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**

<table>
<thead>
<tr>
<th>A</th>
<th>Check one box only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiopulmonary Resuscitation (CPR)</strong></td>
<td></td>
</tr>
<tr>
<td>Yes CPR: Attempt Resuscitation</td>
<td></td>
</tr>
<tr>
<td>No CPR: Do Not Attempt Resuscitation</td>
<td></td>
</tr>
</tbody>
</table>
| **Note**: Selecting “Yes CPR” requires showing “Full Treatment” in Section 6.
When given in cardiopulmonary arrest, select “Yes CPR” in Section B. |

<table>
<thead>
<tr>
<th>B</th>
<th>Check one box only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Interventions</strong></td>
<td></td>
</tr>
<tr>
<td>Yes, person has lived and is not breathing</td>
<td></td>
</tr>
<tr>
<td><strong>Note</strong>: Person has lived and or is breathing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>Check one box only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artificially Administered Nutrition</td>
<td></td>
</tr>
<tr>
<td>No, artificial nutrition by tube</td>
<td></td>
</tr>
<tr>
<td><strong>Note</strong>: If artificial nutrition by tube is requested, complete “Additional Orders”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>Check one box only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussed with patient (check all that apply)</td>
<td></td>
</tr>
<tr>
<td><strong>Note</strong>: If no discussion, complete “Additional Orders”</td>
<td></td>
</tr>
</tbody>
</table>

*Signature of Patient (Adult)*

*Signature of Patient (Minor)*

*Signature of Authorized Person*
ADDITIONAL INFORMATION: Please provide contact information below in case you follow up or have more information needed:

Gender

[ ] Male

[ ] Female

Date of Birth

Primary Care Provider for Patient

Relationship with Patient/Proxy/Power of Attorney

Other Organizational Information

Healthcare Professional Reporting Form

Provider: [Name]

Date: [Date]

Signature:

[ ] Yes

[ ] No

Medical Home (if no)

[ ] Yes

[ ] No

PERMANENT ADDRESSES:

Residence Program (3 applicable avenues)

[ ] Yes

[ ] No

Residence Phone Number

[ ] Yes

[ ] No

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

Getting the MOST Form:

• MOST form templates may be downloaded from www.ColoradoMOST.com and photocopied onto Avery® 8167* "Kleen* Brain*" or "Futura* Brain*" 80# paper. The copies’ papers are strongly encouraged but not required. Visit www.ColoradoMOST.com for a link to paper specifications.

• The form must be signed by a physician, advanced practice nurse, or physician assistant to be valid as medical orders. Physician assistants must include their name and contact information. In the absence of a provider signature, however, the patient’s 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 execute a MOST form as a condition of being admitted to, or continuing medical treatment from, the healthcare facility per C.R.S. 25-18-7100.

• 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-stature, or guardian may complete these orders on behalf of an incapacitated patient, making selections consistent with patient preferences. If known.

• "Proxy-by-stature" is a decision maker selected through a proxy process, per C.R.S. 15-13.5-103(8). Such a decision maker may not decline critical life-sustaining treatment (ALST) for an incapacitated patient without an attending physician and second physician (both trained in neurology certifying that "the provision of ANH is meant to prolong the act of dying and is intended 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:

• For C.R.S. 25-18-7100, "Emerging medical professional, a healthcare provider, or healthcare facility staff comply with all adults’ properly executed MOST form that has been executed in this state or another state in and apparent and immediately available. The fact that the signing person’s physician, advanced practice nurse, or physician assistant does not have admitting privileges in the facility where the adult is receiving care does not impair the legal authority of the order. Medical professionals 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, the provider should discuss concerns with the patient or surrogate legal decision maker and review orders only after obtaining the patient or surrogate consent.

• If Section A or C is not completed, full treatment is implied for that section.

• Conform care is never optional. Among other comfort measures, oral fluids and nutrition must be offered if tolerated.

• If "Conform Hematopoietic Treatment" is checked in Section A, 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.

Reversing the Medical Orders:

• These medical orders should be reviewed:

  o regularly by the person’s attending physician or facility staff with the patient and/or patient’s legal decision maker,

  o as admission or discharge from facility or an transfer between care settings or levels,

  o as any substantial change in the person’s health status or treatment preferences, and

  o when legal decision maker or contact information changes.

• If subscriber changes are made, please complete a new form and void the signed one.

• To void the form, draw a line across Sections A through C and write "VOID" in large letters, Sign and date.

REVIEW OF THE COLORADO MOST FORM

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Reviewer</th>
<th>Location of Review</th>
<th>Review Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Date]</td>
<td>[Name]</td>
<td>[Location]</td>
<td>[Comment]</td>
</tr>
</tbody>
</table>

*COMMENTS:* Please provide comments or suggestions for improving the form. Please return to Colorado MOST (MOST) at ColoradoMOST.com.
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 (e.g., 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 choose?"
| **Appreciation** | The ability to explain how information applies to oneself. | To assess appreciation of diagnosis: "Can you tell me in your own words what you see as your medical problem?"
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.