Advancing Advance Care Planning

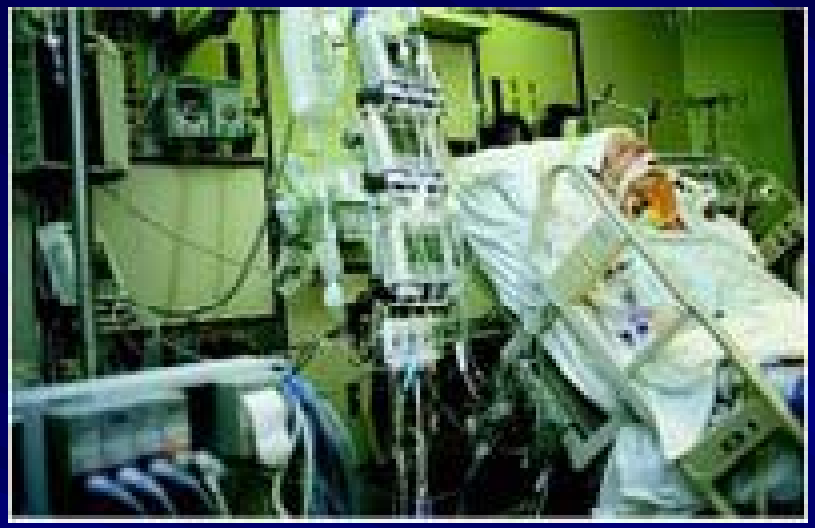
Implementation of *MOST* in Colorado

David Koets, MD

Chief Medical Officer, The Denver Hospice

Chair, Colorado Advance Directives Consortium

National POLST Paradigm Task Force Board

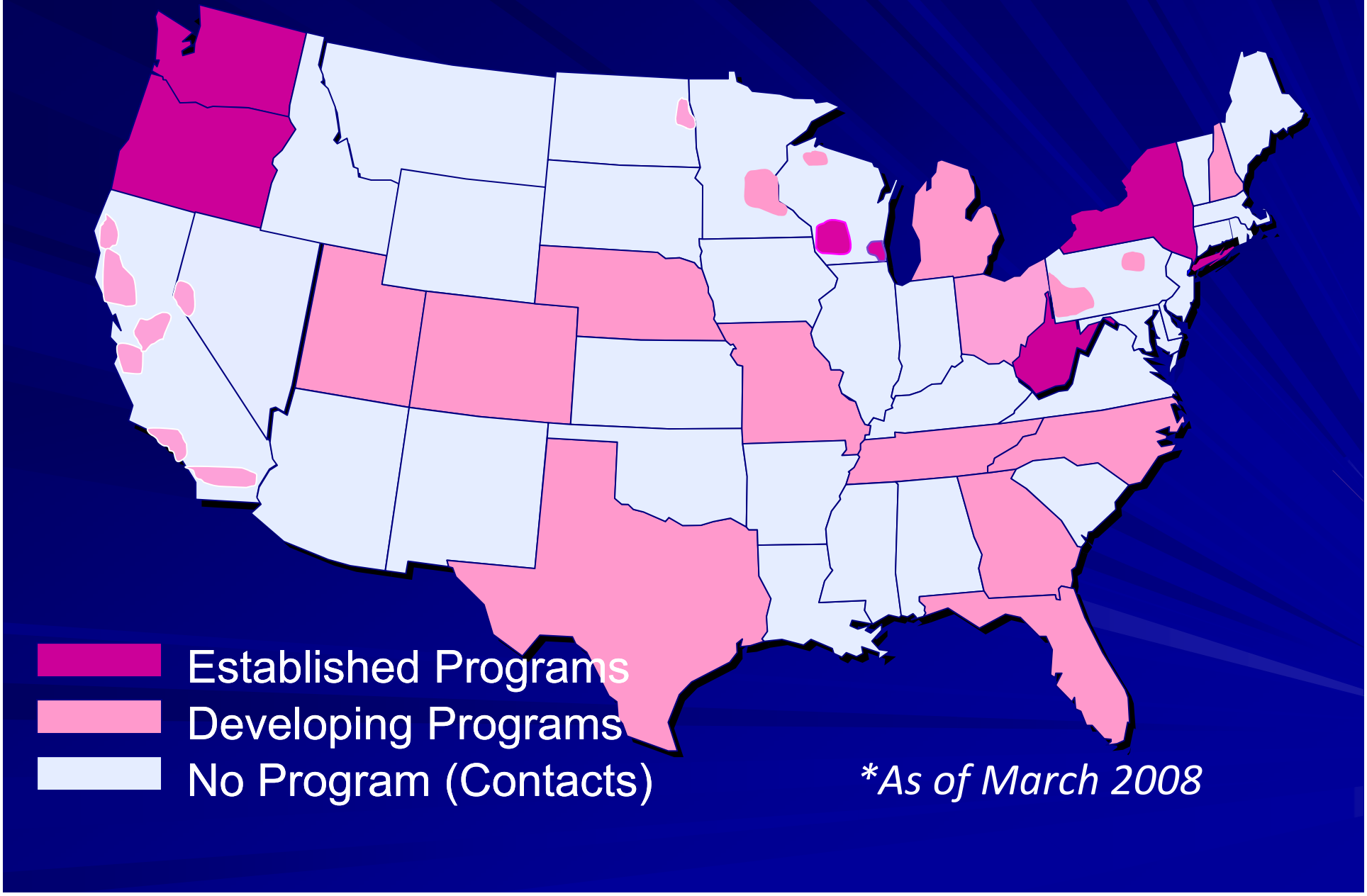


The POLST Paradigm

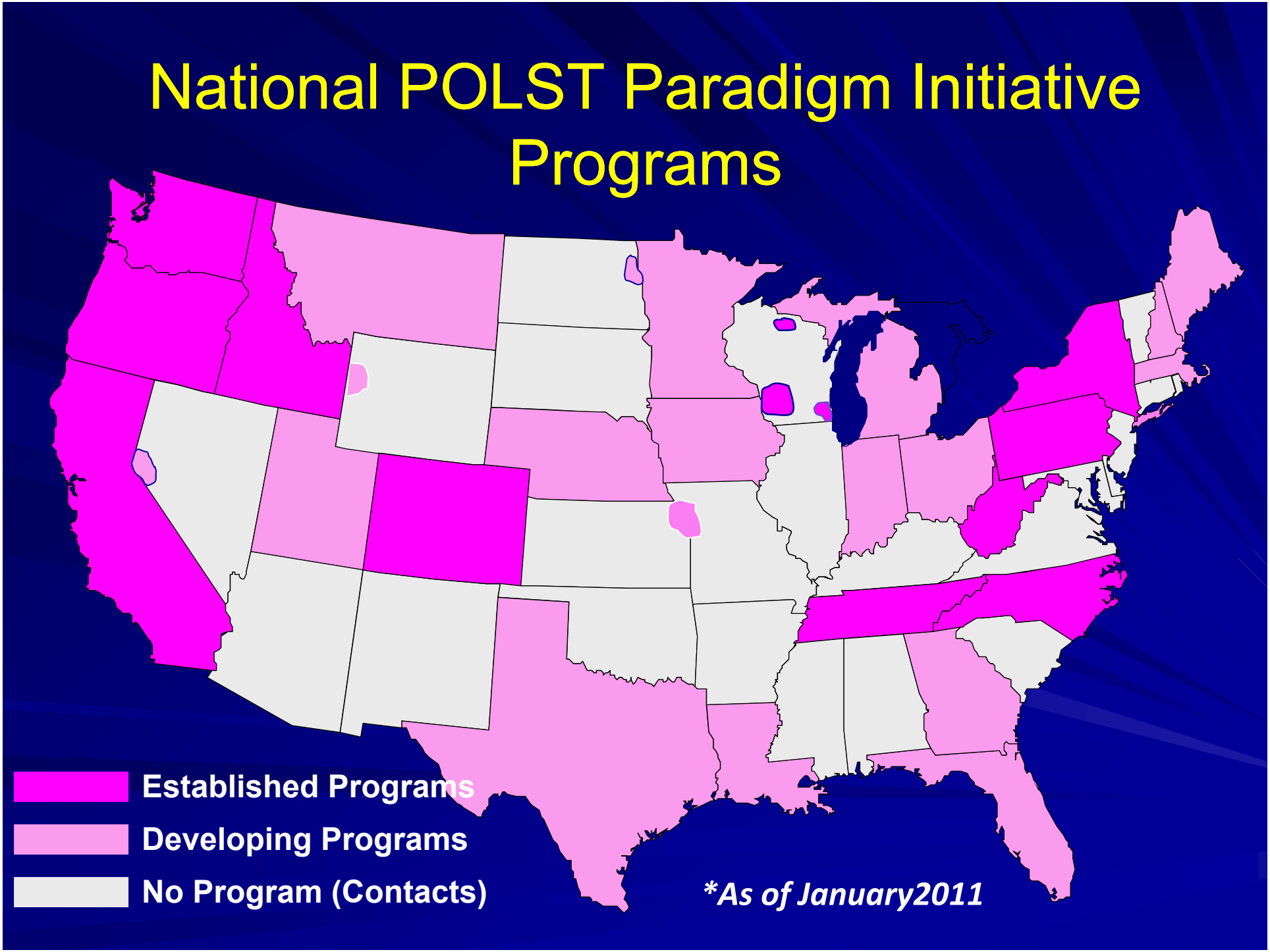
- POLST—Physician Orders for Life Sustaining Treatment
- MOLST—Medical Orders for Life Sustaining Treatment
- POST—Physician Orders for Scope of Treatment

- **MOST**—Medical Orders for Scope of Treatment

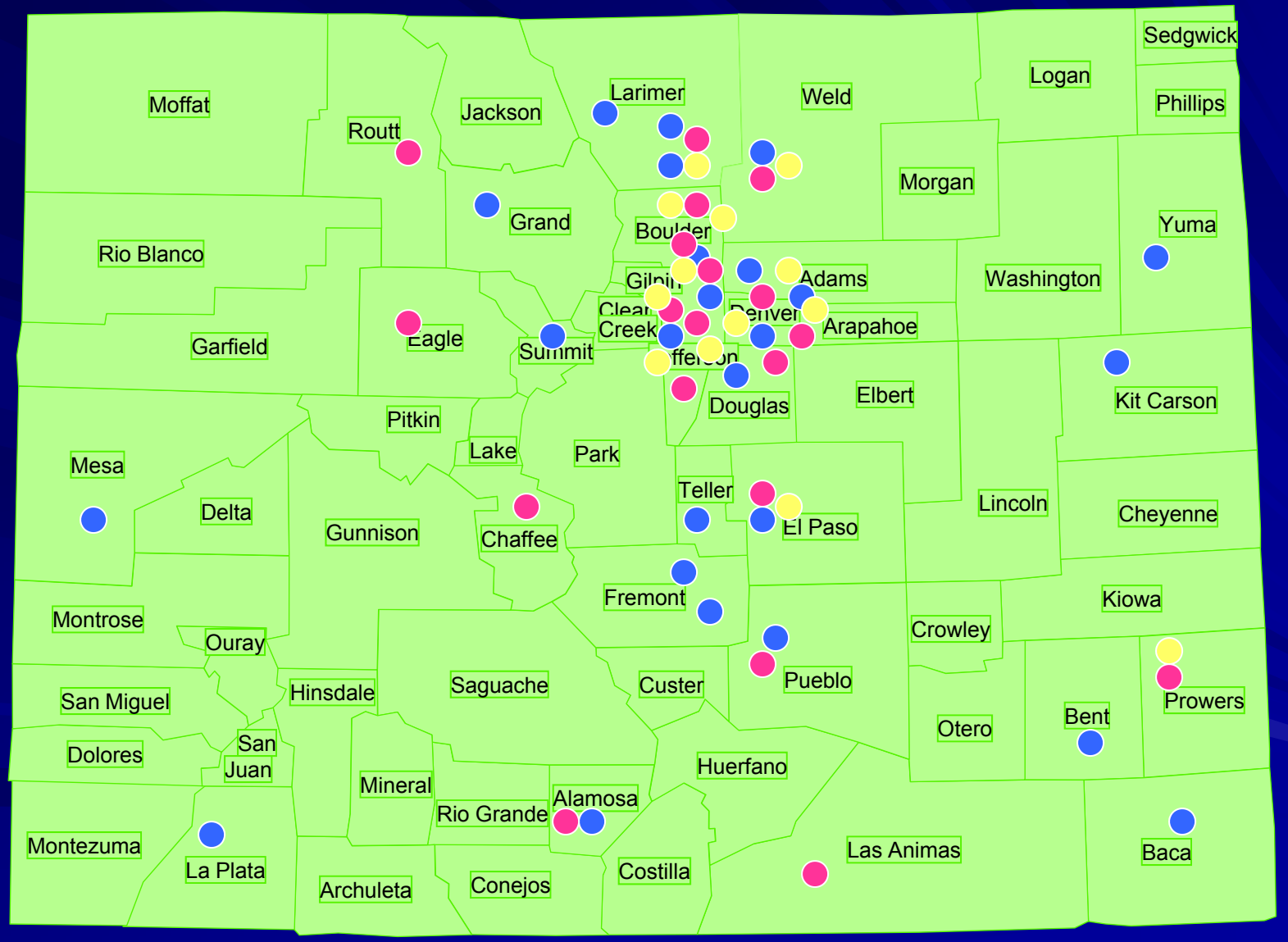
National POLST Paradigm Initiative Programs



National POLST Paradigm Initiative Programs



MOST Implementation-*Train the Trainer*



CDPHE-Colorado CPR Directive Regulatory Revisions

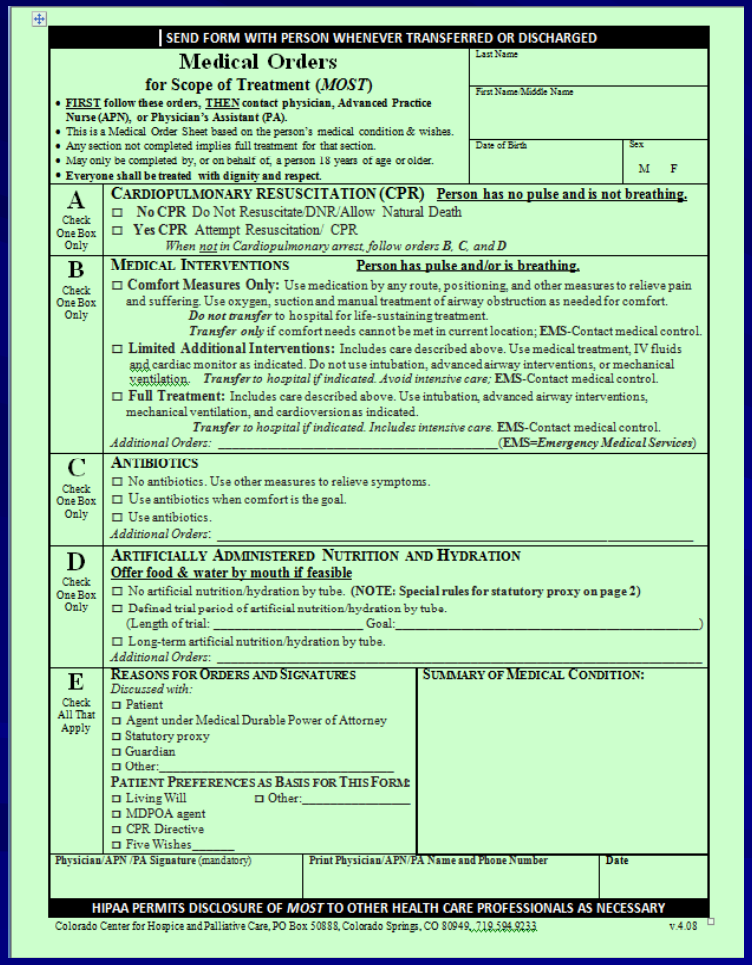
6 CCR 1015-2 Rules Pertaining to the Implementation of CPR Directives by EMS Personnel

- Acknowledges “other” forms
- Copies/faxes/electronic versions are valid
- Electronic and fax signature by MD are valid
- Only the physician can sign—*statutorily defined*

C.R.S. § 15-18.7 Directives Concerning Medical Orders for Scope of Treatment—*MOST*

- Establishes *Advance Directives* as *Medical Orders*
- Defines care options beyond the CPR Directive
- Portable across healthcare settings
- Allows NPs and PAs to sign these orders
- Copies are valid
- Immunity clause for following the orders
- Reciprocity with other POSLT states

THE *MOST* FORM
MEDICAL ORDERS FOR SCOPE OF TREATMENT



SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Medical Orders
for Scope of Treatment (*MOST*)

- **FIRST follow these orders, THEN contact physician, Advanced Practice Nurse (APN), or Physician's Assistant (PA).**
- This is a Medical Order Sheet based on the person's medical condition & wishes.
- Any section not completed implies full treatment for that section.
- 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.**

Last Name | First Name Middle Name | Date of Birth | Sex M F

A Check One Box Only — **CARDIOPULMONARY RESUSCITATION (CPR)** **Person has no pulse and is not breathing.**
- ☐ **No CPR** Do Not Resuscitate/DNR/Allow Natural Death
- ☐ **Yes CPR** Attempt Resuscitation/ CPR
  When not in Cardiopulmonary arrest, follow orders B, C, and D

B Check One Box Only — **MEDICAL INTERVENTIONS** **Person has pulse and/or is breathing.**
- ☐ **Comfort Measures Only:** Use medication by any route, positioning, 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 for life-sustaining treatment.
  Transfer only if comfort needs cannot be met in current location; **EMS**-Contact medical control.
- ☐ **Limited Additional Interventions:** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. *Transfer to hospital if indicated. Avoid intensive care;* **EMS**-Contact medical control.
- ☐ **Full Treatment:** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
  Transfer to hospital if indicated. Includes intensive care. **EMS**-Contact medical control.

Additional Orders: _____ (**EMS=*Emergency Medical Services***)

C Check One Box Only — **ANTIBIOTICS**
- ☐ No antibiotics. Use other measures to relieve symptoms.
- ☐ Use antibiotics when comfort is the goal.
- ☐ Use antibiotics.

Additional Orders: _____

D Check One Box Only — **ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION**
Offer food & water by mouth if feasible
- ☐ No artificial nutrition/hydration by tube. **(NOTE: Special rules for statutory proxy on page 2)**
- ☐ Defined trial period of artificial nutrition/hydration by tube.
  (Length of trial: _____ Goal: _____)
- ☐ Long-term artificial nutrition/hydration by tube.

Additional Orders: _____

E Check All That Apply — **REASONS FOR ORDERS AND SIGNATURES**
Discussed with:
- ☐ Patient
- ☐ Agent under Medical Durable Power of Attorney
- ☐ Statutory proxy
- ☐ Guardian
- ☐ Other: _____

PATIENT PREFERENCES AS BASIS FOR THIS FORM:
- ☐ Living Will ☐ Other: _____
- ☐ MDPOA agent
- ☐ CPR Directive
- ☐ Five Wishes _____

SUMMARY OF MEDICAL CONDITION:

Physician/APN/PA Signature (mandatory)	**Print Physician/APN/PA Name and Phone Number**	**Date**

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

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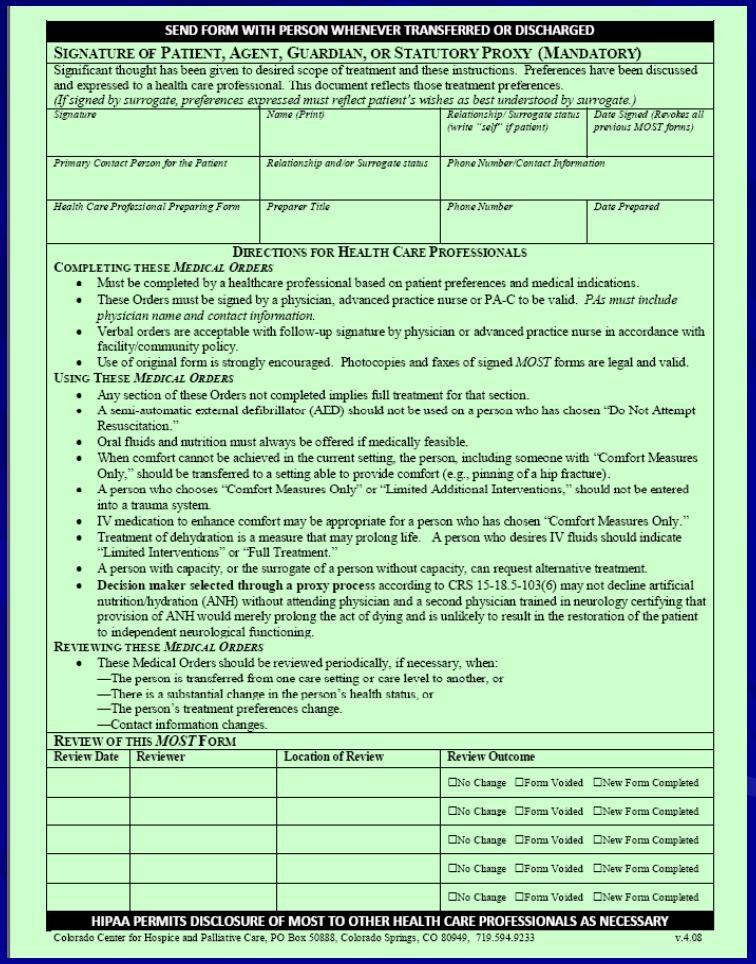

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

SIGNATURE OF PATIENT, AGENT, GUARDIAN, OR STATUTORY PROXY (MANDATORY)

Significant thought has been given to desired scope of treatment and these instructions. Preferences have been discussed and expressed to a health care professional. This document reflects those treatment preferences.
(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature	*Name (Print)*	*Relationship/ Surrogate status (write "self" if patient)*	*Date Signed (Revokes all previous MOST forms)*
Primary Contact Person for the Patient	*Relationship and/or Surrogate status*	*Phone Number/Contact Information*	
Health Care Professional Preparing Form	*Preparer Title*	*Phone Number*	*Date Prepared*

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

COMPLETING THESE *MEDICAL ORDERS*
- Must be completed by a healthcare professional based on patient preferences and medical indications.
- These Orders must be signed by a physician, advanced practice nurse or PA-C to be valid. *PAs must include physician name and contact information.*
- Verbal orders are acceptable with follow-up signature by physician or advanced practice nurse in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and faxes of signed *MOST* forms are legal and valid.

USING THESE *MEDICAL ORDERS*
- Any section of these Orders not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., pinning of a hip fracture).
- A person who chooses "Comfort Measures Only" or "Limited Additional Interventions," should not be entered into a trauma system.
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure that may prolong life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
- A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.
- **Decision maker selected through a proxy process** according to CRS 15-18.5-103(6) may not decline artificial nutrition/hydration (ANH) without attending physician and a second physician trained in neurology certifying that provision of ANH would merely prolong the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning.

REVIEWING THESE *MEDICAL ORDERS*
- These Medical Orders should be reviewed periodically, if necessary, when:
  —The person is transferred from one care setting or care level to another, or
  —There is a substantial change in the person's health status, or
  —The person's treatment preferences change.
  —Contact information changes.

REVIEW OF THIS *MOST* FORM

Review Date	Reviewer	Location of Review	Review Outcome
			☐No Change ☐Form Voided ☐New Form Completed
			☐No Change ☐Form Voided ☐New Form Completed
			☐No Change ☐Form Voided ☐New Form Completed
			☐No Change ☐Form Voided ☐New Form Completed
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Advance Directive Discussions

- Having the Conversation
  - Patient
  - Family
  - Providers
- Effective Communication
  - Honest Prognosis/Expectations
  - Goals of Care/Resolving Conflicts
- Comprehensive/Portable Documentation
  - Communication across all care settings
  - Re-evaluation with changes in condition

Barriers

Patient Barriers to completion of Advance Directives

- Belief that physicians should initiate discussions
- Discomfort with the topic
- Procrastination/Apathy
- Belief that family should decide
- Family would be upset by the planning process
- Fear of burdening family members

Physician Barriers to addressing Advance Care Planning

- Belief that patients should initiate discussions
- Discomfort with the topic
- Time constraints
- Lack of knowledge about Advance Directives
- Negative attitude
- Perception of Failure

Advance Directives* vs. *MOST*

Advance Directives

- For every adult
- Decisions about potential future conditions & treatments
- Preferences need to be defined
- Needs to be retrieved
- Requires interpretation

MOST

- For the seriously/chronically ill
- Decisions relative to the current condition, treatment options & goals of care
- Preferences presented as options
- Stays with the patient
- Physician's Orders

* Living Will, Five Wishes, Medical Durable Power of Attorney, other similar forms

Fagerlin & Schneider. *Enough: The Failure of the Living Will*. Hastings Center Report 2004;34:30-42.

CPR Directive vs. *MOST*

Colorado CPR Directive

- DNR is the only option
- Other care options *implied*
- Regulatory constraints
- Repeated across settings

MOST

- DNR or Full Resuscitation
- Other Care options defined
- Regulatory latitude
- Remains with the patient

Implementation Stakeholders

- Patient and Family Members
- Healthcare Providers: Primary Care Physicians, NP, PA
- Caregivers
- Facility Staff/Corporate Legal
- EMS Providers
- ER Staff/Physicians
- Hospitalists/Sub-specialists

Quality Measures & Tracking

Qualitative:

- How are patients and families responding to discussions: positive, negative, neutral?
- What has the experience been like for the facility: barriers, roadblocks, efficiencies, improvements?
- How would you rate level of acceptance/understanding of the form and process by family, staff, and other providers?

Quantitative:

- % penetration over 3-4 month period
- % discussion vs. completion
- Timeframe between introduction and completion; how many conversations needed; refusals (goal to uncover best methods for introducing and completing)

Summary of *MOST*

- For the seriously or chronically ill
- Guidance, requires ongoing conversation
- Addresses current condition, preferences
- Clear choices; allows annotation
- Belongs to, stays with the patient
- Portable across settings
- Regularly updated
- Copies, faxes, scans are valid

Summary of *MOST* (cont'd)

- Clarity, rigidity for pre-hospital, transitions
- Clarity, flexibility for in-hospital/facility
  - Medical appropriateness
  - Conscience "out"
- *Does NOT:*
  - Replace or eliminate Advance Directives
  - Appoint an agent—*separate process/form*
  - Imply, support or suggest euthanasia, PAS/PAD

Future Directions

- Advance Care Planning as the “avenue” to opening discussions on EOL care including appropriate access to hospice and palliative care
- National POLST Paradigm Task Force
- Federal Legislation and “Death Panels”
  - Introduction of the *Personalize Your Care Act* of 2011 (H.R. 1589) U.S. Rep. Earl Blumenauer in April 2011

Resources

- *Colorado Advance Directives Consortium: www.ColoradoAdvanceDirectives.com*
- *Life Quality Institute: www.lifequalityinstitute.org*
- *Iris Project: www.irisproject.net*
- *POLST National Organization: www.polst.org*
- *www.nationalhealthcaredecisionsday.org*
- *Caring Connections: www.caringinfo.org*

References-POLST Paradigm

- www.polst.org –Multiple recent publications
- Dunn, P, et.al., *The POLST Paradigm: Respecting the Wishes of Patients and Families.* Annals of Long-Term Care, 2007; 15 (9): 33-40
- Emanuel, LL, *Advance Directives and Advancing Age*, Editorial, JAGS 2004; 52: 641-642
- Meier, D., Beresford, L., *POLST Offers Next Stage in Honoring Patient Preferences,* J Pall Med 2009; 12 (4): 291-295