

# Medical Orders for Scope of Treatment (MOST): Honoring Patient Preferences Across the Continuum of Care

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The Medical Orders for Scope of Treatment (MOST) form is a medical directive signed by a patient or his or her legal representative and the patient's physician, nurse practitioner, or physician assistant. Based on the national Physician Orders for Life-Sustaining Treatment (POLST) paradigm [1], the North Carolina MOST form is a bright pink document that instructs health care providers about the appropriate application of medical treatments in both emergency and nonemergency situations. Section A of the MOST form indicates whether cardiopulmonary resuscitation should be attempted (if the patient has no pulse and is not breathing), and sections B, C, and D outline the treatments the patient would want in the event of seriously illness that does not involve cardiopulmonary arrest [2]. The MOST form does not replace an advance directive (a living will or health care power of attorney); rather, it translates a patient's preferences for treatments into medical orders and conveys those orders across different settings of care.

The North Carolina MOST form was established by statute in 2007 [3]. The form is primarily intended for seriously ill patients who are at high risk of losing their ability to make medical decisions or for those who already rely on a surrogate to make medical decisions. The MOST form empowers the patient or the patient's legal representative to delineate treatment preferences regarding cardiopulmonary resuscitation, intubation with mechanical ventilation, and intensive care. Alternatively, the patient can specify a wish to avoid future hospitalizations and to receive only comfort-focused care. In addition, instructions for using or withholding antibiotics, intravenous fluids, and feeding tubes can be documented using the MOST form [2]. A sample form is available on the Web site of the North Carolina Department of Health and Human Services (<http://www.ncdhhs.gov/dhsr/ems/pdf/ncmostform.pdf>).

There is more than a decade of literature describing the use of POLST paradigm forms to communicate and honor patient preferences across the continuum of care. Nursing homes, in particular, have reported high rates of POLST form adoption [4-6]. In several states, POLST forms have been shown to accurately convey patient preferences and are associated with high rates of adherence in nursing homes [5, 7-9]. In one study [5], nursing home residents with POLST forms indicating the full scope of treatment received the same intensity of treatment as residents without a POLST form. Residents in that same study with a POLST order indicating that they wanted comfort measures only were much less likely to receive life-prolonging interventions or hospital transfers than were residents who had a POLST designation for the full scope of treatment, a tra-

ditional do not resuscitate (DNR) order, or no POLST form [5]. The accuracy of documented preferences and high rates of adherence were 2 major reasons why the POLST paradigm was included in the National Quality Forum's 2006 report describing preferred practices for palliative and hospice care quality [10].

Health care providers have identified POLST paradigm forms as useful tools for initiating conversations with patients and families about treatment preferences and for moving the conversation beyond the usual solicitation of preferences for cardiopulmonary resuscitation [11, 12]. In some cases, a nursing home resident expresses a desire to avoid future hospitalizations before specific treatment preferences are discussed [12]. If this discussion initiates a plan to provide comfort measures only and to transfer to the hospital only if symptoms cannot be controlled at the facility, then the POLST paradigm form offers a way to formalize a "do not hospitalize" order [13]. A recent study showed that a POLST order for comfort measures only was associated with high rates of dying at home or in a long-term care setting [14].

The North Carolina Division of Health Service Regulation prints and distributes the MOST form in North Carolina. Between June 2013 and April 2014, the Division's Office of Emergency Medical Services distributed 90,368 MOST forms across the state (written communication from Amy Douglas, trauma systems manager, Office of Emergency Medical Services; May 2014). In a recent statewide survey conducted by the North Carolina Institute of Medicine, nearly one-half of the 242 responding long-term care representatives and hospital case managers reported using the MOST form [15]. Respondents noted that when the form was being used in their facilities, its use was often the result of efforts by local champions; this observation has also been reported in regards to the dissemination of the POLST form in California nursing homes [6].

Despite apparently high utilization, several barriers to the use of MOST and POLST forms have been identified. Long-term care providers have been concerned that time constraints limit opportunities for form completion and that the medical language on the form may be difficult for patients and families to understand [12, 15, 16]. A general concern is losing the original form during transitions from one health care setting to another [6, 12, 15]. This has prompted some states to establish electronic registries [17].

More than 2 decades after passage of the Patient Self-Determination Act in 1990, we are still struggling to elicit, document, and communicate patient preferences for med-

ical treatments [18]. Although high-quality conversations are essential, documents play an important role in fostering discussions, recording treatment preferences, and transferring instructions to health care professionals [19]. Innovative and systematic approaches like the one facilitated by the MOST form offer new hope that patients' wishes will be honored across the continuum of health care. **NCMJ**

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