island health

Making Informed Decisions

Medical Orders for Scope of Treatment

[MOST]

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Overview

1. What is MOST?
2. Why MOST , why now?
3. Who should have a MOST?
4. How does MOST link to Advance Care Planning (ACP) & Goals of Care?
5. What are some of the key elements of the MOST initiative?
6. How to engage in ACP & Goals of care conversations?
7. How can we support MOST in our practice?

What is MOST

MOST is a physician's order that has six designations that provide direction on code status, critical care interventions, and medical interventions.

- MOST is a medical order that is valid across all care settings and is honored by the BC ambulance service.
- MOST replaces No CPR orders (March 19)
- The MOST policy aligns with the existing:
  - 9.1.2 P Adult Cardiopulmonary Resuscitation (CPR) Policy.
  - 10.3.9 Cardiopulmonary Resuscitation for Residential Services

Designation indicating decisions regarding scope of **Medical Interventions**

- **M1** ▸ **Supportive care, symptom management and comfort measures only.**
- **M2** ▸ **Medical treatments within current location of care, excluding critical care interventions, CPR and intubation.**
- **M3** ▸ **Medical treatments including transfer to higher level of care, excluding critical care interventions, CPR, and intubation.**

Designation indicating decisions regarding scope of **Critical Care Interventions**

- **C0** ▸ **Critical Care Interventions, excluding CPR and intubation.**
- **C1** ▸ **Critical Care Interventions, excluding CPR but including intubation.**
- **C2** ▸ **Appropriate Critical Care Interventions, including CPR, and intubation.**

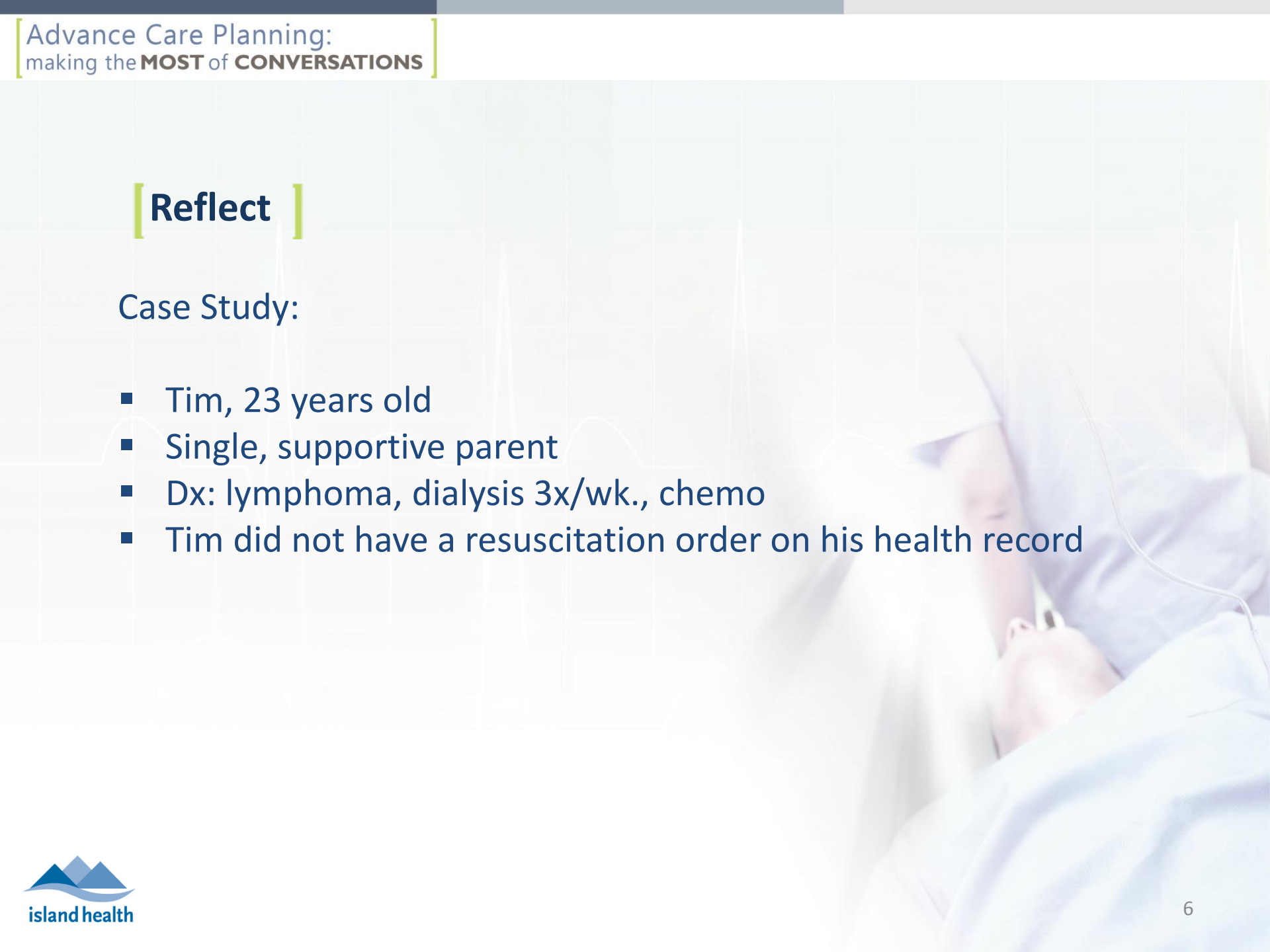
Why MOST, why NOW?

- Integral part of Electronic health record ("see latest MOST" in banner bar until full activation)
- Resuscitation will be removed from clinical order sets
- Clarify the intent of treatment and helps health care providers (HCP) deliver care that aligns with patients' values, goals and health condition
- Minimizes unnecessary or unwanted treatment
- Standardizes the Most Responsible Physician (MRP) orders regarding resuscitation status and scope of health care treatments

Reflect

Case Study:

- Tim, 23 years old
- Single, supportive parent
- Dx: lymphoma, dialysis 3x/wk., chemo
- Tim did not have a resuscitation order on his health record



National Research-ACCEPT Study

Advance Care Planning Evaluation in Elderly Patients (ACCEPT):

- Design: Prospective study
- Setting: 12 acute care hospitals in Canada (b/w Sept 2011-March 2012).
- Participants: Elderly pt.'s who were at high risk of dying over the next 6 months and their families
- Conclusion: Pt's and family members have expressed preferences for medical treatments at the EOL. However, communication with HCP and documentations remains inadequate.

"Agreement between patients' expressed preferences for EOL care and documentation in the medical record was 30.2%"

Failure to Engage Hospitalized Elderly Patients and Their Families in Advance Care Planning *JAMA Intern Med.* 2013;173(9):778-787. doi:10.1001/jamainternmed.2013.180

National Landscape

NATIONAL

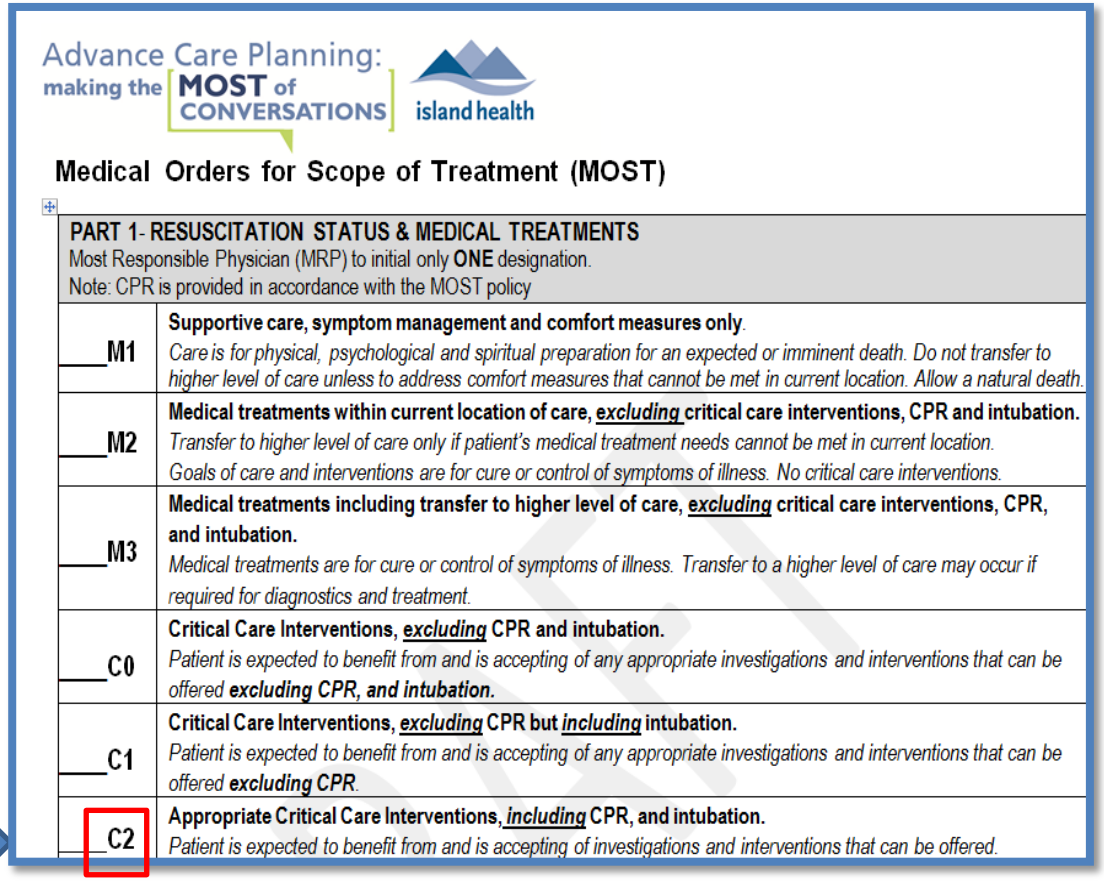
- **Alberta**
  Alberta Health Goals of Care Designation
  2011: (Calgary)
  2014: (Province wide)

- **British Columbia**
  2009: Providence- Options for care
  2013: Fraser Health
  2015: Northern Health, Interior Health ,Van Coastal
  2016: Island Health

MOST in Clinical Practice

- Ihealth new platform sites: MRP places order through computerized order entry
- All other sites (including community):paper form

C2- only designation with CPR



Advance Care Planning: making the MOST of CONVERSATIONS — island health

Medical Orders for Scope of Treatment (MOST)

PART 1- RESUSCITATION STATUS & MEDICAL TREATMENTS Most Responsible Physician (MRP) to initial only **ONE** designation. Note: CPR is provided in accordance with the MOST policy	
___M1	**Supportive care, symptom management and comfort measures only.** *Care is for physical, psychological and spiritual preparation for an expected or imminent death. Do not transfer to higher level of care unless to address comfort measures that cannot be met in current location. Allow a natural death.*
___M2	**Medical treatments within current location of care, *excluding* critical care interventions, CPR and intubation.** *Transfer to higher level of care only if patient's medical treatment needs cannot be met in current location.* *Goals of care and interventions are for cure or control of symptoms of illness. No critical care interventions.*
___M3	**Medical treatments including transfer to higher level of care, *excluding* critical care interventions, CPR, and intubation.** *Medical treatments are for cure or control of symptoms of illness. Transfer to a higher level of care may occur if required for diagnostics and treatment.*
___C0	**Critical Care Interventions, *excluding* CPR and intubation.** *Patient is expected to benefit from and is accepting of any appropriate investigations and interventions that can be offered **excluding CPR, and intubation.***
___C1	**Critical Care Interventions, *excluding* CPR but *including* intubation.** *Patient is expected to benefit from and is accepting of any appropriate investigations and interventions that can be offered **excluding CPR**.*
___C2	**Appropriate Critical Care Interventions, *including* CPR, and intubation.** *Patient is expected to benefit from and is accepting of investigations and interventions that can be offered.*

MOST in Clinical Practice

PART 2- Additional direction(s) related to MOST (OPTIONAL)	
PART 3- SUPPORTING DOCUMENTATION (check all documents reviewed)	
☐ Previous MOST Order ☐ Written expression of wishes ☐ Advance Directive ☐ Rep 9 agreement ☐ No CPR Form (BC) ☐ Health care provider documentation ☐ Other:_____	
PART 4- MOST order entered following a CONVERSATION with (check all that apply)	
☐ Capable Patient ☐ Personal Guardian (Committee) Name:_____ ☐ Representative Name:_____ ☐ Temporary Substitute Decision Maker (TSDM) Name:_____ ☐ Patient incapable/TSMD unavailable ☐ Consultation with other health care provider(s)	
SIGNATURE OF ORDERING PHYSICIAN	
As the patient's ordering Physician I have considered the available documents noted in Part 3 and discussed the benefits and consequences and preferences of the above Order with the indicated individual(s) in Part 4.	
Name of MRP (please print)	Signature
Date (dd/mm/yyyy) Time	Location of patient
REVALIDATION OF THE MOST	
☐ MOST order revalidation (No Change) Signature:	Date (dd/mm/yyyy)
☐ MOST order revalidation (Update) Prepare new MOST form, and strike through this one	Date (dd/mm/yyyy)

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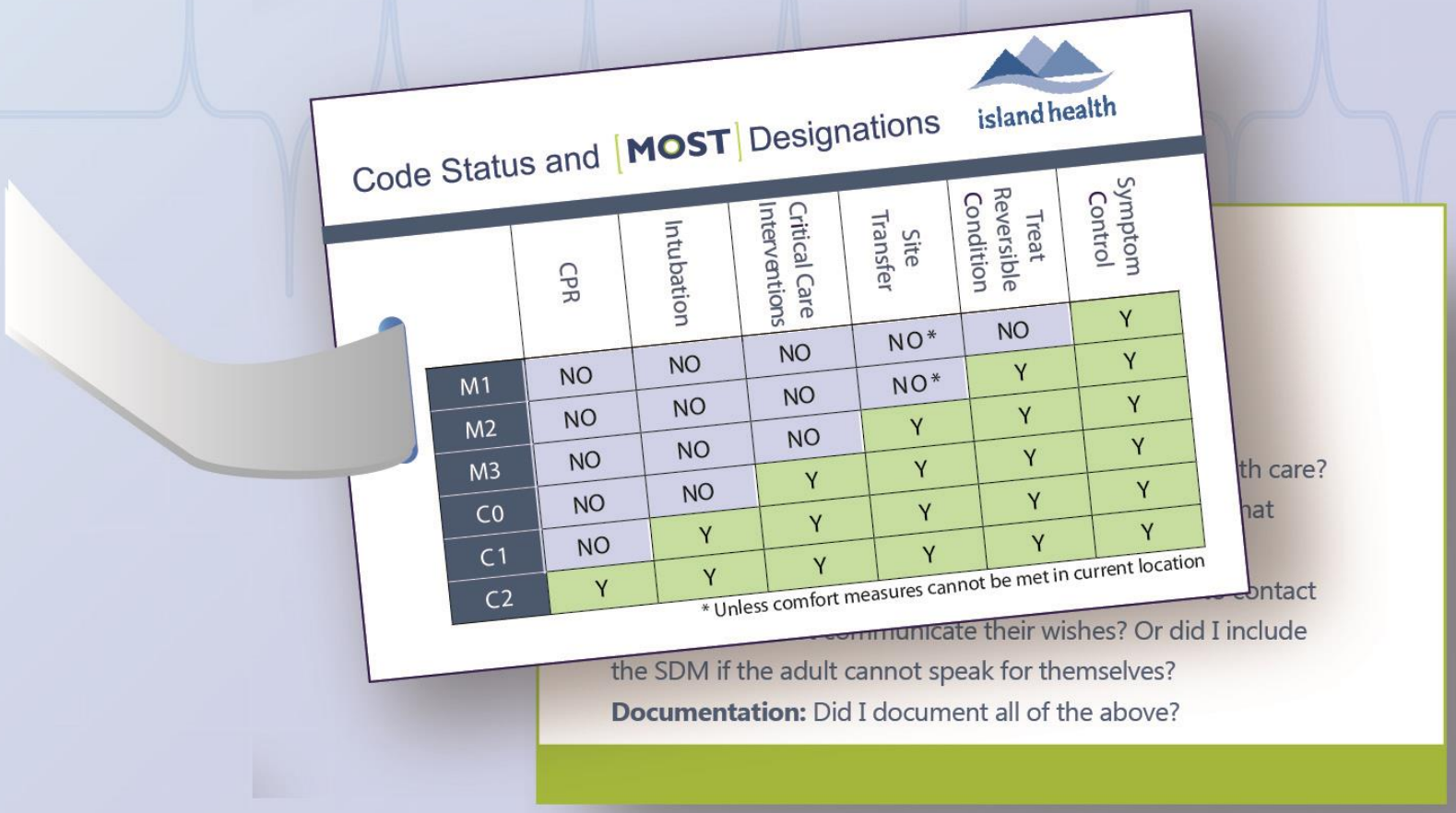

Code Status and MOST Designations

	CPR	Intubation	Critical Care Interventions	Site Transfer	Treat Reversible Condition	Symptom Control
M1	NO	NO	NO	NO*	NO	Y
M2	NO	NO	NO	NO*	Y	Y
M3	NO	NO	NO	Y	Y	Y
C0	NO	NO	Y	Y	Y	Y
C1	NO	Y	Y	Y	Y	Y
C2	Y	Y	Y	Y	Y	Y

* Unless comfort measures cannot be met in current location

WHO SHOULD have a MOST

- Where possible, all adult patients/clients should have a Medical Orders for Scope of Treatment (MOST) designation on their chart.

- This policy applies to adults (19 years of age or older) , especially those with a life limiting or advanced medical illness.

Who should have a MOST?

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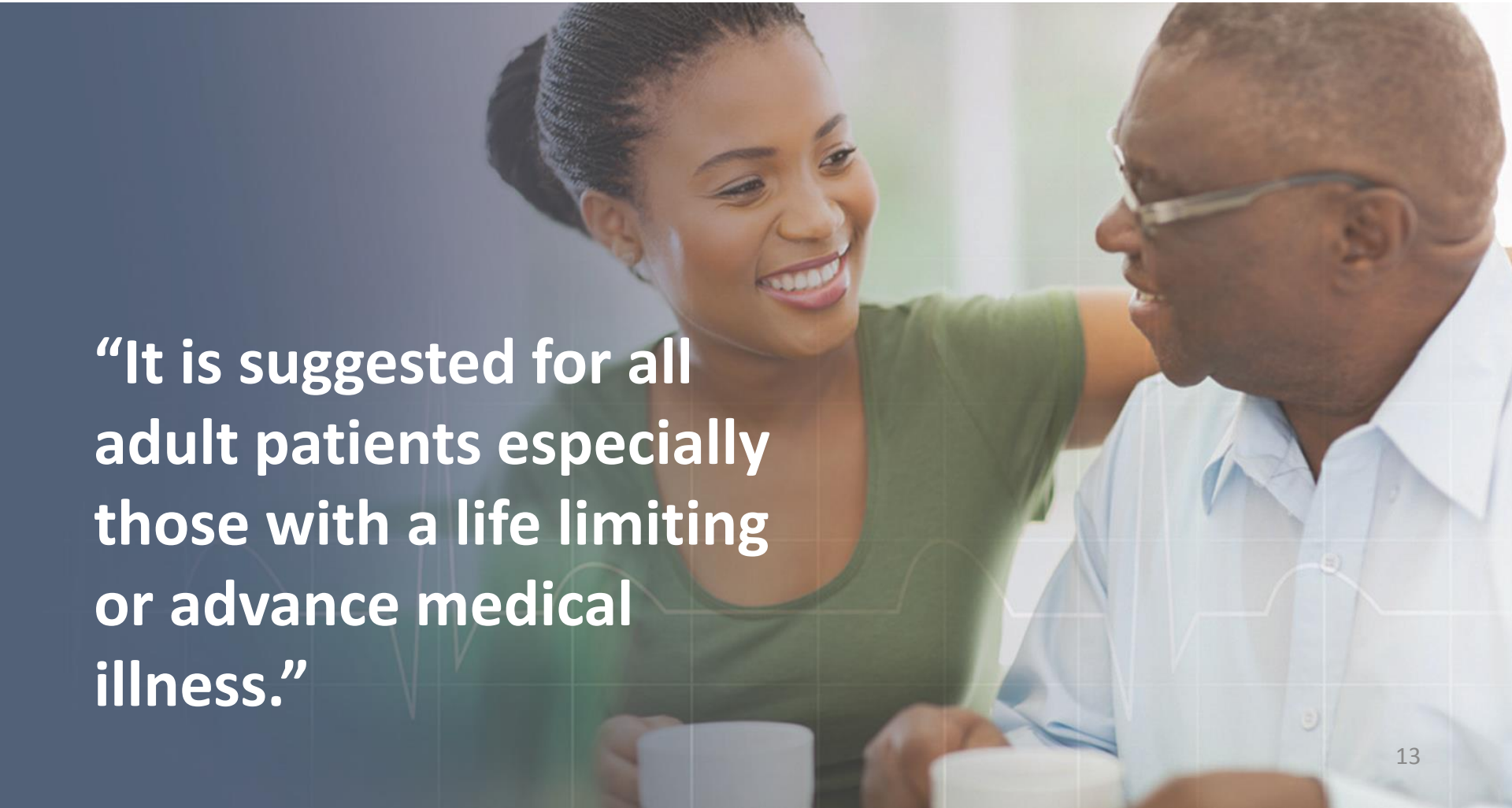


“It is suggested for all adult patients especially those with a life limiting or advance medical illness.”

Prognostic Tools

Surprise Question

"Would you be surprised if this patient died in the next 12 months?"

- Validated in clinical studies:
- If physicians answered "NO", patient 3.5 times more likely to have died in 1 yr. compared to "YES" pt.

Moss, CJASN 2008

Frailty Scale

- Is a 7-point tool that provides a practical approach to assessing frailty using physical and functional indicators of health and illness burden

- Proactively identifies those who could benefit from interventions.

A global clinical measure of fitness and frailty in elderly people.

Prognostic Tools

The Supportive and Palliative Care Indicators Tool is a guide to identifying people at risk of deteriorating health and dying.

Supportive and Palliative Care Indicators Tool (SPICT™)

NHS Lothian

The SPICT™ is a guide to identifying people at risk of deteriorating health and dying. Assess these people for unmet supportive and palliative care needs.

Look for two or more general indicators of deteriorating health.

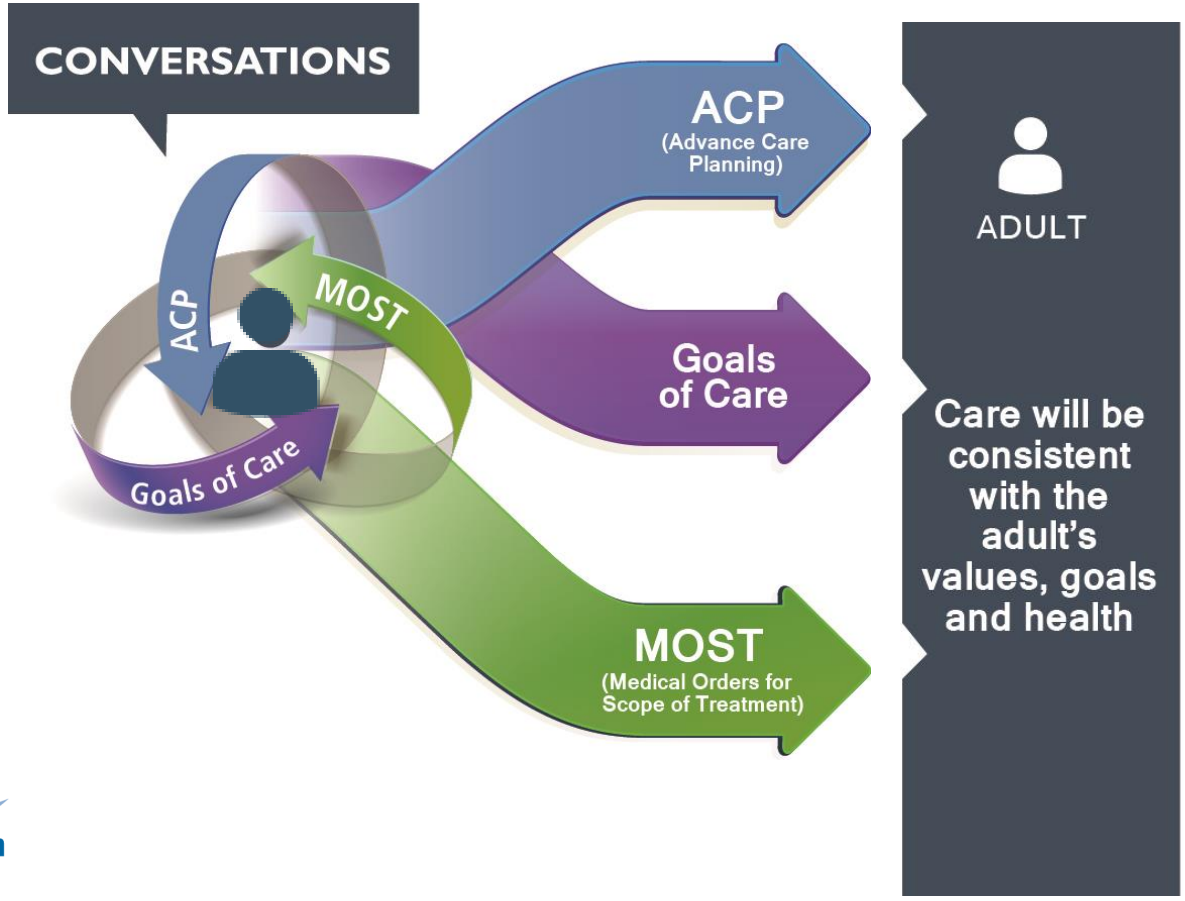
- Performance status is poor or deteriorating (the person is in bed or a chair for 50% or more of the day); reversibility is limited.
- Dependent on others for most care needs due to physical and/or mental health problems.
- Two or more unplanned hospital admissions in the past 6 months.
- Significant weight loss (5-10%) over the past 3-6 months, and/ or a low body mass index.
- Persistent, troublesome symptoms despite optimal treatment of underlying condition(s).
- Patient asks for supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of one or more advanced conditions

te (www.spict.org.uk) for information and updates.

http://www2.gov.bc.ca/assets/gov/health/forms/349fil.pdf

How does MOST link to ACP & Goals of Care?



ACP

Conversations about:

- Written expression of wishes
- Advance Directives
- Representation Agreements

The adult engages in ACP conversations with loved ones and health care providers

GOALS OF CARE

Conversations about:

- Clarification or review of ACP
- Diagnosis, prognosis, risks, and benefits of treatment.
- Medically appropriate options for health care that aligns with the adult's goals of care.

MOST

Conversations about:

- Between the adult, Most Responsible Provider and other health care providers about the kinds of health care to provide in certain circumstances.

The Most Responsible Physician completes a MOST

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Key Points of the MOST Initiative

MOST

- A MOST is valid across all care settings.
- The Most Responsible Physician (MRP) will determine a MOST designation, based on the ACP and goals of care discussions with capable adult, if adult incapable then with SDM.

Cont'd

MOST

- MOST provides direction on resuscitation, medical and critical treatment interventions.

- A MOST requires review :
  - when there is a significant change in the adult's condition, and
  - periodic review for e.g.; within 48 hours after admission to acute care and 30 days after admission to residential care, and
  - every 12 months

Con't

MOST

- Always ask the adult about their preferences for care then they are able to speak for themselves. If incapable ask their SDM.

- In an emergency, if the adult is incapable and SDM is not able to provide direction, the MOST would be followed.

- MOST orders **are not** suspended during procedures. If a MOST order is changed specifically for a procedure, it should be reviewed again after the procedure.

MOST

- On discharge or transfer the patient/client or SDM should be offered a copy of the MOST if possible.

- Encourage the adult to keep a copy at home and have it in an accessible place (e.g. the front of fridge)

  Note: Paramedics and contracted alternate service providers (non medical pt. transportation) will honor the following documents:

  - A MOST, Provincial No CPR order
  - A physician's No CPR order
  - An Advance Directive refusing CPR.

Absence of a MOST

All care settings (except Residential Care)

Staff will initiate CPR in the event of witnessed cardiac arrest (C2 designation) unless one or more of the following circumstances apply:

- The adult has an advance directive refusing CPR.
- The adult has reasonable grounds (e.g., based on a direct conversation) to believe that the patient/client, when capable, expressed the wish to refuse CPR.
- The adult is incapable, the substitute decision maker has refused CPR on behalf of the patient, and this refusal is consistent with the adult's pre-expressed wishes.
- The adult is wearing a Medic Alert bracelet engraved with 'No CPR'.

(MOST Policy;1.3 Absence of a MOST Designation)

Absence of a MOST

Residential Care

By default, CPR will NOT be offered to persons living in Residential Care, except if CPR is requested in advance by the patient/client or their legally appointed substitute decision maker (based on the known wishes of the patient/client). In this case, a MOST C2 designation can be ordered.

(MOST Policy;1.3 Absence of a MOST Designation)

Where will MOST & ACP documents be stored?

Greensleeve is a green plastic page protector that is placed at the front of the health record to identify resuscitation status, scope of treatment and store ACP documents.

- MOST (In Non IHealth sites)
- ACP Documents- copies ONLY (e.g., Representation Agreement, Advance Directive, written expression of wishes)
- ACP Notes and conversations (Non Ihealth new platform sites)

Note: can be ordered from MONKS (RLXSP2034)

Greensleeves have been ordered for acute care and residential care sites

Community Services

- When MOST orders that are completed by community providers, it is recommended a copy is provided to the adult in order to share with other HCP's
- The MOST will be used in the community the same way as the current Provincial No CPR form.
- BC Ambulance will respect the orders stated on a MOST form.
- Advise the adult to keep in an accessible place (1st responders will look on the front of the fridge).

MOST & ACP& Goals of Care

MOST is completed as a result of an ACP and Goals of Care conversations.

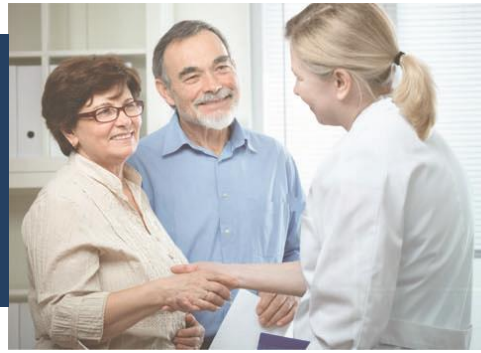
Consider using the Conversation Guide for ACP and Goals of Care

Advance Care Planning

Advance Care Planning lets you have a say in the health care you will receive if you are unable to speak for yourself. Discussing and documenting your wishes with your loved ones and health care providers means they will be better able to speak on your behalf when needed.

Advance Care planning may consist of :

- **Conversations** about future health care wishes
- **Written or verbal expression of wishes** (in US called a living will)
- **A Representation Agreement:** An adult while capable appoints someone to make health care and personal care decision on their behalf in the event they are unable to speak for themselves.
- **An Advance Directive:** is a document that gives/refuses consent for specific treatment in advance. HCP is bound by law to refer to the A.D as the source of consent. If instructions unclear, seek consent from SDM.



Roadblocks for HCP'S

- Discomfort with the topic
- Lack of understanding
- Belief that it is not my job/role

On admission to hospital only 24.8% of pt.'s and 31.7% of family members reported being asked about prior discussions or written documentation

(Failure to Engage Hospitalized Elderly Patients and Their Families in ACP, 2013)

- Not enough time or the right time
- Too depressing
- Don't want to suggest someone giving up

"When ACP engagement is timely and appropriate it can positively enhance rather than diminish patients' hope."

Davison & Simpson, 2006

Conversation Guide is located on the back of the MOST form

MOST decision Support tools

MOST is completed as a result of an Advance Care Planning (ACP) and Goals of Care conversations. Consider using the Conversation Guide for ACP and Goals of Care below:

Conversation Guide for ACP & Goals of Care:

Keep in mind that ACP is an ongoing process and may take several conversations over time

Questions you can consider asking:

- What do you understand about your illness?
- How much information would you like about what to expect with your illness?
  Tip: Some people like to know about how much time they have, others like to know about what to expect, others like both

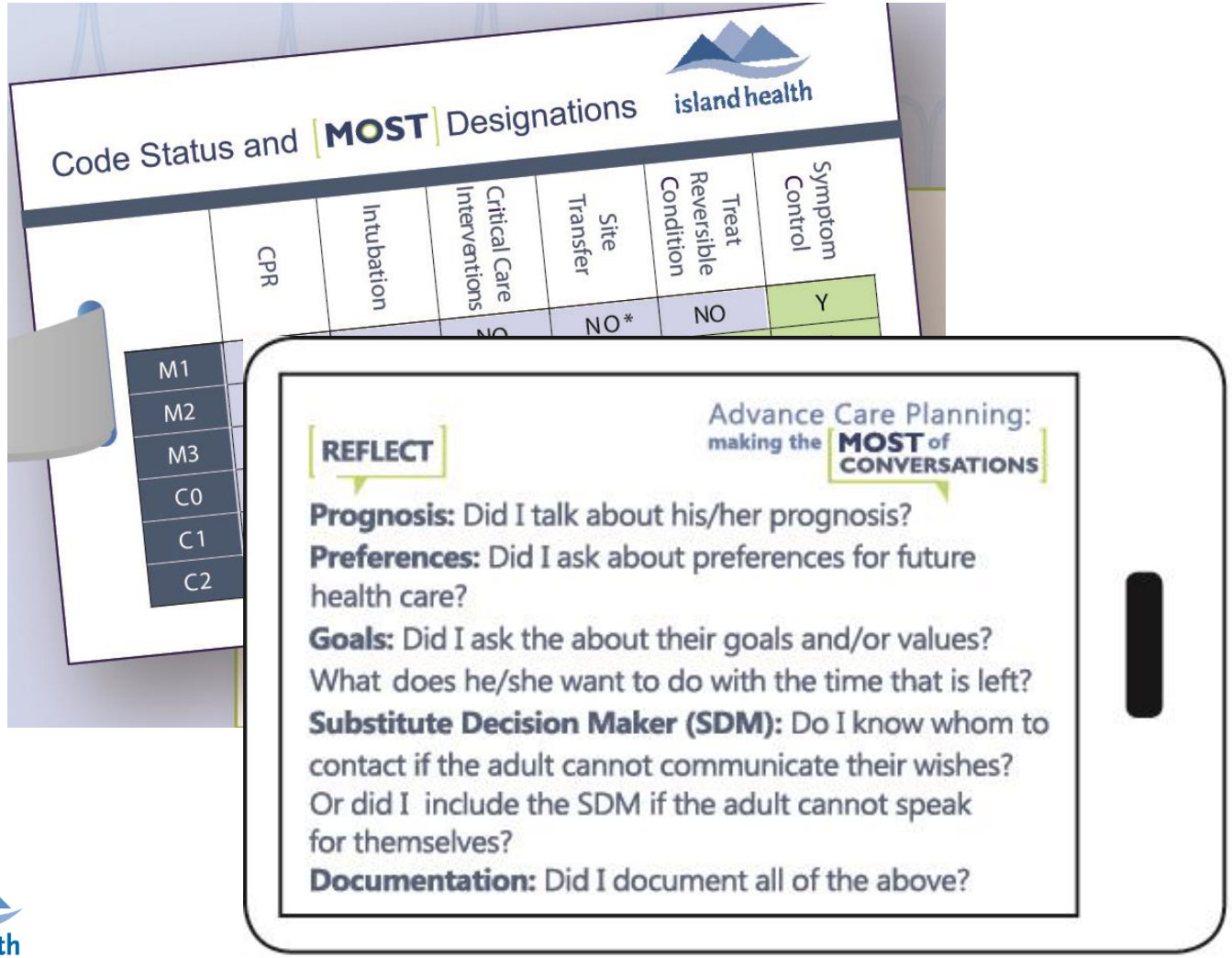
  Offer to provide your view of prognosis and possible trajectory, tailored to information preferences
- Have you talked with anyone about your health goals or preferences? Do you have an advance care plan? Do you know what I mean by an advance care plan?
  - If yes: discuss details.
  - If no: then ask, "If medical decisions need to be made about your care and you are unable to speak for yourself, who would you want me to speak to about your wishes?"
- If your health situation worsens, what are your most important goals of care?
- What are your fears or worries about the future?
- Do you have the information you need to make decisions about the kinds of procedures you do or do not want if you become very sick?
- How much do your loved ones know about your wishes and goals of care? Tip: Suggest bring a family member or friend next visit.

Clarify Understanding & Provide Medical Information Regarding Diagnosis, Prognosis & Treatment Options

Atul Gawande

http://www.youtube.com/watch?v=45b2QZxDd_o&feature=list_related&playnext=1&list=SP602EF6A965291D5E

Pocket Card


Code Status and MOST Designations
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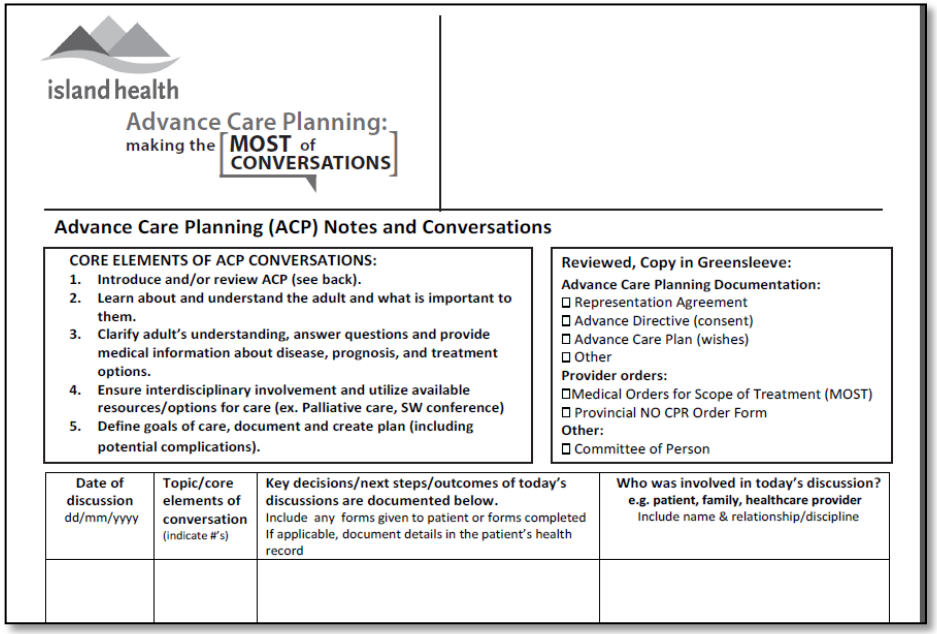
CPR
Intubation
Critical Care Interventions
Site Transfer
Treat Reversible Condition
Symptom Control
M1
M2
M3
C0
C1
C2
NO*
NO
Y
REFLECT
Advance Care Planning:
making the MOST of CONVERSATIONS
Prognosis: Did I talk about his/her prognosis?
Preferences: Did I ask about preferences for future health care?
Goals: Did I ask the about their goals and/or values? What does he/she want to do with the time that is left?
Substitute Decision Maker (SDM): Do I know whom to contact if the adult cannot communicate their wishes? Or did I include the SDM if the adult cannot speak for themselves?
Documentation: Did I document all of the above?

Documentation:
ACP Notes and Conversations

- Provides guidance to and documents ACP conversations and Scope of treatment conversations
- Placed in "Greensleeve"
- Paper form available on the ACP Intranet
- In IHealth new platform sites recommended to document in ACP Section



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Advance Care Planning:
making the MOST of CONVERSATIONS

Advance Care Planning (ACP) Notes and Conversations

CORE ELEMENTS OF ACP CONVERSATIONS:

1. Introduce and/or review ACP (see back).
2. Learn about and understand the adult and what is important to them.
3. Clarify adult's understanding, answer questions and provide medical information about disease, prognosis, and treatment options.
4. Ensure interdisciplinary involvement and utilize available resources/options for care (ex. Palliative care, SW conference)
5. Define goals of care, document and create plan (including potential complications).

Reviewed, Copy in Greensleeve:

Advance Care Planning Documentation:
☐ Representation Agreement
☐ Advance Directive (consent)
☐ Advance Care Plan (wishes)
☐ Other

Provider orders:
☐ Medical Orders for Scope of Treatment (MOST)
☐ Provincial NO CPR Order Form

Other:
☐ Committee of Person

Date of discussion dd/mm/yyyy	Topic/core elements of conversation (indicate #'s)	Key decisions/next steps/outcomes of today's discussions are documented below. Include any forms given to patient or forms completed If applicable, document details in the patient's health record	Who was involved in today's discussion? e.g. patient, family, healthcare provider Include name & relationship/discipline

How can we support our practice areas?

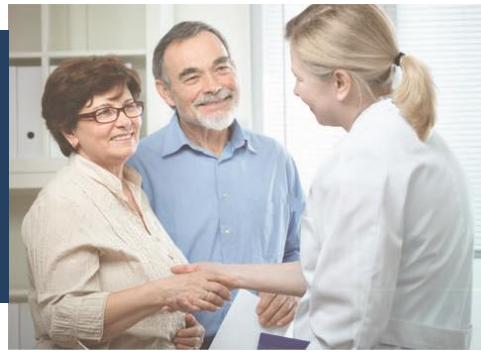
Guide staff to

- ☐ Review Island Health's MOST policy
- ☐ Review the MOST form
- ☐ Review Key messages
- ☐ Complete the MOST E-learning module
- ☐ Offer in-services using the MOST PowerPoint
- ☐ Review the MOST Intranet page

Use the new supplies:

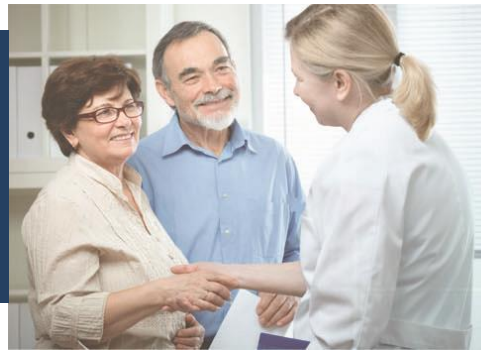
- MOST pocket card
- MOST patient pamphlet
- CPR patient pamphlet
- MOST Infographic

- ☐ Familiarize yourself with new ACP tools:
  - *ACP Notes and Conversations* record
  - *Greensleeve*



MOST Key Messages

- Engaging in ACP and & Goals of Care discussions is an interdisciplinary practice and the role of ALL HCP's
- Pt's should always be asked about their preferences for care when they are able to speak for themselves; when incapable their SDM's are asked
- In an emergency situation if the adult is incapable and the SDM is not able to provide direction, the MOST would be followed



MOST Key Messages

- A MOST provides direction for providers to follow in any Island Health setting and is honored by BC ambulance and contracted transportation service
- The ACP Notes and Conversations flow sheet is a useful tool to record ACP and goals of care discussions
- A Greensleeve is recommended to store the MOST (non Ihealth sites) and copies of ACP documents

ACP
(Advance Care Planning)

Goals of Care

MOST
(Medical Orders for Scope of Treatment)

Care will be consistent with the adult's values, goals and health

Resources

BC Seniors:

- http://www.seniorsbc.ca/legal/healthdecisions/
- Failure to Engage Hospitalized Elderly Patients and Their Families in Advance Care Planning. JAMA Intern Med/Vol 173 (No 9), May 12, 2013.

Island Health Internet Site:

- http://www.viha.ca/advance_care_planning/
- Medical orders for life-sustaining treatment: Is it time yet? Palliative and supportive Care (2014), 12, 101-105.

Speak-Up Campaign:

- http://www.advancecareplanning.ca/
- What really matters in end-of-life discussions? Perspectives of patients in hospital with serious illness and their families. CMAJ Nov 3, 2014.
- What to discuss near life's end. Mc Master Network. Spring 2015.
- A global clinical measure of fitness and frailty in elderly people. Rockwood K1, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, Mitnitski
  CMAJ. 2005 Aug 30;173(5):489-95.
- MOST Policy

Acknowledgements

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- Cari Hoffman, Project Coordinator, Advance Care Planning, Fraser Health http://www.fraserhealth.ca/your-care/advance-care-planning/
- Judy Nichol, Regional Practice Leader, Interior Health https://www.interiorhealth.ca/YourCare/EndOfLife/MOST/Pages/default.aspx
- Island Health MOST Committee
- Island Health Advance Care Planning Committee
- Learning & Performance Support

Questions

[MOST]

Thank you

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Please complete the evaluation:
https://viha.fluidsurveys.com/s/most-evaluation/

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