Advancing Advance Care Planning
Implementation of MOST in Colorado

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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

Established Programs
Developing Programs
No Program (Contacts)

*As of March 2008
National POLST Paradigm Initiative

Established Programs
Developing Programs
No Program (Contacts)

*As of January 2011
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

<table>
<thead>
<tr>
<th>Medical Orders for Scope of Treatment (MOST)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> CPR/Compressions Resuscitation (CPR)</td>
</tr>
<tr>
<td>Person has no pulse and is not breathing.</td>
</tr>
<tr>
<td>□ No CPR  □ Do Not Resuscitate (DNR)</td>
</tr>
<tr>
<td>Patient is in Cardiopulmonary arrest; follow orders B, C, and D.</td>
</tr>
<tr>
<td><strong>B</strong> Medical Interventions</td>
</tr>
<tr>
<td>□ Comfort Measures Only</td>
</tr>
<tr>
<td>□ Limited Additional Interventions</td>
</tr>
<tr>
<td>□ Full Treatment</td>
</tr>
<tr>
<td>Person has a civil authority, national health care or medical need.</td>
</tr>
<tr>
<td>Use resuscitation, advanced life support (ALS), and other measures to resuscitate and stabilize the patient.</td>
</tr>
<tr>
<td><strong>C</strong> Antibiotics</td>
</tr>
<tr>
<td>□ No antibiotics</td>
</tr>
<tr>
<td>□ Limited Additional Interventions</td>
</tr>
<tr>
<td><strong>D</strong> Artificially Administered Nutrition and Hydration</td>
</tr>
<tr>
<td>□ No enteral nutrition by tube (NOTE: artificial nutrition by tube)</td>
</tr>
<tr>
<td>□ Full treatment</td>
</tr>
<tr>
<td><strong>E</strong> Reasons for Orders and Signatures</td>
</tr>
<tr>
<td>□ Composed with:</td>
</tr>
<tr>
<td>□ Patient</td>
</tr>
<tr>
<td>□ Agent under Medical Directive Person of Attorney</td>
</tr>
<tr>
<td>□ Attorney</td>
</tr>
</tbody>
</table>

SUMMARY OF MEDICAL CONDITION:

- Reason for MOST order
- Patient's medical history
- Current medical condition

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

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

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”
Resources

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