



HANDOUT

MORE ABOUT THE MOST: The MOST Conversation

1. Determine capacity: if there is any doubt, ensure that the MDPOA is present before you continue with more specific conversation.

- If competent; proceed with PERSON as decision maker.
- If not competent; ensure MDPOA is present and affirm their role.
- Proceed in presence of PERSON, ask for and listen to resident's input, but record decisions of MDPOA.

2. Explain purpose of ACP/Normalize process:

*"Advance care planning is a way for us to explore your goals and preferences, answer your questions, clarify what choices you might have to make about care and treatment, and record your decisions."
"We do this with all our [patients, clients, residents]."*

3. Ask for any previously completed documents you don't already have on file:

"Do you know if you ever completed a living will or CPR directive or medical power of attorney before? [If yes,] "Do you have them with you?" or "Can we get copies for our files?"

- If none, proceed.
- If likely but uncertain, proceed but ask agent/family member to look for them and make a note to check back.
- If available, refer to them throughout process to ensure consistency between MOST and other documents.
- **IMPORTANT: Identify MDPOA!!**

"It's possible that [during your stay with us/during your treatment], you might not be able to make your own decisions for care and treatment—for instance, if you were to become ill or if your [DIAGNOSIS] gets worse. Have you appointed a family member or friend as your healthcare agent or medical power of attorney?"

- If none, and the person is competent, do this first!!
- If none, and the person is not competent, must complete Proxy process first.

4. Explain/clarify the Healthcare Agent role:

“Basically, the healthcare agent’s job is to speak for you [the person] when you [he/she] can’t. The agent must follow and affirm any wishes or preferences that you [the person] have [has] expressed or written down. As long as you [the person] are [is] able to make your [his/her] own decisions, we will ask you [the person] for your [the person’s] wishes. The agent’s job only starts when you [the person] cannot speak for yourself [him-/ herself]. The healthcare agent, then, should be a family member or friend who knows you [the person] really well, is able to talk to you about these issues, and is able to tell us and your [the person’s] other healthcare providers what you [the person] want[s].”

- The healthcare agent is NOT responsible for financial matters or decisions unless same person holds a general or financial power of attorney.
- Clarify, expand if needed.

5. Explore understanding of medical condition, prognosis, and likely course:

*“What have your doctors told you about your [illness, injury, specific diagnosis]?”
“Has he/she talked with you about how you [illness, recovery from injury, specific dx] is likely to progress?”
“Has your doctor discussed what kind of complications might occur with this [illness, injury, specific dx]?”*

- Correct/clarify misinformation; note questions for doctor as needed
- If the person or family member ask questions, add some *information IF YOU FEEL COMPETENT TO DO SO.*

6. Explore understanding of possible risks, complications, burdens:

*“Has your doctor discussed what kind of complications might occur with this [illness, injury, specific dx]?”
“Treatment for your [diagnosis] can be pretty rough. Has your doctor discussed possible risks, side effects, or burdens from the treatment?”*

- Correct/clarify misinformation; note questions for doctor as needed
- If the person or family member ask questions or are not aware of likely complications, add some *information IF YOU FEEL COMPETENT TO DO SO.*

7. Explore/refer back to experiences: You may know the answers from the person’s records, but it’s important to hear it in their own words.

“Tell what’s been going on with your health the past few weeks/months.” [If the person has been admitted from the hospital,] “What happened that you needed to be in the hospital?”

Listen for conclusions that have been drawn from the experience: “I never want to be on that dang machine again!” or “ICU was horrible!” or “They sure took good care of me, I’m so glad I got the surgery.”

Explore what this experience meant to the resident:

“What did you learn from your experience in the hospital?” “What have you learned about your health over the past few months?”

8. Explore what “quality of life” means to the resident: Throughout – just LISTEN and ACKNOWLEDGE – don’t try to allay fears or worries unless they are based on misinformation.

“Describe for me what a ‘good day’ would be for you.”
“What activities do/did you enjoy?”
“What gives your life purpose and meaning?”
“What fears do you have when you think about your future?”
“Are you worried about particular aspects of your illness or your care?”
“What do you need right now to feel better?”
“What are your sources of strength and support?”

9. Introduce MOST form: At this point, take out the MOST form and explain:

“The MOST is a form we complete to record some very specific choices. The document is used to communicate quickly and clearly to other care providers what you want and don’t want. We will keep a copy in our chart, but this original form belongs to you and should go with you when you leave here, whether that’s to home or another facility. We’ll go through the choices and then the [doctor, PA, APN] will sign it. You will sign it too. OK?”

From your earlier conversation, you may have a very good idea of what the persons’s preferences on the MOST might be. Take your cue from that . . .

10. Complete the sections of the form: The basic formula for each of the MOST sections is the same. Repeat this pattern with each section of the form:

- Explore THE PERSON’S understanding of the plan of care or any specific treatment/procedure being proposed.
- Explore THE PERSON’S understanding of risks, burdens, possible benefits
- Explore THE PERSON’S goals or expectations for this procedure or treatment
- Explore THE PERSON’S fears or concerns.

When you are asking the person about his/her understandings, explore with:

“Tell me in your own words what you understand about [our plans for your care or the proposed treatment].”
“What are you hoping will be the result of [our plan of care or the proposed treatment]?”
“We’ll all do our very best to care for you and keep you well, but with your [particular illness or proposed treatment], it’s possible for things not to turn out as well as we’d like. Has your doctor talked over the [risks/possible complications]?”

For each section of the MOST, fill in any gaps in knowledge if you feel confident to do so, OR note down questions to ask someone else at the facility or the doctor; *leave a section blank if you need to and come back to it.*

a. Section A: CPR: It is *very important* that persons and family members be given an accurate picture of the risks and benefits of CPR. If they do not have a realistic view, you should gently – as objectively as you can – present the facts. (See CPR Information Sheet.)

“You know, CPR is really not as effective as often as people tend to think . . . ”

Use the CPR fact sheet. Allow for questions, and then ask,

“Based on everything we’ve talked about so far, what would be your preference about CPR – if your heart or breathing stop, should we try to resuscitate you?”

b. Section B: Scope of Treatment. Note that if, after a thorough discussion, **the person has selected “Yes” CPR, the only possible choice in this box is “Full Treatment.”** Let the person know this – it might prompt a further discussion or reconsideration of the CPR choice.

If the person selected “No CPR,” explain the options using the framework explained earlier and ask for their choice. You can prompt the resident based on what you’ve heard so far:

“From everything we’ve talked about so far, it sounds to me like you would prefer Comfort-focused Treatment, is that correct?”

“It sounds to me like you might be willing to have some treatment, and to go back to the hospital if you have to, but you’d prefer not to be in ICU or have very aggressive treatment, is that right?”

Alternative approach: You might consider leading with Section B, as a less scary place to start. Then, based on the answer here, the answer for Box A will likely be evident.

- If the person chooses Comfort-focused Treatment, the only possible choice for CPR is “No.”
- If choice in this box is “Selective Treatment,” CPR is possible as long as it does not involve intubation or mechanical ventilation.
- If choice in this box is “Full Treatment,” person may still refuse CPR – “everything BUT” CPR is valid.

c. MOST form Section C: Follow basic framework:

Explore understanding:

“Tell me what you understand about artificial nutrition or ‘tube feeding.’”

- Correct misinformation/misunderstandings if they arise
- Especially describe distinction between short-term tube feeding (for an acute illness, following surgery, etc.) and long-term (during severe brain injury, prolonged or permanent coma, end-stage disease, disability)

Explore understanding of risks, burdens, benefits

“Each of these options might involve particular risks, burdens, and benefits.” [IF COMFORTABLE, DESCRIBE WHAT THESE OPTION MIGHT SPECIFICALLY ENTAIL FOR THAT PERSON’S MEDICAL CONDITION]

“Do you have any questions about these possibilities?” [IF YOU CAN’T ANSWER THE QUESTIONS, NOTE THEM DOWN FOR THE PHYSICIAN]

Explore goals, expectations

“What are you hoping will be the result of tube feeding, if it were necessary?”

Explore fears or concerns

“We’ve talked a bit about the risks and complications that might result from tube feeding. When you think about the possibility of needing tube feeding, what is your biggest concern or fear?”

From this conversation, and the earlier conversation, you may be in a position to suggest which option the person might choose. For instance:

“From everything we’ve talked about so far, it sounds to me like you would accept short-term tube feeding but would not want it long-term, is that correct?”

“It sounds to me like you feel strongly that feeding should never be discontinued, is that right?”

11. Complete the action

- Obtain signatures: resident/agent; physician/ APN/PA; **ensure the signer reviews the choices!!**
- T.O.s OK; fax OK
- File/follow-up per facility policy
- Complete contact information on Side 2
- Review at quarterly care conference; any change in condition; any dc/readmission
- Send ORIGINAL with resident on transfer or discharge