



What?

- MOST stands for Medical Orders for Scope of Treatment.
- It is medical orders that outline a plan of care respecting the patient's wishes after being diagnosed with a terminal condition in the last year of life.
- MOST is a voluntary, transportable medical order signed by a health care provider and a patient or authorized representative which is valid across all care settings and in all facilities, including the home.

Why?

- The goal of the MOST initiative is to inform and empower patients to clearly state their end-of-life care wishes, to activate (where applicable) an advance directive, and to authorize health care providers to carry out those wishes.
- A MOST form is standardized medical orders that help patients keep control over what medical care they wish to receive after being diagnosed with a terminal illness.

How?

The MOST form must be prepared by a medical provider in consultation with the patient. MOST must be signed and dated by an MD, DO, NP or PA and the patient or patient's authorized representative.



The National POLST Paradigm is an approach to end-of-life planning and began in 1991 designed to support patients transitioning between facilities by communicating patient treatment wishes. South Dakota is one of the last states to join the POLST movement in promoting advance care planning conversations between healthcare professionals and patients. South Dakota passed senate bill 118 in 2019 to establish the South Dakota MOST, Medical Orders for Scope of Treatment, which was developed by LifeCircle South Dakota, a statewide collaboration of institutions, organizations and people committed to improving end-of-life care.

A MOST form is portable, actionable medical orders for a patient diagnosed with a terminal condition that helps ensure patient treatment wishes are known and honored, and helps prevent initiation of unwanted, disproportionately burdensome treatment. MOST is a medical order, not an advance directive. An advance directive is a legal document and mechanism for naming a durable power of attorney for healthcare (a healthcare agent) and/or a living will (providing general treatment wishes). Patients diagnosed with a terminal condition should have both documents as a part of their advance care plan.



MOST is voluntary. It is shared decision-making between patients and health care providers. The conversation involves the patient discussing his/her values, beliefs and goals for care, and the health care provider presents the patient's diagnosis, prognosis, and treatment alternatives, including the benefits and burdens of life-sustaining treatment. Together they reach an informed decision about desired treatment.

A MOST allows patients to make decisions consistent with the United States Conference of Catholic Bishops Ethical and Religious Directives for Catholic Health Care Services (ERDs).

MOST:

- Is a thoughtful, facilitated, advance care planning conversation between health care providers, patients, and those close to them, to determine what treatments patients do and do not want based on their personal beliefs and current state of health.
- Helps ensure the provision of reverent care and appropriate medical treatment that support the patient's goals and wishes throughout the patient's life and during the process of natural death.
- Helps prevent the use of medical interventions that are unwanted, ineffective, burdensome and/or do not support the patient's goals and wishes.



Providers

- A MOST form must be completed by a physician, nurse practitioner or physician assistant based on a patient's preferences and/or best interests and medical indications.
- South Dakota MOST must be signed and dated by a MD, DO, NP or PA to be valid.
- If there is a conflict between a patient's MOST and a patient's oral directives, or any written directives in an advance health care directive, the medical provider shall treat the patient in accordance with the most recent instruction.
- Medical providers and their patients must evaluate the use of technology at their disposal based on available information. Judgements about the use of technology to maintain life must reflect the inherent dignity of the patient and the purpose of medical care. The purpose of medical care should be to ensure that everyone is treated with dignity and respect.
- Any medical provider who receives a valid MOST will make the document part of the patient's medical record.
- A document executed in another state or jurisdiction that meets the requirements for a valid medical orders for scope of treatment in that state or jurisdiction is valid in this state.

Patients

- A MOST form is only for patients who have a terminal condition as defined by SD law as an incurable and irreversible condition such that death is imminent if life-sustaining treatment is not administered.
- A MOST Form give patients more control over receiving treatments they want to receive and avoiding treatments they do not want to receive in the event they are not able to speak for themselves during a medical emergency.
- A MOST is voluntary and should never be mandatory.
- South Dakota MOST must be signed by the patient or the patient's authorized representative.
- Patients should be aware that a MOST may override the directives contained in their Power of Attorney or living will if executed prior to the MOST.
- If an agent has been appointed under a healthcare power of attorney, the agent shall be the authorized representative under the MOST.
- A patient who wishes to revoke their MOST must do so by communicating their wishes to their medical provider.

Resources

MOST Form

The MOST form is available on the South Dakota Department of Health website or at your healthcare facility. www.doh.sd.gov

South Dakota Senate Bill 118

Senate bill 118, to establish certain provisions regarding advance care planning, was signed by the governor on March 27, 2019.

LifeCircle South Dakota

The South Dakota MOST program was developed by LifeCircle South Dakota. LifeCircle is a statewide collaboration of institutions, organizations and people committed to improving end-of-life care. The organization is governed by an advisory committee and is based in the Sanford School of Medicine since 1999. (<https://sdaho.org/lifecircle/>)

National POLST Paradigm

Recognizing that advance directives were inadequate for the patients with serious illness or frailty, who frequently require emergency medical care. A group of stakeholders developed a new tool for honoring patients' wishes for end-of-life treatment. After several years of evaluation, the program became known as Physician Orders for Life-Sustaining Treatment (POLST). (www.polst.org)

Advance Care Planning South Dakota

In order to meet South Dakota's need for Advance Care Planning (ACP), in 2015 the University of South Dakota's (USD) Department of Nursing assembled an interdisciplinary collaborative network of health professionals called Advanced Care Planning: Quality Conversations. Ever since then, this coalition of health care educators and providers has come together to discuss strategies that help implement ACP across South Dakota. The mission of the group is to enable greater access to Advance Care Planning conversations for adults in South Dakota through quality, collaborative healthcare. (www.advancedcareplanningsd.com)