

Endorsed Program Description for:		<b>COLORADO</b>	
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<b>Date Completed:</b>	10/24/2010	<b>Date Updated:</b>	2/11/2011
<b>Program Name:</b>	MOST-Medical Orders for Scope of Treatment		
<b>State or Region:</b>	Colorado		
<b>Area of Use:</b>	Statewide		
<b>Program Status Requested:</b>	<input type="checkbox"/>	No Program (possibly state contacts)	
	<input type="checkbox"/>	Developing Program	
	<input checked="" type="checkbox"/>	Endorsed by National POLST Paradigm Initiative Task Force	
<b>Name of Program:</b>	<b>MOST</b>		
<b>Program Requirements</b>			
Does the program meet the following requirements?			
Yes	No	<b>POLST PARADIGM COMPONENTS</b>	
X		1. The form constitutes a set of current (also known as standing) medical orders.	
X		2. The process includes ongoing training of health care professionals across the continuum of care about the goals of the program as well as the creation and use of the form.	
X		3. Use of the form is recommended for persons who have advanced chronic progressive illness and/or frailty, those who might die or lose decision-making capacity in the next year or anyone wishing to further define their preferences of care.	
X		4. As allowed by statute and regulations, the National POLST Paradigm Task Force <b>strongly</b> recommends that all POLST Paradigm programs require the signature of either the patient or the patient's legal representative (or witnessed verbal consent as allowed by state law) to make the form valid. The signature of the patient (or the patient's legal representative if the patient lacks decision-making capacity) provides evidence that patients or their legal representatives agree with	

		the orders on the form. In this respect, the requirement that patients or their legal representatives review and sign the form provides a safeguard for patients that the orders on the form accurately convey their preferences.
X		5. Completion of a POLST Paradigm form is a recommended preferred practice for advance care planning in multiple health care settings (eg, emergency medical services, long-term care, hospice, and hospice), but the completion of the form and the decisions recorded on it should always be a matter of voluntary, informed consent. The completion of a POLST Paradigm form should be based on the patient's goals for care to ensure that the patient receives the care he or she desires.
X		6. There is a plan for ongoing evaluation of the program and its implementation.
X		7. There is a single strong entity within the region or state that is willing to accept ownership for the program (e.g., hospital association, state dept of health, hospice and palliative care association, university-affiliated ethics center, etc) and has the resources to implement it.
<b>Form Requirements</b>		
Does the form meet the following requirements?		
<b>Yes</b>	<b>No</b>	<b>Optional</b>   <b>POLST PARADIGM COMPONENTS</b>
X		1. The treatment being considered requires a medical order that needs signature by a health care professional.
X		2. The medical order is based on medical indication and a person's preferences for treatment (e.g. as expressed in an oral statement or written advance directive).  a) The treatment is a "comfort measure"; or b) The order is an instruction regarding hospital transfer; or c) The medical order is a life-sustaining treatment that is being considered for use in a person with advanced progressive illness and/or frailty and has these characteristics: <ul style="list-style-type: none"> <li>• is <i>frequently</i> needed by health care professionals (e.g. EMS protocol, emergency department and ICU care, long-term care or hospice); and/or</li> <li>• is <i>urgently</i> needed by health care professionals (e.g. EMS protocol, emergency department and ICU care; long-term care or hospice); and/or</li> <li>• requires an <i>informed consent process that is complex</i> (e.g. tube feeding treatment); and/or is <i>not effectively specified as "Additional orders"</i>.</li> </ul>
X		3. In addition to orders with regard to CPR, the POLST Paradigm form must indicate the level of medical intervention for the patient: comfort measures only; limited additional interventions; or full treatment. The level of intervention shall contain a description of the services to be provided and the site in which they will be provided. For example, a comfort measures order may indicate that the patient is not to be transferred unless comfort needs cannot be met in the person's current setting.

X		4. The form requires a valid clinician (Physician, Nurse Practitioner or Physician Assistant depending upon POLST paradigm program) signature and a date of signature. Either the date or some other element on the form describes the effective date and there is a clear way to show which are the current orders and which are outdated or voided orders.
X		5. The form provides explicit direction about resuscitation (CPR) status if the patient is pulseless <b>and</b> apneic.
X		6. The form also includes directions about other types of intervention that the patient may or may not want. For example, decisions about transport, ICU care, artificial nutrition, etc. Space is provided for additional orders.
X		7. The form accompanies the patient, and is transferable and applicable across all care settings (i.e. home, long-term care, hospice, EMS, hospital).
X		8. The form is uniquely identifiable and standardized within a state/region.
X		9. The form indicates with whom the orders were discussed.
X		10. The form indicates a transfer option if the patient's comfort needs cannot be met in the current setting of care.

### OPTIONAL ELEMENTS

The following issues may be handled by programs in different ways depending on state law and local preferences. Does the program include the following components?

Yes	No	POSSIBLE POLST PARADIGM COMPONENTS
X		1. Ideally, a legal surrogate should be able to make decisions about treatment choices and complete a POLST Paradigm form for a patient without decision-making capacity, but states have varying laws regarding surrogates and decision-making.
X		2. Some states may recognize the form as the only out-of-hospital DNR form; in others there may be other means of DNR ID as well. Use of the form is always voluntary.
X		3. Ideally, states would accept forms completed in other states (reciprocity).
X		4. Medical orders may address antibiotics and artificially administered nutrition and hydration. This may vary based on medical practice standards, regulations or laws of that state.
X		5. The National POLST Paradigm Task Force <b>strongly recommends</b> that all original, paper POLST Paradigm forms have a bright, easily seen uniform color but recognizes that FAXED or electronic representations of the POLST Paradigm form on white paper are valid.

### EXTENT OF USE

<b>Start year:</b>	The program was introduced in 2005 as a pilot in long-term care facilities in El Paso County and rural Southern Colorado.
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<b>Settings of skills:</b>	The form is being used across all healthcare settings; home/home health, outpatient clinics, assisted living residences, long-term care and skilled nursing facilities, hospice, and hospitals. Additional organizational implementation is being evaluated by Kaiser Permanente and Total Long-term Care/PACE programs.		
<b>Range of use:</b>	Implementation has begun primarily in the long-term care setting. Processes are underway for implementation across all health care settings. Specific issues related to the ER and hospitals are being addressed.		
<b>Use by those under 18yrs:</b>	No. Use by those under 18 to be addressed at a later date.		
<b>Distributed per month:</b>	Unable to determine. The form is available for download with copying directions for the designated card stock and color.	<b>Distributed per year:</b>	Unable to determine

**HISTORY:**

The POLST document was first used in rural communities in southern Colorado and expanded to utilization in El Paso County. The paradigm then came to the attention of the newly formed Colorado Advance Directives Consortium in 2006 as one of four issues needing a collaborative effort for revision and updating, including: the Living Will Statute, the Colorado CPR Directive regulations, Surrogate/Proxy decision makers, and Portability of Advance Directives.

The Consortium includes broad representation from the medical, legal, ethics and legislative communities. In addition to physicians, attorneys, and a former state senator and representative, it includes members from the Colorado Department of Public Health and Environment, both facilities and EMS divisions, the Colorado Health Care Association, the Ombudsman Program, the Colorado Hospital Association, and the Colorado Center for Hospice and Palliative Care.

In January 2009, legislation was introduced and ultimately laid over to allow for further discussions exploring latitude in regulatory options. In January 2010, legislation was re-introduced (HB10-1122), signed May 26, 2010, with the law going into effect August 11, 2010.

**BARRIERS OVERCOME:**

Initial barriers included the interpretation and utilization of the Colorado CPR Directive regulations. A task force within the EMS Division of the Colorado Department of Public Health and Environment, with representation from the Consortium, completed a revision of the CPR Directive regulations which were adopted by the Board of Health in March 2010. Provisions to recognize and accept a MOST document (and other forms) are included in the revisions. It establishes the use of faxed copies, photocopies or other documents as valid. The physician signature requirement on the current CPR Directive form has been the source of much discussion as a barrier to honoring and implementing an individual's advance directive, and wishes, if not signed. The regulatory revisions allow electronic/faxed signatures as valid, though there remains a statutorily defined requirement for the attending physician's signature on the state CPR Directive form. Legislation was necessary to expand the latitude of the signature requirement to include Advance Practice Nurses and Physicians Assistants on a MOST form. Legislation was also needed to address the concern of following orders written by a physician, NP or PA, in a setting where they do not have privileges. There was strong consensus this be addressed legislatively as opposed to a regulatory or standard of practice policy within individual facilities.

The legislation establishes:

- the requirement of health care providers to honor MOST orders across settings;
- the signature requirement includes physicians, advance practice nurses and physicians assistants;
- the form must be signed by the individual (or substitute decision maker when indicated);
- the validity of photocopies, faxed or electronic versions (including signatures);

- immunity for honoring a MOST form that appears valid;
- reciprocity to accept and honor POLST-like documents from other states

Educational efforts will be an ongoing process relative to the implementation of new processes as well as a change in the culture of long established practices. A MOST training and “train the trainer” curriculum has been established with statewide educational opportunities targeting providers in all healthcare settings. This is a collaborative effort utilizing the infrastructure of the Colorado Hospital Association, the Colorado Health Care Association, the Colorado Department of Public Health and Environment, the Colorado Center for Hospice and Palliative Care, and is coordinated by the Colorado Advance Directives Consortium and Life Quality Institute.

#### **STATE LAW AND REGULATIONS:**

**C.R.S. § 15-18.7** Directives Concerning Medical Orders for Scope of Treatment

*Other related statutes and regulations include:*

**C.R.S. § 15-18.6** Directive Relating to Cardiopulmonary Resuscitation

**6 CCR 1015-2** Rules Pertaining to the Implementation of CPR Directives by EMS Personnel (Colorado CPR Directive regulations-revised 2010)

**C.R.S. § 15-18.5** Proxy Decision-makers for Medical Treatment and Surrogate Decision-makers for Health Care Benefit Decisions (specifically 15-18.5-103(6) regarding ANH)

**C.R.S. § 15-18** Colorado Medical Treatment Decision Act –updated 2010 (Living Will revisions)

**C.R.S. § 25-1-1204** Concerning a Central On-line Registry of Medical Orders for Scope of Treatment Forms (passed in 2010 but no fiscal note to fund, does allow for a private entity to develop)

#### **POLST IN THE HEALTH CARE SETTING**

##### **Policies (hospitals, nursing homes, EMS, etc.):**

Specific policy and procedures are being developed across all settings. In the long-term care setting and assisted living residences utilizing the resources of the Colorado Health Care Association, for EMS through the Colorado Department of Public Health and Environment, ER practices in collaboration with the Colorado Chapter of the American College of Emergency Physicians, in specific hospital systems in conjunction with the Colorado Hospital Association, and for hospice organizations through the Colorado Center for Hospice and Palliative Care. Individual policy and procedures within other care settings, (i.e. Veterans Health Administration, Kaiser, etc.), will be encouraged using the guidelines available through the National POLST Paradigm Initiative Task Force and in conjunction with the Colorado Advance Directives Consortium.

##### **Registry for POLST Paradigm Forms:**

**C.R.S. § 25-1-1204** Concerning a Central On-line Registry of Medical Orders for Scope of Treatment Forms (passed in 2010 but no fiscal note to fund, does allow for a private entity to develop)  
Mechanisms to implement are currently being evaluated.

#### **MANAGEMENT**

##### **Describe program management:**

The Colorado Advance Directives Consortium in conjunction with Life Quality Institute and in collaboration with the Colorado Hospital Association and Colorado Health Care Association.

##### **Who will distribute forms:**

The form is available for download, with copying directions for the designated card stock and color, from the Consortium web site at [www.ColoradoAdvanceDirectives.com](http://www.ColoradoAdvanceDirectives.com) .

##### **How will oversight of the program ensure quality:**

Ongoing education and training to ensure consistency in the implementation are key components of the oversight. Continued monitoring and feedback from stakeholders has been established to identify any inconsistencies.

Outcome measures are being established to quantify the important quality components.

## **TRAINING**

### **Training for health care professionals:**

A MOST implementation curriculum has started with a full day “train the trainer” program and has included participants from all health care settings and from all areas of the state including rural communities as well as metropolitan communities. A statewide educational program through the Colorado Center for Hospice and Palliative Care focusing on advance care planning has been active for the last 3-4 years. These presenters have participated in the “train the trainer” program and are including education for MOST implementation in their programs and communities. Focused education to specific provider groups, including EMS, is underway. Presentations to various annual conferences of state organizations have been done or are scheduled.

Educational offerings, implementation handbook, FAQs, and links to resources are available on our website at [www.ColoradoAdvanceDirectives.com](http://www.ColoradoAdvanceDirectives.com) . Focused educational sessions have been underway addressing the complexities of the advance care planning processes related to statutes and regulations including the role of MOST in the process. Web-based training resources are being developed. A monthly conference call for individuals who have completed the training and are beginning implementation started in September 2010. These calls facilitate networking statewide and provide a forum for discussion and identifying any problems or challenges in the process.

### **Training to assure that health care professionals who discuss the choices offered on the POLST Paradigm form are competent to conduct and facilitate these discussions and decisions with their patients or surrogates:**

Initial training will utilize the resources available on the POLST web site and utilizing the models and materials developed in current programs and available on their web sites. Plans for a more formal training program in “having the conversation” utilizing the *Respecting Choices*® program in LaCrosse, WI, is planned and will be implemented in 2011.

### **Training for the public and patients:**

The Colorado Center for Hospice and Palliative Care-Advance Care Planning Workgroup began a statewide initiative for advance care planning education and awareness in 2007. Training of these presenters specifically on MOST and the paradigm has started. Their expertise and contacts in multiple parts of the state will be utilized to extend the education and awareness of the POLST Paradigm and MOST to their communities.

## **EVALUATION**

### **CQI projects and research:**

Initial qualitative and limited quantitative data collection has started. Specific projects and measures are yet to be determined and will be aligned with national efforts and design.

## **ADDITIONAL INFORMATION**