Discussion Items

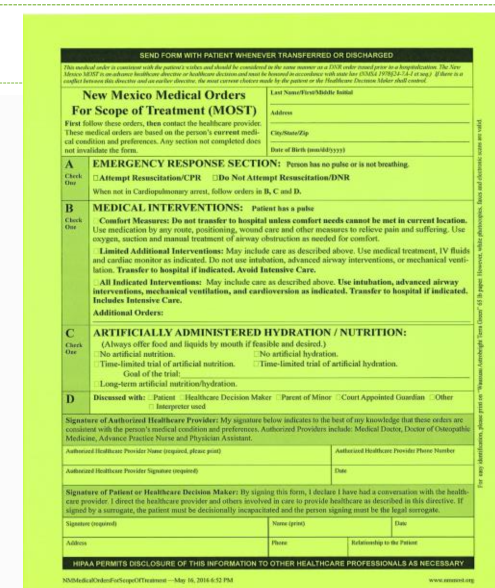
- It will be important that clinicians know the importance of reviewing a document that is already in the patient's file before creating a new document.
  - If a document reflects a patient's current wishes – a new document is not necessary
- What education opportunities exist?
- How can I support you?
- What are your goals for the new advance care planning option?
- Can we create some joint quality measures that include Vynca?

1

NEW MEXICO MOST

MEDICAL ORDERS FOR SCOPE of TREATMENT

The MOST is a two-sided bright green document that provides a short summary of treatment preferences, the option for the designation of a healthcare decision maker, and medical order for care that is easy to read in an emergency situation.



SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

This medical order is consistent with the patient's wishes and should be considered in the same manner as a DNR order issued prior to a hospitalization. The New Mexico MOST is an advance healthcare directive or healthcare decision and must be honored in accordance with state law (NMSA 1978§24-7A-1 et seq.) If there is a conflict between this directive and an earlier directive, the most current choices made by the patient or the Healthcare Decision Maker shall control.

New Mexico Medical Orders For Scope of Treatment (MOST)

First follow these orders, **then** contact the healthcare provider. These medical orders are based on the person's **current** medical condition and preferences. Any section not completed does not invalidate the form.

Last Name/First/Middle Initial

Address

City/State/Zip

Date of Birth (mm/dd/yyyy)

A Check One — **EMERGENCY RESPONSE SECTION:** Person has no pulse or is not breathing.

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR**

When not in Cardiopulmonary arrest, follow orders in **B, C** and **D.**

B Check One — **MEDICAL INTERVENTIONS:** Patient has a pulse

☐ **Comfort Measures: Do not transfer to hospital unless comfort needs cannot be met in current location.** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.

☐ **Limited Additional Interventions:** May include care as 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.**

☐ **All Indicated Interventions:** May include care as described above. **Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes Intensive Care.**

Additional Orders:

C Check One — **ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:**

(Always offer food and liquids by mouth if feasible and desired.)

☐ No artificial nutrition. ☐ No artificial hydration.

☐ Time-limited trial of artificial nutrition. ☐ Time-limited trial of artificial hydration.

Goal of the trial:

☐ Long-term artificial nutrition/hydration.

D — **Discussed with:** ☐ Patient ☐ Healthcare Decision Maker ☐ Parent of Minor ☐ Court Appointed Guardian ☐ Other ☐ Interpreter used

Signature of Authorized Healthcare Provider: My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences. Authorized Providers include: Medical Doctor, Doctor of Osteopathic Medicine, Advance Practice Nurse and Physician Assistant.

Authorized Healthcare Provider Name (required, please print)	Authorized Healthcare Provider Phone Number
Authorized Healthcare Provider Signature (required)	Date

Signature of Patient or Healthcare Decision Maker: By signing this form, I declare I have had a conversation with the healthcare provider. I direct the healthcare provider and others involved in care to provide healthcare as described in this directive. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing must be the legal surrogate.

Signature (required)	Name (print)	Date
Address	Phone	Relationship to the Patient

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NMMedicalOrdersForScopeOfTreatment —May 16, 2016 6:52 PM www.nmmost.org

For easy identification, please print on "Wausau Astrobright 'Terra Green'" 65 lb paper. However, white photocopies, faxes and electronic scans are valid.

2

The MOST program protects and promotes patient autonomy in several important ways

1. The MOST is created in conjunction with a healthcare provider and addresses a patients current situation.
2. The MOST is very visible and is transferable to other care settings.
3. The MOST is written with medical language on a standardized form.
4. The MOST is signed by a physician, APC, or PA allowing for greater compliance by other providers.

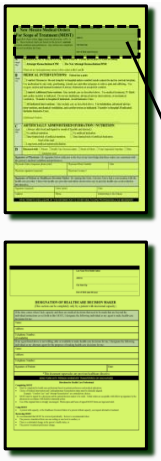
3

New Mexico MOST

- The bright green paper allows the document to be easily identified in an emergency situation
- The form should be printed on:
  - Wausuau Astrobright Terra Green 65 lb. paper
  - However plain white copies and faxes of the document are valid and should be honored

4

The MOST – in detail



- The top section of the form should be completed with the patient's:
  - Name
  - Address
  - Date of Birth
- **This is necessary to ensure proper identification**

New Mexico Medical Orders For Scope of Treatment (MOST)

First follow these orders, then contact the physician, APN, or PA. These medical orders are based on the person's **current** medical condition and preferences. Any section not completed does not invalidate the form.

Last Name/First/Middle Initial

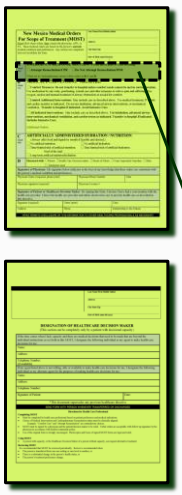
Address

City/State/Zip

Date of Birth (mm/dd/yyyy)
/ /

5

Section A – Emergency Response Section



Section A

- This section will be used to capture a patient's preference regarding resuscitation
- A patient should be counseled on all resuscitation options including:
  - The benefits and burdens of each option
  - The ability to change a resuscitation status at any time

A *Check One*	**EMERGENCY RESPONSE SECTION:** Person has no pulse or is not breathing. ☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** When not in Cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

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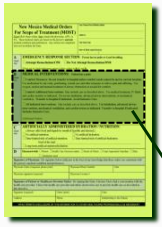
Section B: Medical Interventions



- Section "B" allows a patient to define the level of care that is consistent with their care preferences
- There are three options
- Space is provided for *Additional Orders* when necessary

B *Check One*

MEDICAL INTERVENTIONS: **Patient has a pulse**

☐ **Comfort Measures: Do not transfer to hospital unless comfort needs cannot be met in current location.** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.

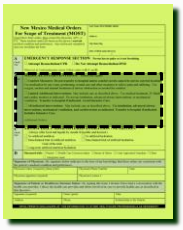
☐ **Limited Additional Interventions:** May include care as described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid Intensive Care.**

☐ **All indicated interventions:** May include care as described above. **Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes Intensive Care.**

Additional Orders:

7

Section B: Medical Interventions



- Comfort Measures – allows a patient to receive comfort care where they reside UNLESS comfort needs cannot be met in the current location

B *Check One*

MEDICAL INTERVENTIONS: **Patient has a pulse**

☐ **Comfort Measures: Do not transfer to hospital unless comfort needs cannot be met in current location.** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.

☐ **Limited Additional Interventions:** May include care as 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.**

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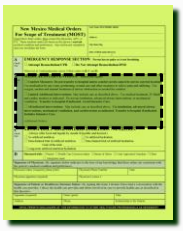
Additional Orders:

8

Section B: Medical Interventions



- Limited Additional Interventions – allows a patient to choose hospital care and limited interventions as necessary, but avoid Intensive Care / aggressive treatment

B *Check One*

MEDICAL INTERVENTIONS: **Patient has a pulse**

☐ **Comfort Measures: Do not transfer to hospital unless comfort needs cannot be met in current location.** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.

☐ **Limited Additional Interventions:** May include care as 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.**

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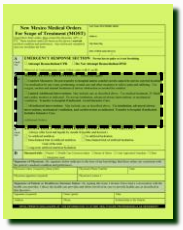
Additional Orders:

9

Section B: Medical Interventions



- All Indicated Interventions – Includes any and all medical treatment that is available including the Intensive Care Unit. It is a choice for aggressive treatment

B *Check One*

MEDICAL INTERVENTIONS: **Patient has a pulse**

☐ **Comfort Measures: Do not transfer to hospital unless comfort needs cannot be met in current location.** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.

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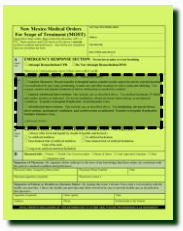
Additional Orders:

10

Section B: Medical Interventions



- Additional Orders – specific orders for starting / stopping treatments or about treatments not otherwise listed (such as dialysis, transfusions, etc.)

B *Check One*

MEDICAL INTERVENTIONS: **Patient has a pulse**

☐ **Comfort Measures: Do not transfer to hospital unless comfort needs cannot be met in current location.** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.

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Additional Orders: _____

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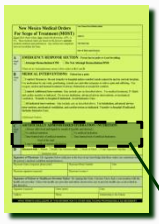
Section C: Artificially Administered Hydration / Nutrition



- This section addresses a patient's goals regarding hydration and / or nutrition
- If the time limited trail option is selected, the goal of the trial must be quantified and qualified

C *Check One*

ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:

(Always offer food and liquids by mouth if feasible and desired.)

☐ No artificial nutrition. ☐ No artificial hydration.

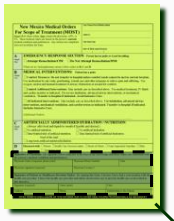
☐ Time-limited trial of artificial nutrition. ☐ Time limited trial of artificial hydration.

Goal of the trial: _____

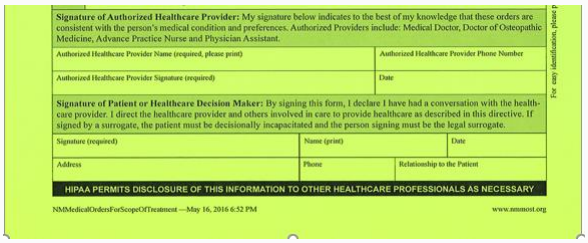
☐ Long-term artificial nutrition/hydration.

12

Physician / Patient Signature Section



- The MOST document must be signed by a physician, advance practice clinician or a physician assistant to be considered valid.
- The patient (or their legally recognized Healthcare Decision Maker / POA for Healthcare if the patient is unable to sign) must sign and date the document.



Signature of Authorized Healthcare Provider: My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences. Authorized Providers include: Medical Doctor, Doctor of Osteopathic Medicine, Advance Practice Nurse and Physician Assistant.

Authorized Healthcare Provider Name (required, please print)	Authorized Healthcare Provider Phone Number
Authorized Healthcare Provider Signature (required)	Date

Signature of Patient or Healthcare Decision Maker: By signing this form, I declare I have had a conversation with the health-care provider. I direct the healthcare provider and others involved in care to provide healthcare as described in this directive. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing must be the legal surrogate.

Signature (required)	Name (print)	Date
Address	Phone	Relationship to the Patient

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

For easy identification, print on

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Designation of a Healthcare Decision Maker (page 2)

- If a patient has not named a Healthcare Decision Maker (sometimes known as a POA for Healthcare) the back of the form provides a space to do this
- Note – this can only be completed by a patient with decisional capacity

DESIGNATION OF HEALTHCARE DECISION MAKER
(This section can be completely only by a patient with decisional capacity.)

If the time comes when I lack capacity and there are medical decisions that need to be made that are beyond the individual instructions as set forth in this MOST, I designate the following individual as my agent to make health-care decisions for me:
Name:
Address:
Telephone Number: (if available)
If my agent listed above is not willing, able or available to make health-care decisions for me, I designate the following individual as my alternate agent for the purposes of making health-care decisions for me:
Name:
Address:
Telephone Number:
Signature of Patient: Date:

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