



Medical Orders for Scope of Treatment Frequently Asked Questions

Note: This list is in progress—Keep checking back, and if you don't see your question here, please email us: ColoradoAdvanceDirectives@gmail.com.

1. **NEW** What changes have been made to the MOST form in 2015?
2. **NEW** Are old MOST forms (completed prior to 2015 revision) still valid, or do we have to redo MOST forms for all our patients/clients/residents?
3. **NEW** Where can I get copies of the MOST form for myself or our healthcare facility?
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14. Will a Colorado MOST form be honored in another state?
15. What can be done to help ensure that the form actually stays with the patient into and out of the hospital and returns to the facility or home with the patient?
16. Should/can hospitals initiate the MOST process for patients who do not come into the hospital with a MOST?
17. What should hospitals do with the MOST before the patient leaves the hospital?
18. Should changes to MOST orders be made as annotations on an existing form or should a new form be created?
19. How and where should staff document a telephone order for the MOST? Would this be written in some way on the form itself, and dated, or would this be on the TO form usually used and attached to the MOST form? If the doctor isn't going to visit the facility soon, would you then mail the original for signature, keeping a copy in the chart until it returns?
20. If the MDPOA is out of town, and consent to the MOST must be gathered by phone, is there a process suggested? [Our] facility has two witnesses to any phone call requiring a verbal consent from an MDPOA, and that's documented. Would this be a good process for getting the MOST consent witnessed? Would we then mail the original MOST to the MDPOA for a signature or is the verbal sufficient? What if the patient is in the home? How would you document this so that it was considered sufficiently witnessed?

21. If a person [completing the MOST] has capacity, but is physically unable to write a legible signature, how is that handled? Is an "X" adequate if it's been witnessed by the facility staff?
22. An ALR administrator said that because they are not a skilled facility, if someone falls and has bleeding or head injury, the facility is required to send the person to the ER for evaluation. Their question is how to address this if the person has selected "Comfort-Focused Treatment" in Section B, which includes the instruction "Do not transfer."
23. Why isn't there a signature line for the healthcare professional helping to prepare the form?
24. If the CPR directive triplicate form is not being used anymore, or if the MOST is being used as a CPR directive, how does someone get the bracelet or necklace?
25. Is there a way for a healthcare provider to bill for the time it takes to complete the MOST form with a patient? Some providers might be reluctant to take the time if they cannot be reimbursed.
26. Can we make multiple copies of the MOST Instruction booklet for our staff and provider partners?

1. **NEW** What changes have been made to the MOST form in 2015?

Here is a brief recap of changes made to the MOST form in 2015:

- The form prompts providers completing the form to ask about and review previously completed advance directives when completing a MOST.
- Order of options has been reversed so that YES CPR and Full Treatment are shown first.
- Providers and patients are reminded that if YES CPR is selected in Section A, the only possible choice in Section B is "Full Treatment."
- Options in Section B have been reworded slightly and the primary goal of each option is clearly stated.
- The previous form Section C offered choices on the use of antibiotics. In accordance with emerging national standards for the POLST paradigm, this box has been removed.
- New Section C (old Section D) options now refer only to artificial nutrition, not artificial nutrition and hydration. Choices for provision of artificial nutrition have been simplified and reworded (short-term/temporary, long-term/permanent, none).
- Space for all required signatures, patient/agent and provider, have been moved to the first page.

2. **NEW** Are old MOST forms (completed prior to 2015 revision) still valid, or do we have to redo MOST forms for all our patients/clients/residents?

MOST forms completed prior to April 16, 2015, remain valid until the form is revoked, the patient expires, or the form is revised at the patient's request.

3. **NEW** Where can I get copies of the MOST form for myself or our healthcare facility?

A master MOST form may be downloaded from the Colorado Advance Directives Consortium Web site:

<http://coloradoadvancedirectives.com/links-and-downloads/medical-orders-for-scope-of-treatment-most-in-colorado/>. It is strongly recommended that this master form be photocopied onto the regulation "Astrobrights® Vulcan Green" (or "Terra Green") paper, but this is not required. Photocopies, faxes, and scans are equally valid.

4. Is there a Spanish version of the MOST?

The MOST is intended as a communication tool between the patient and healthcare providers and between healthcare providers themselves, such as nursing facilities and EMS. As English is the primary language of healthcare in Colorado, a Spanish-language MOST would not be helpful as a communication tool. The official MOST form, signed by physician/APN/PA and patient or patient's authorized decision maker MUST be the two-sided, English-language, official form. However, as a tool to facilitate discussion and reassure Spanish-speaking patients, we have created a Spanish version of the front side of the form. (See the Colorado Advance Directives Consortium Web site, www.ColoradoAdvanceDirectives.com, MOST Downloads). The Spanish version is not an actionable medical order; ***it is only to be used in the discussion of choices. NOTE: The Spanish version corresponds to the older version of the MOST form. We will update the Spanish version as soon as possible.***

5. What if we run out of review lines on the MOST form, but no changes to the MOST are needed? Do we have to complete a new form?

A new form can be completed, but you can also use the supplemental review form provided on the Colorado Advance Directives Consortium Web site (www.ColoradoAdvanceDirectives, MOST Downloads).

6. Is it possible to select “NO CPR” and “Full Treatment”? What about “YES CPR” and “Comfort-focused Treatment (Comfort Measures Only)?”

It is possible to select “NO CPR” and “Full Treatment”: In this case, healthcare providers would perform any and all life-saving treatment EXCEPT CPR, just as if the patient had a CPR directive but no other instructions limiting treatment. It is also possible to select “NO CPR” and “Selective Treatment” (previously, “Limited Interventions”) as well as “NO CPR” and “Comfort-focused Treatment” (previously “Comfort Measures Only”).

Selecting “YES CPR” and “Comfort-focused Treatment” (previously “Comfort Measures Only”), however, is not clinically possible. In this case, if a patient were suffering from heart failure, and the patient’s heart stopped, CPR would be administered to restart the heart, but no other life-saving interventions would be allowed; then the patient’s heart fails again, and CPR is given again, but no other life-saving interventions would be allowed, and so on. It sets up a perpetual, and futile, cycle of interference that would not benefit patients and would distress healthcare providers. If patients insist on selecting “YES CPR,” then “Full Treatment” is the only possible choice in Section B.

7. Are healthcare providers/facilities required to complete a MOST for every patient/resident?

No—use of the MOST by providers, facilities, or individuals is **not required by** Colorado law and **cannot legally be required** as a matter of facility policy. A MOST is strongly recommended for persons with serious, chronic, or life-limiting illness in frequent contact with healthcare settings and providers or already residing in a nursing facility.

8. Which staff member of a facility or medical practice should be the one to complete the MOST with a patient?

Any staff member with sufficient medical knowledge to be able to explain the procedural and medical implications of the various treatment choices can complete the form with the patient. This could be a physician, physician assistant, nurse, or medical social worker; although facilities may have their own specific policies on this. The completion of the MOST is not just a “check-the-box” exercise—it requires thorough and thoughtful conversation. Items requiring more information from a physician or nurse can be left incomplete and referred to the appropriate provider. Note, however, that if Sections A or B are left blank, CPR and Full Treatment are implied. **Once the form is completed, the physician, PA, or NP who signs the form is responsible for reviewing and approving the choices.** The choices should be clear, consistent with the patient’s medical condition and prognosis and values. If there is any question, the person signing the form should follow up with the patient or the professional who helped complete the form.

9. If the facility has not yet developed a specific policy with regard to the MOST, are the staff legally able to initiate or comply with MOST orders?

Yes, the MOST statute provides all the necessary protections.

10. Does a MOST replace or revoke advance directives?

No. The **MOST is a medical order set, not an advance directive.** The treatment types and choices on a MOST are only a few of the possible issues that advance directives can address. If a person has advance directives in place (living will, MDPOA, etc.), the person completing the MOST with the patient/resident should review the advance directives so that

the MOST orders match the advance directives—or the advance directives should be revised or revoked to match current choices documented on the MOST. The advance directives remain in effect and valid.

If a person completing a MOST does not have any other advance directives, the MOST covers the key life-sustaining treatment choices, and there is room to add additional orders. However, it cannot be used to appoint a healthcare agent, nor does it address personal care or nonmedical matters.

The MOST may function as a CPR directive for any person who has a MOST, but standalone CPR directives are still valid. Until all EMS services and ED/ERs are familiar with the MOST, it's a good idea for a patient/resident to have both. Some long-term care facility policies require a facility-specific CPR directive form. There is no problem with using those forms along with a MOST as long as the instructions do not conflict.

11. What if MOST orders conflict with the patient's other advance directives?

As noted above, the general rule of thumb is that in cases of conflict between a MOST and other advance directives, the most recent document rules. However, there are some nuances to this, depending on who has completed which document when:

The MOST and CPR directives: If a person completed a CPR directive (refusing CPR) before completing a MOST, but then on the MOST says "Yes" to CPR; the most recent document prevails. If the person completed a CPR directive (refusing CPR), and later is incapacitated and the MOST is completed by the person's Healthcare Agent choosing "Yes CPR," the prior CPR directive prevails: Healthcare Agents cannot revoke or overrule a CPR directive completed by a competent patient.

The MOST and living wills: A Healthcare Agent cannot complete a living will for an incapacitated patient. Likewise, a Healthcare Agent cannot override or revoke the person's living will unless specific authority to do so is stated in the living will or the MDPOA document. If the Healthcare Agent completes a MOST for the person and a previously completed living will contradicts any of the MOST provisions, the living will prevails. If the patient completes a MOST for him/herself and a previously completed living will contradicts the MOST, the MOST prevails.

IMPORTANT: *This is why it is essential, before completing a MOST, to ask about previously completed advance directives to make sure the documents do not conflict.*

12. Can a Healthcare Agent (MDPOA), Proxy, or Designated Beneficiary (DB) complete, revise, or revoke a MOST for an incapacitated person?

Yes, in accordance with the person's known wishes or in his/her best interests. However, changes to the MOST form should only be made if there are good reasons to make changes—such as a change in the condition, prognosis, or goals of the person. Agents and other proxies should not just wait for "Granny to conk out" and then redo the MOST. Any changes to a MOST form should also take into account the advice of the healthcare professional who will sign the form.

Also, an Agent must abide by the person's choices documented in a previously executed CPR directive or a living will, unless the living will or MDPOA document specifically grants an override right to the Agent. A Proxy or DB must abide by the person's choices in a CPR directive or living will, period. If, for instance, the person completed a living will some years ago and indicated there a preference to continue artificial nutrition even when other life-sustaining procedures are withdrawn, the Healthcare Agent cannot execute or revise a MOST that refuses all artificial nutrition, or vice versa. As well, a Proxy or DB cannot withhold or withdraw artificial nutrition/hydration from a patient unless and until two physicians, one of whom is trained in neurology, certify that the provision of artificial nutrition will not contribute to the patient's recovery and will only prolong dying.

13. What if a patient brings in a MOST/POLST/POST/MOLST form from another state that doesn't exactly comply with Colorado requirements for the MOST?

The MOST statute says that MOST/POLST/POST/MOLST forms from other states must be honored, subject to the exceptions/limitations in Colorado's law.

14. Will a Colorado MOST form be honored in another state?

Whether a Colorado MOST form will be honored in another state is entirely up to the laws of that state. A valid Colorado MOST form presented to a healthcare provider in another state will likely carry a great deal of weight as a strong indication of patient preferences with the endorsement of the healthcare professional who signed the form; however, providers in other states may not be obliged to follow the orders.

15. What can be done to help ensure that the form actually stays with the patient into and out of the hospital and returns to the facility or home with the patient?

First, although the form belongs to and should stay with the patient, facilities/hospice agencies should always keep a copy in the patient's chart. If the resident/patient leaves the facility with a MOST but comes back without one, contact the hospital and ask for it back. Hospitals should list the form as "personal property" and have procedures in place to review/update/replace the form during discharge process to make sure orders are current and the form leaves with patient.

16. Should/can hospitals initiate the MOST process for patients who do not come into the hospital with a MOST?

Yes, for the target patient population (seriously or chronically ill, being discharged to a facility or to home with hospice or home health). The goal of the MOST program is to make sure that vulnerable patients have orders in place regarding life-sustaining treatments as they transfer across healthcare settings. NOTE: Some hospitals are balking at initiating advance directive forms. Remember, **the MOST is NOT an advance directive!** It is a medical order set that communicates patients' desires for particular treatments.

17. What should hospitals do with the MOST before the patient leaves the hospital?

If the patient already has a MOST, it should be reviewed and (likely) revised prior to discharge by the hospitalist or attending. He or she should review the choices on the form in light of the course of the patient's hospitalization, current condition, and prognosis. If substantive changes are called for, a new form should be initiated. The old form should be voided out (by writing VOID clearly across both sides of the form), but returned to the patient.

18. Should changes to MOST orders be made as annotations on an existing form or should a new form be created?

General ruling principle: do whatever is MOST likely to be clear and authoritative. If annotations or changes might create confusion or doubt about the validity or clarity of the order, then do a new form and void the old one. If annotations are used to indicate changes or additions/deletions, they should be initialed by signing professional (MD/DO, APN, or PA) and patient or agent.

19. How and where should staff document a telephone order for the MOST? Would this be written in some way on the form itself, and dated, or would this be on the TO form usually used and attached to the MOST form? If the doctor isn't going to visit the facility soon, would you then mail the original for signature, keeping a copy in the chart until it returns?

Here is how the legislation addresses verbal orders:

An adult's physician, advanced practice nurse, or if under the supervision of the physician, physician's assistant may provide a verbal confirmation to a health care provider who shall annotate on the MOST form the time and date of the verbal confirmation and the name and license number of the physician, advanced practice nurse, or physician's assistant. The physician, advanced practice nurse or physician's assistant shall countersign the annotation of the verbal confirmation of the MOST form within a time period that satisfies any applicable state law or within 30 days, whichever period is less, after providing the verbal confirmation. (Section 15-18.7-104)

Documentation of verbal/telephone orders should follow these guidelines and any other existing facility procedures for verbal or telephone orders. If the physician/APN/PA is not going to visit the facility (or the patient if the patient is at home) within 30 days, the form may be faxed for countersignature.

- 20. If the MDPOA is out of town, and consent to the MOST must be gathered by phone, is there a process suggested? [Our] facility has two witnesses to any phone call requiring a verbal consent from an MDPOA, and that's documented. Would this be a good process for getting the MOST consent witnessed? Would we then mail the original MOST to the MDPOA for a signature or is the verbal sufficient? What if the patient is in the home? How would you document this so that it was considered sufficiently witnessed?**

There is no legal requirement for "witnessing" the MOST. The signatures of the physician/APN/PA and patient/agent are sufficient. However, the process described for confirming a verbal consent from an agent sounds perfectly fine. The MOST form can then be faxed to the agent for signature and faxed back.

- 21. If a person [completing the MOST] has capacity, but is physically unable to write a legible signature, how is that handled? Is an "X" adequate if it's been witnessed by the facility staff?**

This is not directly addressed in the legislation. This situation should be handled according to policies the facility/provider has in place for any signature of important documents, for instance MDPOA, living will, etc. The facility/provider should consult with their legal advisors as to what would be the best method if they do not have policies in place covering other similar situations. NOTE: Facility staff are probably not the best witnesses in this or similar cases as they are specifically forbidden to witness living wills.

- 22. An ALR administrator said that because they are not a skilled facility, if someone falls and has bleeding or head injury, the facility is required to send the person to the ER for evaluation. Their question is how to address this if the person has selected "Comfort-focused Treatment" (previously "Comfort Measures Only"), which include the instruction, "Do not transfer."**

The "Comfort-focused Treatment" (previously "Comfort Measures Only") option says "do not transfer to hospital for life-sustaining treatment/transfer only if comfort cannot be met in current location" (underline added). If head injury is possible or if bleeding cannot be controlled by EMS, this would be a completely appropriate reason to transfer the resident, even under the "Comfort-focused Treatment" option. Also, a request for transfer under certain circumstances can always be included on the "additional orders" line.

- 23. Why isn't there a signature line for the healthcare professional helping to prepare the form?**

The purpose of the physician/PA/APN signature is to "translate" the patient choices into medical orders. A medical social worker or RN could help the patient complete the form but cannot sign medical orders; which is why we specifically *did not* include a signature line for any healthcare professional other than the MD/DO/PA/APN. There is a place for the person helping to complete the form (if not the same as the person signing it) to provide their name and contact information, however.

24. If the CPR directive triplicate form is not being used anymore, or if the MOST is being used as a CPR directive, how does someone get the bracelet or necklace?

The Colorado Department of Public Health & Environment was in touch with Award and Sign (providers of the No-CPR bracelets/necklaces) right after the new CPR rules took effect. Award and Sign are aware that there is no single required CPR form anymore. CDPHE suggests folks call them or other companies that make similar jewelry to see what the companies' requirements are. www.awardandsign.com or (303) 799-8979.

25. Is there a way for a healthcare provider to bill for the time it takes to complete the MOST form with a patient? Some providers might be reluctant to take the time if they cannot be reimbursed.

NEW In Colorado, Medicaid providers may bill for the time to counsel a Medicaid beneficiary about the MOST form.

For specific requirements/instructions, contact Richard Delaney, richard.delaney@state.co.us or (303) 866-3436. For non-Medicaid patients, there is no billing code specifically for advance care planning conversations (yet!). However, there is a mechanism within Medicare to bill for “prolonged services,” and this is often used to bill for counseling or visits that exceed the Medicare time definitions per guidelines. Visit the Colorado MESA Initiative Web site for more information on time-based billing and prolonged visit codes (www.ColoradoMESA.org).

26. Can we make multiple copies of the MOST Instruction booklet for our staff and provider partners?

Yes! And we encourage you to do so. You may even add your facility or organization’s logo to the cover. What you CAN’T do is edit, add to, or alter the content. If you have suggestions for additions or edits, please direct them to the CADC through the Contact Us form on the Web site: www.coloroadvancedirectives.com.