annually.  
 Patient's First Name, Middle Initial: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

**Section A** **CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.**  
 Check One Box Only  
 Attempt Resuscitation (CPR)  Do Not Attempt Resuscitation (DNR/no CPR)  
 When not in cardiopulmonary arrest, follow orders in B, C, and D.

**Section B** **MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.**  
 Check One Box Only  
 Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, cardiopulmonary resuscitation as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**  
 Limited Additional Interventions: Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation; also provide comfort measures. **Transfer to hospital if indicated.**  
 Avoid intensive care.  
 Comfort Measures: Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and removal of secretions, chest physiotherapy as needed.  
 In all cases, **do not transfer to hospital unless comfort needs cannot be met in current location.**  
 Other Instructions: \_\_\_\_\_

**Section C** **ANTIBIOTICS**  
 Check One Box Only  
 Antibiotics if life can be prolonged.  
 Determine use or limitation of antibiotics when infection occurs.  
 No Antibiotics (use other measures to relieve symptoms).

**Section D** **MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.**  
 Check One Box Only in Each Column  
 IV fluids long-term if indicated  Feeding tube long-term if indicated  
 IV fluids for a defined trial period  Feeding tube for a defined trial period  
 No IV fluids (provide other measures to ensure comfort)  No feeding tube  
 Other Instructions: \_\_\_\_\_

**Section E** **DISCUSSED WITH AND AGREED TO BY:**  
 Check The Appropriate Box  
 Basis for action must be documented in medical record.  
 Patient  Majority of patient's reasonably available parents and adult children  
 Patient's guardian if patient is a minor  Majority of patient's reasonably available adult siblings  
 Health care agent  Legal guardian of the patient  
 Attorney-in-fact with power to make health care decisions  An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient  
 Spouse

MD/DO, PA, or NP Name (Print): \_\_\_\_\_ MD/DO, PA, or NP Signature (Required): \_\_\_\_\_ Phone #: \_\_\_\_\_

Signature of Person, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative  
 (Signature is required and must either be on this form or on file)  
 I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.  
 If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.  
**You are not required to sign this form to receive treatment.**

Patient or Representative Name (print): \_\_\_\_\_ Patient or Representative Signature: \_\_\_\_\_ Relationship (write "self" if patient): \_\_\_\_\_

**SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED**

# Section D: MEDICALLY ADMINISTERED FLUIDS AND NUTRITION

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

**Medical Orders for Scope of Treatment (MOST)**  
 This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: \_\_\_\_\_ Effective Date of Form: \_\_\_\_\_  
Form must be reviewed at least annually.

Patient's First Name, Middle Initial: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

**Section A**  
 Check One Box Only  
**CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.  
 Attempt Resuscitation (CPR)  Do Not Attempt Resuscitation (DNR/no CPR)  
 When not in cardiopulmonary arrest, follow orders in B, C, and D.

**Section B**  
 Check One Box Only  
**MEDICAL INTERVENTIONS:** Person has pulse and/or is breathing.  
 Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, cardiopulmonary resuscitation, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**  
 Limited Additional Interventions: Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation; also provide comfort measures. **Transfer to hospital if indicated.** Avoid intensive care.  
 Comfort Measures: Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual removal of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**  
 Other Instructions: \_\_\_\_\_

**Section C**  
 Check One Box Only  
**ANTIBIOTICS**  
 Antibiotics if life can be prolonged.  
 Determine use or limitation of antibiotics when infection occurs.  
 Other Instructions: \_\_\_\_\_

**Section D**  
 Check One Box Only in Each Column  
**MEDICALLY ADMINISTERED FLUIDS AND NUTRITION:** Offer oral fluids and nutrition if physically feasible.  
 IV fluids long-term if indicated  Feeding tube long-term if indicated  
 IV fluids for a defined trial period  Feeding tube for a defined trial period  
 No IV fluids (provide other measures to ensure comfort)  No feeding tube  
 Other Instructions: \_\_\_\_\_

**Section E**  
 Check The Appropriate Box  
**DISCUSSED WITH AND AGREED TO BY:**  
 Patient  Majority of patient's reasonably available persons and adult children  
 Patient's guardian if patient is a minor  Health care agent  Majority of patient's reasonably available adult siblings  
 Legal guardian of the person  Attorney-in-fact with power to make health care decisions  An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient  
 Spouse  
 (Note: Basis for order must be documented as mouth or second.)

MD/DO, PA, or NP Name (Print): \_\_\_\_\_ MD/DO, PA, or NP Signature (Required): \_\_\_\_\_ Phone #: \_\_\_\_\_

Signature of Person, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative  
 (Signature is required and must either be on this form or on file)  
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 If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.  
**You are not required to sign this form to receive treatment.**

Patient or Representative Name (print): \_\_\_\_\_ Patient or Representative Signature: \_\_\_\_\_ Relationship (write "self" if patient): \_\_\_\_\_

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

- IV fluids options:
  - ❑ To receive if indicated
  - ❑ To receive for a defined trial period
  - ❑ No IV fluids
  
- Feeding tube options:
  - ❑ To receive if indicated
  - ❑ To receive for a defined trial period
  - ❑ No feeding tube



“If you can’t get an enchilada  
down that thing, it ain’t food.”

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(Where was the ‘feeding tube’  
invented and for what patient  
population?)





# AHN Benefits and Burdens

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- Often religious and cultural beliefs guide a patient's decision
- Discussed in the context of goals of medical care
- IV fluids may not promote comfort at the end of life
  - Swelling
  - Shortness of breath
  - Need for frequent urination.
  - Excessive secretions
- Feeding Tube decisions are complex
  - Promotes longevity in some cases (ie. brain injury)
  - No clear survival benefit in advanced dementia
- Comfort care measures: ice chips and mouth care

# Trial Periods



- Not starting and stopping are equivalent
- Emotionally, stopping is often more difficult
- When goal is not achieved, shift focus
- Sometimes difficult to define duration

# Section E:

## DISCUSSED WITH AND AGREED TO BY:

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

### Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. When the need occurs, first follow these orders, then contact physician.

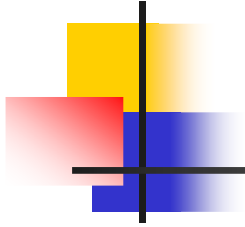
Section A Check One Box Only	<b>CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.</b> <input type="checkbox"/> Attempt Resuscitation (CPR) <input type="checkbox"/> Do Not Attempt Resuscitation (DNR/no CPR) When not in cardiopulmonary arrest, follow orders in B, C, and D.	Patient's Last Name: _____ Effective Date of Form: _____ <i>Form must be reviewed at least annually.</i>
Section B Check One Box Only	<b>MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.</b> <input type="checkbox"/> Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. <b>Transfer to hospital if indicated.</b> <input type="checkbox"/> Limited Additional Interventions: Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation; also provide comfort measures. <b>Transfer to hospital if indicated. Avoid intensive care.</b> <input type="checkbox"/> Comfort Measures: Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <b>Do not transfer to hospital unless comfort needs cannot be met in current location.</b> <i>Other Instructions:</i> _____	Patient's First Name, Middle Initial: _____ Patient's Date of Birth: _____
Section C Check One Box Only	<b>ANTIBIOTICS</b> <input type="checkbox"/> Antibiotics if life can be prolonged. <input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs. <input type="checkbox"/> No Antibiotics (use other measures to relieve symptoms). <i>Other Instructions:</i> _____	
Section D Check One Box Only in Each Column	<b>MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.</b> <input type="checkbox"/> IV fluids long-term if indicated <input type="checkbox"/> IV fluids for a defined trial period <input type="checkbox"/> No IV fluids (provide other measures to ensure comfort) <i>Other Instructions:</i> _____	<input type="checkbox"/> Feeding tube long-term if indicated <input type="checkbox"/> Feeding tube for a defined trial period <input type="checkbox"/> No feeding tube
Section E Check The Appropriate Box	<b>DISCUSSED WITH AND AGREED TO BY:</b> <i>Basics for order must be documented in medical record.</i> <input type="checkbox"/> Parent or guardian if patient is a minor <input type="checkbox"/> Health care agent <input type="checkbox"/> Legal guardian of the person <input type="checkbox"/> Attorney-in-fact with power to make health care decisions <input type="checkbox"/> Spouse <input type="checkbox"/> Patient <input type="checkbox"/> Next of kin <input type="checkbox"/> Closest of relatives reasonably available <input type="checkbox"/> Majority of patient's reasonably available adult siblings <input type="checkbox"/> An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient	
MD/DO, PA, or NP Name (Print): _____ MD/DO, PA, or NP Signature (Required): _____ Phone #: _____		
Signature of Person, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative (Signature is required and must either be on this form or on file) I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent. <i>If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.</i> <b>You are not required to sign this form to receive treatment.</b>		
Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)
_____	_____	_____
<b>SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED</b>		



## Section E: Informed Consent

---

- Alert patient with capacity to decide
- Parent of a minor
- Health Care Agent
- Legal guardian
- Attorney-in-fact with power to make health care decisions
- Spouse
- Majority of pt's 'reasonably available' parents & adult children
- Majority of pt's 'reasonably available' adult siblings
- Someone with known relationship with pt who is acting in good faith and can reliably convey pt's wishes



How is this physician order different from any other you've seen?

When should it be reviewed?



# MOST: Signatures

---

- Medical Order: signature of the authorizing physician (MD/DO), physician assistant, or nurse practitioner
- Signature of the patient or the patient representative
- Effective date of form (page 1): all signatures completed
- If a patient representative cannot be present
  - Copy of completed form sent to the patient representative electronically
  - Representative signs copy, sends it back
  - Include the notation "on file" in the signature field on the original MOST

# When is MOST Appropriate?



- Serious, terminal illness
- Prognosis is death within a year
- Debilitating chronic progressive illness
- Not for healthy, disabled or stable patients with longer life expectancy
- Or anyone wanting to convey their preferences using MOST





# Goals of Medical Care

---

- Prioritized goals provide context for medical decision making
  - 1) Longevity
  - 2) Function (maintain/restore)
  - 3) Comfort
- Rarely, can all three goals be maximized simultaneously
- As clinical circumstances change, goals are reprioritized

# MOST Validity and Review

- Original pink form (no copies)
- Signed by physician, NP, or PA issuing the order
- Signature of patient or authorized representative
- MOST must be reviewed *at least annually*, or when
  - 1) Patient admitted and/or discharged from a health care facility
  - 2) Substantial change in the patient's health status
  - 3) Patient's treatment preferences change.

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information

Patient Representative:	Relationship:	Phone #:
Health Care Professional Preparing Form:	Preparer Title:	Cell Phone #: Preferred Phone #:
		Date Prepared:

**Directions for Completing Form**

**Completing MOST**

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be reviewed and signed by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or their representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- There is no requirement that a patient have a MOST.
- MOST is recognized under N.C. Gen. Stat. 90-21.17.

**Reviewing MOST**

This MOST must be reviewed at least annually or earlier if

- The patient is admitted and/or discharged from a health care facility;
- There is a substantial change in the patient's health status; or
- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A - E and write "VOID" in large letters.

**Revocation of MOST**

This MOST may be revoked by the patient or the patient's representative.

Review of MOST			
Review Date	Reviewer and Location of Review	MD/DO, PA, or NP Signature (Required)	Signature of Patient or Representative (Required)
			<input type="checkbox"/> Not Change <input type="checkbox"/> FORM VOIDED: new form completed <input type="checkbox"/> FORM VOIDED: see new form
			<input type="checkbox"/> Not Change <input type="checkbox"/> FORM VOIDED: new form completed <input type="checkbox"/> FORM VOIDED: see new form
			<input type="checkbox"/> Not Change <input type="checkbox"/> FORM VOIDED: new form completed <input type="checkbox"/> FORM VOIDED: see new form
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			<input type="checkbox"/> Not Change <input type="checkbox"/> FORM VOIDED: new form completed <input type="checkbox"/> FORM VOIDED: see new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

# Revocation of MOST

**HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY**

**Medical Orders for Scope of Treatment (MOST)**  
This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. When the need occurs, first follow these orders, then contact physician.

Patient's Last Name: \_\_\_\_\_ Effective Date of Form: \_\_\_\_\_  
Form must be reviewed at least annually.  
Patient's First Name, Middle Initial: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

**Section A** **CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.  
 Attempt Resuscitation (CPR)  Do Not Attempt Resuscitation (DNR/no CPR)  
When not in cardiopulmonary arrest, follow orders in B, C, and D.

**Section B** **MEDICAL INTERVENTION:** Person has pulse and/or is breathing.  
 Full Scope of Treatment: Intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment (drugs, etc); also provide comfort measures. **Transfer to hospital if indicated.**  
 Limited Additional Interventions: Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, mechanical ventilation, or chest compressions. **Transfer to hospital if indicated.**  
 Comfort Measures: Keep person cool and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**  
Other Instructions: \_\_\_\_\_

**Section C** **ANTIBIOTICS:**  
 Antibiotics if beneficial to patient.  
 Determine use or purpose of antibiotics to prevent infection.  
 No Antibiotics (use antibiotics only if necessary to prevent infection).  
Other Instructions: \_\_\_\_\_

**Section D** **MEDICALLY ADMINISTERED FLUIDS AND NUTRITION:** Offer oral fluids and nutrition if physically feasible.  
 IV fluids long-term if indicated.  IV fluids long-term if indicated.  
 IV fluids for a defined trial period.  IV fluids for a defined trial period.  
 No IV fluids (provide other measures to maintain hydration).  
Other Instructions: \_\_\_\_\_

**Section E** **DISCUSSED WITH AND AGREED TO BY:**  
 Patient  Majority of patient's reasonably available parents and adult children  
 Parent or guardian if patient is minor  Majority of patient's reasonably available adult siblings  
 Health care agent  Legal guardian of the person (if none, check this box)  
 Basis for order must be documented in medical record.  An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient  
 Spouse

MD/DO, PA, or NP Name (Print): \_\_\_\_\_ MD/DO, PA, or NP Signature (Printed): \_\_\_\_\_ Phone #: \_\_\_\_\_

Signature of Person, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative (Signature is required and must either be on this form or on file).  
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**You are not required to sign this form to receive treatment.**

Patient or Representative Name (print): \_\_\_\_\_ Patient or Representative Signature: \_\_\_\_\_ Relationship (write "self" if patient): \_\_\_\_\_

**SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED**

- MOST no longer reflects patient's preferences
- Put line through the front page and write "void"
- "Form VOIDED" in the Review section on back of MOST
  - New form completed
  - No new form



# MOST is . . .

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- **Optional**
  - Won't work for everyone
  - Another instrument to help honor patient wishes
- **Identifiable**
  - Bright pink color
- **Flexible**
  - Accept or reject medical treatments
  - More than resuscitation preferences
- **Portable**
  - Travels with the patient
  - Directs care in a variety of settings
- **Medical Order**
  - Immediately directs care
- **Reviewed Regularly**
  - Annually
  - Changes in health status
  - Admissions/discharges



# MOST is NOT...

---

- A replacement for an advance directive
- Intended for those with a low risk of dying
  - Rather than progressive decline from chronic disease, healthy patients are at risk for sudden catastrophic events associated with prognostic uncertainty
  - Likely to benefit more from a Health Care Power of Attorney
- Available for patients to download or from their attorney
  - Must be signed as a medical order by a physician, PA, or NP
  - Should be completed after a discussion of goals of care, prognosis, and benefits/burdens of treatments.



# Benefits of Pink MOST Form

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- Identifiable: consistent pink color
- Flexible: allows accepting or refusing treatments
- Actionable: medical orders
- Up-to-date: reviewed regularly
- Portable: transfer across health care settings

# Benefits of MOST

- Facilitates appropriate EMS tx
- Facilitates HIPAA compliant transfer of records between healthcare settings
- Centralizes info; facilitates record keeping
- Enhances link among LTC, EMS, ED, ICU, Palliative Care Services, Hospice







# An invitation to talk

---

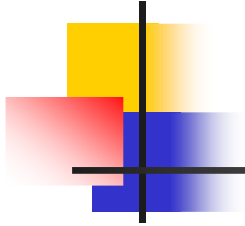
- Elicit and prioritize goals of care
- Discuss prognosis and expectations
- Present treatments relevant to an underlying disease
- Discuss benefits and burdens of treatment options
- Assess knowledge and educate
- Connect treatment decisions with goals of care
- Recommendations from health care professional



# Barriers

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- Not enough time
- Not enough education
- Low comfort level
- Low skill level
- Change is hard
- Avoidance



- Benefits are not recognized
- Doesn't travel with patient
- Availability of family or surrogate
- What about after hours? By phone?
- Choice of words



# So, what to do???

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- “go-to” person
- Facilitated conversation up to signature line
- Mortality committees want fewer deaths in hospitals; hospices want earlier referrals???
- Routinize education for MD, NP, PA, RN, SW
- Policy
- Procedures
- Protocols
- Paradigm shift in systems – raise expectations

# Follow the Leaders

## LADS II... '07-'08 (N=400)

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- 67% of decedents had a POLST document.
- 98.5% of POLST forms were in the medical record of the health organization where the person died.
- The most recent POLST form was completed 4.5 months prior to death.
- 96% of all decedents had either an AD or a POLST form at the time of death.



**Susan Tolle, MD**

Director, Center for Ethics in Health Care  
Chair, Cornelia Hayes Stevens  
Professor of Medicine , Division of General Internal  
Medicine and Geriatrics, OHSU



**Bud Hammes, PhD**

Director, Medical Humanities  
Gundersen Lutheran Medical Foundation  
Chair, National POLST Paradigm Task Force



## Data from CA, OR & WI indicate:

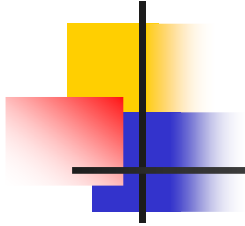
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1. Palliative medicine leaders play key roles in health system implementations of POLST Paradigm
2. POLST is associated with reduced unwanted hospitalizations
3. Electronic registry's can improve access



# The Oregon POLST Registry





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*Think....*

*Talk....*

*Document....*

*Think....*

*Talk....*

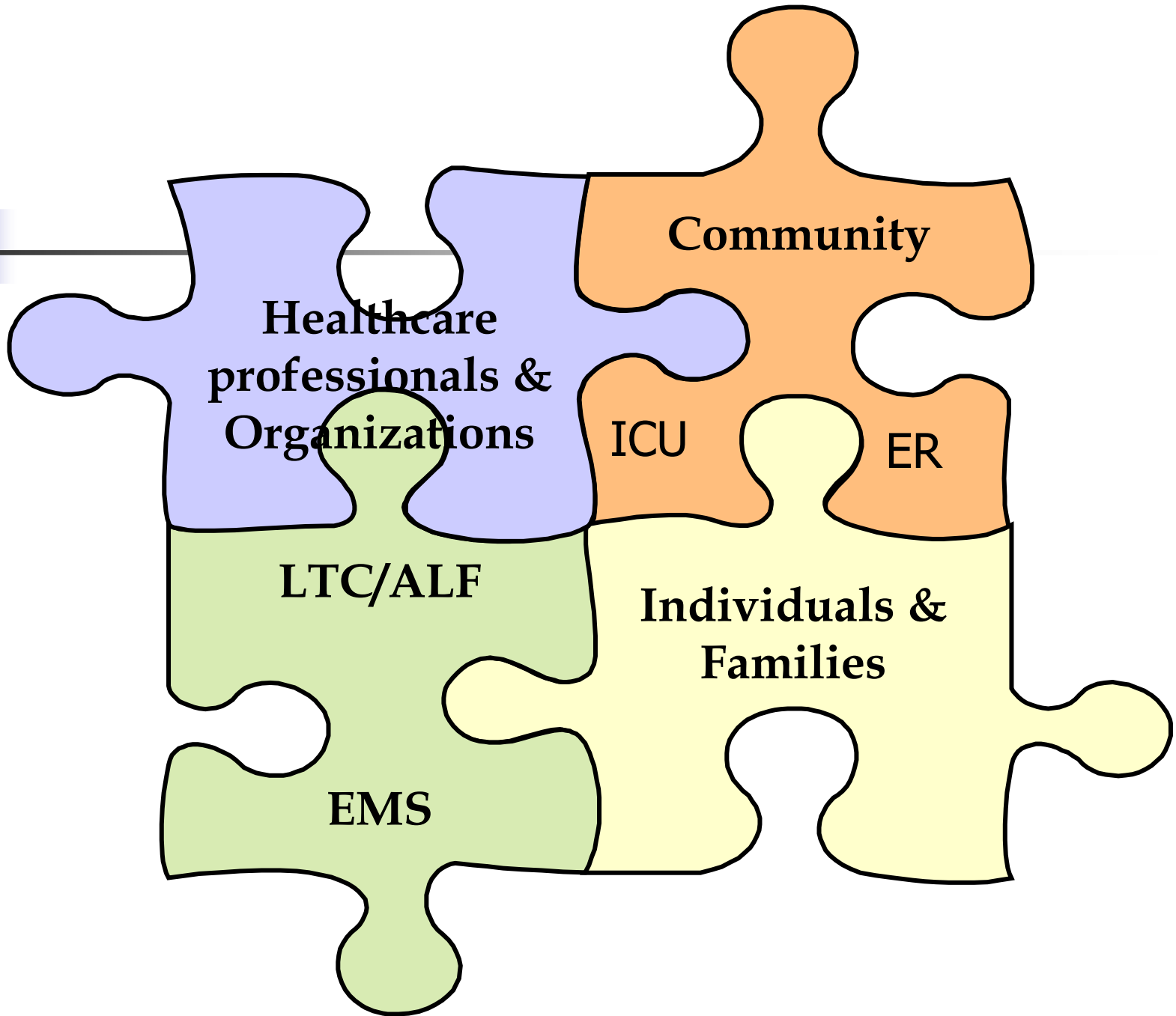
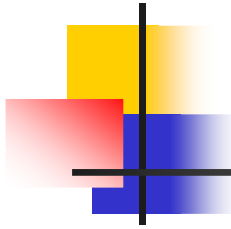
*Document*



# Who needs to be involved?

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- ✓ Patients and families
- ✓ Trained facilitators!!
- ✓ Administrators, nurses, social workers
- ✓ Physicians & attorneys
- ✓ Clergy & friends





# Creating successful systems

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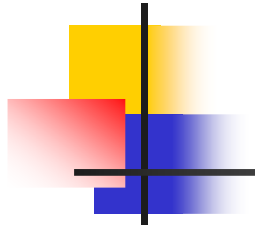
- Community
- Workplaces
- Medical Centers
- Retirement communities
- Long-term care facilities
- Physicians' practices



# Win-Win for ???

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- Patients
- Physicians
- Families
- Nurses
- ER personnel
- EMS personnel
- Risk managers
- LTC & ALF staff
- ICU staff
- Primary Care MDs
- Hospice med staff
- Palliative care staff
- Social workers
- CFOs
- Ethics committees
- Administrators



*Questions?*

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# Contact information

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