*This is an Interior Health CONTROLLED document. A copy of this document in paper form is not controlled and should be checked against the electronic file version to ensure accuracy*



# AH4000 - MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) AND ADVANCE CARE PLANNING (ACP)

## 1.0 PURPOSE

To utilize a person-centered approach to ensure an adult's wishes and/or instructions are acknowledged and respected regarding their health care and end of life care.

To provide a standardized framework and documentation process for conversations about advance care planning, goals of care and determining medically appropriate treatment interventions. The MOST Designation Form (*MOST Form*) translates actionable medical orders that provide direction on code status, critical care interventions and medical interventions based on consideration of the adult's preferences as well as their current health status. The outcome of the ACP/Goals of Care/MOST Cycle is the completion of the *MOST Form* and an individualized Plan of Care which creates a transparent and accountable process for determining medically appropriate care.

To acknowledge the authority of physicians and nurse practitioners (Most Responsible Practitioner) to complete the IH MOST Designation Form.

To standardize the Most Responsible Practitioner (MRP) orders regarding resuscitation status (code status) and scope of health care treatment decisions.

To articulate and manage expectations of one or more of the four goals of medical treatment:

(a) prevention of disease; (b) curative; (c) disease management; and, (d) palliative/comfort care.

## 2.0 DEFINITIONS

See Appendix A

## 3.0 POLICY

### 3.1 Scope

This policy applies to adults (19 years of age or older) where clinically relevant and appropriate.

It ***does not*** apply to children or to the psychiatric treatment of patients who are involuntarily detained under the *Mental Health Act.* However, it ***does*** apply to the non-psychiatric treatment of involuntary patients.

### 3.2 Medical Orders for Scope of Treatment (MOST) Process and Practice

1. The MOST orders are determined by the MRP and encompass six designations that provide direction on: a) Resuscitation Status (code status); b) Critical Care Interventions; and, c) Medical Interventions.

Additional instructions regarding **Specific Interventions** (Appendix B), as appropriate, can be noted but further details would be found on the relevant *Patient Consent Record*.

2. This policy applies to all Interior Health programs and care settings with the exceptions identified in 3.1 above. Therefore all physicians, nurse practitioners (NP) and staff, contracted service providers, students and other persons acting on behalf of Interior Health are obligated to follow this policy and adhere to MOST practices and processes.

   The *MOST Form* is recognized and honoured by the British Columbia Emergency Health Service (BCEHS).

3. The *MOST Form* is completed as an outcome of ACP conversations with an adult capable of providing consent to health care; or, if the adult is no longer capable, by reviewing an available Advance Directive (AD) specific to the health care treatment being proposed; or finally, in the absence of obtaining consent from the capable adult or AD, by approaching their Substitute Decision Maker (SDM) for substitute consent. The ACP conversations should be documented in the health record.

4. The *MOST Form* must be completed by an MRP clarifying the degree of health care interventions and treatments to be provided. The current *MOST F*orm will be filed in the health record and faxed to 1-855-980-6180 for uploading into Meditech.

   i. A new *MOST Form* needs to be completed if there is a change or addition to the previous MOST designation. The previous *MOST Form* should be voided by drawing a line through the form and adding the date the form was voided with the signature of the person who voided the form. The revised *Most Form* is to be placed in the health record.

   ii. The adult will be provided with a copy of their current *Most Form*.

5. Consent will always be sought from the adult directly as long as the adult is capable to provide consent. The adult's previous *MOST Form*, in this situation, would be referenced to reaffirm prior decisions around goals of care and scope of treatment (IH Policy AL0100 Consent - Adults). If an adult has refused consent to a health care treatment (referred to as 'consent refusal'), the Health Care Provider (HCP), upon learning of the consent refusal, must stop or withdraw treatment as per the Health Care (Consent) and Care Facility (Admission) Act (otherwise referred to as the *Consent Act*).

6. The MRP is ultimately responsible for the discussion and documentation of the MOST designation. This includes documentation of the process by which the MOST designation was determined. Reasonable efforts should be made to identify, obtain and understand prior written instructions or wishes in whatever form they exist and to place them in the health record.

7. Another physician/nurse practitioner overseeing care or providing additional care may complete a *MOST Form* provided the situation has been discussed with the MRP, and the physician/nurse practitioner is prepared to complete the required documentation as described in this policy.

8. In the absence of an existing *MOST Form*, a telephone order from the attending MRP may be accepted for a MOST designation by a: registered nurse, registered psychiatric nurse or licensed practical nurse. The MOST designation would then be written by the nurse as a MRP order. As soon as possible, the *MOST Form* would be completed/revised and signed by the MRP and processed according to this policy.

9. A MOST designation requires review and revalidation annually:

   i. If the review indicates that changes are necessary, a new *MOST Form* is to be completed;

   ii. If no changes are required to the current MOST designation, the original[1] *MOST Form* can be revalidated by the MRP by signing and dating it;

   iii. If the original *MOST Form* is not available, a new *MOST Form* must be completed;

   iv. Where no review has taken place within the 12 month time frame, it must be completed as soon as possible.

10. A *MOST Form* will be initiated or reviewed in the context of significant changes in the adult's condition or circumstances relevant to MOST. Review of the adult's plan of care should also be done to ensure it remains current.

11. Review of the *MOST Form* is the responsibility of the MRP, in conjunction with: the health care team; the capable adult; or, if the adult is no longer capable, through their AD; or finally, with the SDM.

12. An existing *MOST Form* will be reviewed by an adult's MRP within the following care settings and time frames:

   i. Acute Care Facility – within twenty-four (24) hours of admission and/or prior to discharge, whichever is shorter;

   ii. Long-term Care Homes – within sixty (60) days of admission and at least every twelve (12) months;

   iii. Renal Program – within ninety (90) days of admission and at least every twelve (12) months;

   iv. Assisted Living, Home Health, Primary Care and clinic settings – at least every twelve (12) months;

   v. IH Palliative Program – upon registration and at least every twelve (12) months; or

   vi. Community Hospice – prior to admission.

13. If an adult is transferred from an institution outside of Interior Health with existing medical orders, those orders remain in place until they are reviewed by the receiving MRP. The receiving MRP ensures an IH *MOST Form* is written within the time frames noted in 3.2 (12). The IH *MOST Form* will be placed at the front of the

---

[1] Original refers to a 'first copy', not a photocopy or scanned document.

health record and be processed electronically as per the MOST Guide for Use (Appendix B). In addition, if a Provincial No Cardiopulmonary Resuscitation – Medical Order (*BC No CPR Order*) is in place, it *must* be consistent with the current MOST designation.

14. The capable adult or SDM should be offered a copy of the *MOST Form*.

**3.3 Advance Care Planning (ACP) Process and Practice**

1. Interior Health supports HCPs to engage in ACP conversations with adults, and their families or substitute decision makers (SDM), in all care settings.
2. ACP is a process that ought to involve interprofessional collaboration early in a capable adult's course of care/treatment and encompass discussions regarding:
   i. Understanding what is important to the adult regarding their quality of life;
   ii. Provision and clarification of medical information about disease progression, prognosis and treatment options to clarify goals of care and consent decisions;
   iii. Personal planning options and related scope of authority as per the *Consent Act* and Representation Agreement Act and/or the Patient's Property Act.
3. Any known consent refusal in an AD must be adhered to by HCPs. Consent for specific treatment in an AD may be followed depending on the health assessment at the time the treatment is being proposed by the HCP. A valid AD must meet legislative requirements as set in the *Consent Act*.
4. Adults, or their SDMs, have a responsibility to inform HCPs if the adult's Advance Care Plan includes an AD, and/or a Representation Agreement. HCPs must then review these documents to ensure alignment with the MOST designation.

**3.4 Emergency Health Care Interventions and Decisions Regarding Resuscitation**

1. Cardiopulmonary Resuscitation (CPR) is an intervention that has the highest chance for success in adults whose cardiac arrest is due to a known/witnessed acute cardiac arrhythmia.
2. When a cardiac arrest is witnessed in the absence of a MOST designation, CPR will be initiated and appropriate orders clarified as soon as possible. In community settings where resuscitation status has not been clarified by the MRP, or there is no MOST designation or *BC No CPR Order*, 911 should be called.
3. CPR is not recommended for an adult who has suffered an un-witnessed cardiac arrest unless they are observed within minutes of the event (e.g. another bystander). When a cardiac arrest is un-witnessed and vital signs, including agonal breathing movements (e.g. attempts at spontaneous respiration or swallowing), are completely absent, there is no indication for resuscitation. If agonal signs are present, or there is a high degree of uncertainty, staff trained in CPR may initiate CPR and/or call 911 or Code Blue depending on the setting.

4. A physician/nurse practitioner assessment regarding the benefit of CPR, based on best clinical judgment, forms the basis of recommendations offered to the capable adult and/or SDM regarding their MOST designation.

5. A physician/nurse practitioner is not obligated to offer treatment (based on their health assessment) where there would be no benefit of that treatment, for example in an emergency situation where an adult is at or near the end of an irreversible disease process, or dying from an acute disease process known to be unresponsive to CPR, or where a consent refusal for that specific intervention in the adult's AD is indicated.

   A person-centered approach regarding communication and documentation of the clinically-appropriate course of treatment and plan of care is required.

6. Where consent is in place for organ donation, life support interventions ought to be continued for optimal viability of the organs even after the pronouncement of neurologic death. In cases of organ donation after cardio-circulatory death, life sustaining interventions ought to support organ retrieval.

### 3.5 Communication Issues and Dispute Resolution

1. Standardized MOST practices and processes will enhance person-centered care with adults as full partners; support care transitions; and heighten clear, concise and effective communication regarding goals of care and treatment choices.

2. Should a dispute occur regarding a MOST designation, efforts will be made to support a resolution as quickly as possible. HCPs should look to resources that build on existing relationships and escalate regionally as required. The MRP may seek opinions from other HCPs with knowledge and skills relevant to the circumstances of the adult's condition.

3. A clinical ethics consultation may be requested to provide support and guidance in resolving ethical dilemmas that arise in specific situations.

4. Consultation for guidance on capability issues, abuse and/or neglect may also be required by professionals.

5. If appropriate avenues of decision support and dispute resolution have been explored, including second opinion review and consultation, and disagreement persists the MRP:

   i. **if the proposed treatment being disputed has not been started**, may, based on best clinical and professional judgment, assign a MOST designation and inform the adult and/or substitute decision maker; or

   ii. **if the disputed treatment has been started** and there is consideration to discontinue such treatment, will discontinue the treatment and complete a new *MOST Form* to reflect this change only after obtaining consent from either the capable adult or their SDM.

6. The capable adult or SDM should be made aware of dispute resolution resources (IH Policy: AK0100-Client Complaint Management) should they wish to elevate a complaint.

7. Risk Management should be consulted when there are concerns related to potential litigation.

## 4.0 PROCEDURES

Refer to Appendix B: MOST Form Guide for Use and Appendix C: Summary of Process.

## 5.0 REFERENCES

BC Medical Association. (2011). *Health care consent laws are changing. What you need to know.* Retrieved from https://www.doctorsofbc.ca/sites/default/files/advance-directive-primer_booklet_webupdatedfeb72013.pdf

BC Medical Association. (n.d.) *Advance Directives.* Victoria: Queen's Printer. Retrieved from https://www.doctorsofbc.ca/news/advance-directives

Government of British Columbia. (1996). *Adult Guardianship Act.* [RSCB 1996] Chapter 6. Victoria: Queen's Printer. Retrieved from http://www.bclaws.ca/Recon/document/ID/freeside/00_96006_01

Government of British Columbia. (1996*). Health Care (Consent) Act and Care Facility (Admission) Act*. [RSBC 1996] Chapter 181. Victoria: Queen's Printer. Retrieved from http://www.bclaws.ca/civix/document/id/complete/statreg/96181_01

Government of British Columbia. (1996). *Patient's Property Act*. [RSBC 1996] Chapter 349. Victoria: Queen's Printer. Retrieved from http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96349_01

Government of British Columbia. (1996). *Representation Agreement Act*. [RSBC 1996] Chapter 405. Victoria: Queen's Printer. Retrieved from http://www.bclaws.ca/Recon/document/ID/freeside/00_96405_01

Government of British Columbia. (2009). *No Cardiopulmonary Resuscitation.* HLTH 302.1. Retrieved from https://www2.gov.bc.ca/assets/gov/health/forms/302fil.pdf

Government of British Columbia. (2011, July). *Health Care Providers' Guide to Consent to Health Care. Ministry Of Health.* Victoria: Queen's Printer. Retrieved from http://www.cotbc.org/PDFs/HealthProvidersGuidetoConsenttoHealthCare.aspx

Government of British Columbia. (2013). Ministry of Health. *My Voice: Expressing My Wishes for Future Health Care Treatment. Advance Care Planning Guide*. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf

Interior Health. (2011, January). AL0200 Consent – Persons Under 19 Years of Age. *Administrative Policy Manual.* Retrieved from http://insidenet.interiorhealth.ca/infoResources/policies/Documents/Consent%20-%20Persons%20Under%2019%20Years%20of%20Age.pdf

Interior Health. (2012, May). AL0100 Consent – Adult. *Administrative Policy Manual.* Retrieved from http://insidenet.interiorhealth.ca/infoResources/policies/Documents/Consent%20-%20Adults.pdf

*This is an Interior Health CONTROLLED document. A copy of this document in paper form is not controlled and should be checked against the electronic file version to ensure accuracy*



Interior Health. (2013, October). MSQ0100 - Most Responsible Practitioner. *Medical Staff Policy Manual.* Retrieved from http://insidenet.interiorhealth.ca/infoResources/policies/Documents/Most%20Responsible%20Practitioner.pdf

Interior Health. (2014, August). AK0100 Client Complaint Management. *Administrative Policy Manual.* Retrieved from http://insidenet.interiorhealth.ca/infoResources/policies/Documents/Client%20Complaint%20Management.pdf

Public Guardian and Trustee of British Columbia. (2014). *It's Your Choice Personal Planning Tools*. Retrieved from http://www.trustee.bc.ca/documents/STA/It's_Your_Choice-Personal_Planning_Tools.pdf

Additional Resources

Additional MOST/ACP resources are available on the InsideNet and the IH Public website.

## APPENDIX A: DEFINITIONS

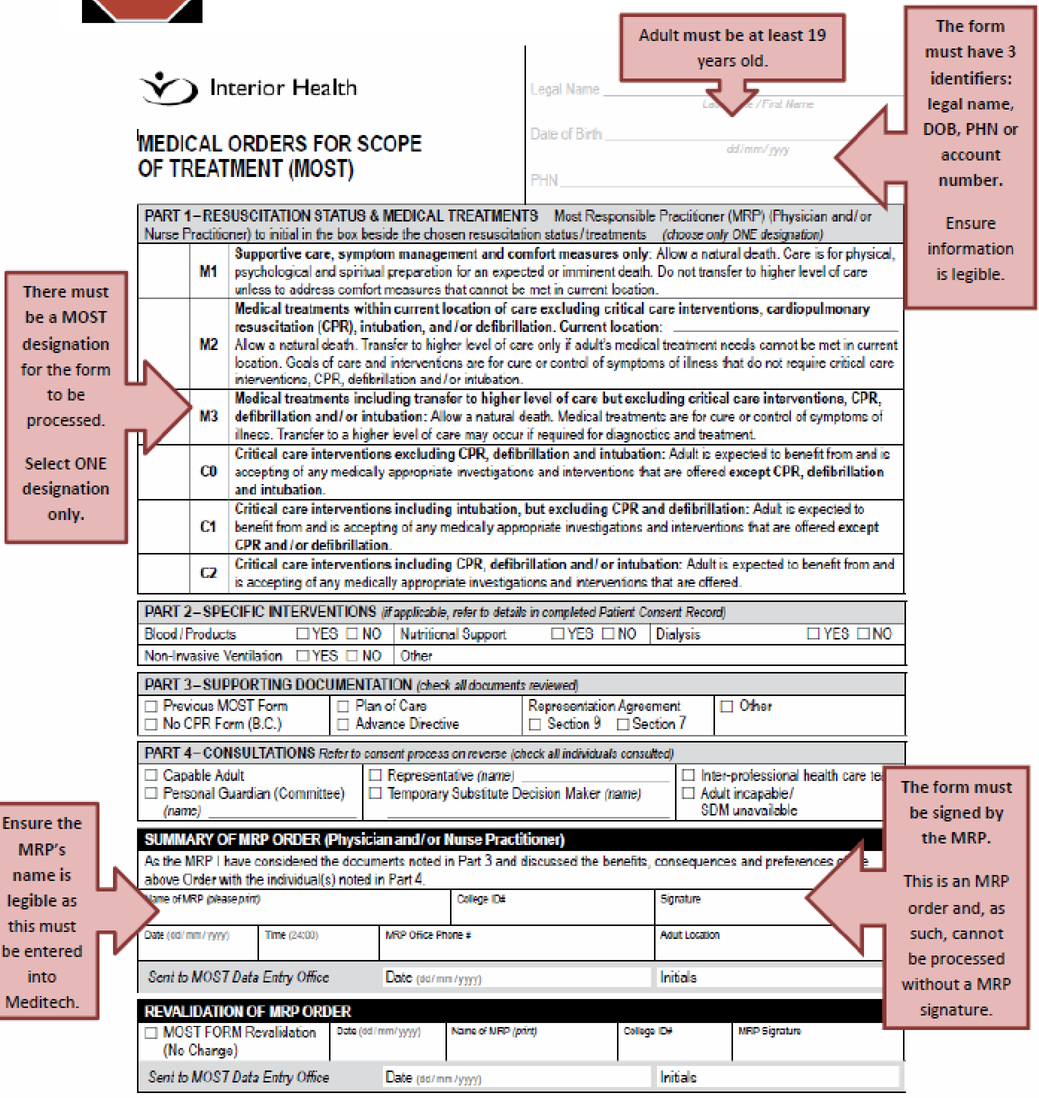
| TERM | DEFINITION |
| --- | --- |
| **Adult:** | In British Columbia, refers to a person 19 years of age or older. |
| **Advance Care Plan (ACP):** | A summary of a capable adult's wishes or instructions. This summary may include documents such as an Advance Directive (AD) and/or Representation Agreement. |
| **Advance Care Planning:** | The ongoing discussion between the capable adult; the MRP and HCP team; family; and others regarding the adult's beliefs, values and wishes regarding health care they wish to consent to or refuse in advance of a situation when they are incapable of making health decisions. (*MoH My Voice Expressing My Wishes for Future Health Care Treatment Advance Care Planning Guide*) |
| **Advance Directive (AD):** | A written instruction, completed by a 'capable adult', that provide instructions directly to the health care provider about the healthcare treatment the adult consents to or refuses. It is effective when the capable adult becomes incapable and only applies to the health care conditions and treatments noted in the AD. An AD that meets the requirements per the *Consent Act*, supersedes the wishes and desires regarding treatment of all others. |
| **Capable Adult:** | All adults are presumed to be capable of making health care decisions until there is clear evidence that the adult is incapable of making a clear decision. In deciding incapability, the decision must be based on whether the adult demonstrates that they:<br>• Understand the information being given about the health condition<br>• Understand the nature of the proposed health care<br>• Understand the information provided applies to them |
| **Cardiac Defibrillation:** | Administration of an electric shock delivered through a device on the exterior of the chest wall intended to normalize or restore the rhythm of the heart. |
| **Comfort Care:** | Refers to medical care for symptom control, psychological and spiritual support with a palliative approach to care. |
| **Committee of Person (also called Personal Guardian):** | Person appointed by the court under the *Patients Property Act* to be the Personal Guardian of an adult. The powers of a Committee of Person, though extensive, can be limited by restrictions imposed in the court order. |
| **Cardio-Pulmonary Resuscitation (CPR):** | Defined as the manual application of chest compressions and ventilation. |

| TERM | DEFINITION |
| --- | --- |
| **Critical Care Interventions:** | Interventions that require advanced monitoring and higher levels of care. |
| **Health Care Provider (HCP):** | A licensed, certified, or registered Professional to provide health care under the Health Care Professions Act and the Social Workers Act. |
| **Health Care (Consent) and Care Facility (Admission) Act - BC:** | Referred to as the *Consent Act*. |
| **Health Care Treatment:** | Anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic, or other health care purpose and may be a series of similar treatments or care given over time or a plan for a variety of care purposes for up to one year. |
| **Intubation:** | The insertion of an endotracheal tube into the trachea to assist with breathing. |
| **Life Prolonging Medical Interventions:** | Health care treatments such as tube feedings, ventilators, kidney dialysis, medications, and cardiopulmonary resuscitation. The Intensive Care Unit (ICU) typically is a location where such interventions are provided in an attempt to restore normal physiology, however, not exclusively. These interventions are considered 'Medically Appropriate Care' when the goal of care is to continue or prolong life. |
| **Medically Appropriate Care:** | Health care treatment offered by a health care provider that is consistent with the adult's condition and goals of care, based on the health care provider's clinical assessment. |
| **MOST Designation Form** | The MOST Designation Form (*MOST Form*) is a document completed by the MRP that translates actionable medical orders that provide direction on code status, critical care interventions and medical interventions based on consideration of the adult's preferences as well as their current health status. |
| **Most Responsible Practitioner (MRP):** | MSQ0100 – Most Responsible Practitioner represents a Physician or Nurse Practitioner. |
| **Non-beneficial Medical Treatments:** | Treatments where, in the best clinical judgment of a MRP, there is no clinical benefit or reasonable hope of recovery or improvement. |
| **Nurse:** | Registered Nurse, Registered Psychiatric Nurse, Licensed Practical Nurse |

| TERM | DEFINITION |
|---|---|
| **Nurse Practitioner (NP):** | Registered Nurse who has met the requirements of the profession to be registered and to use the title of Nurse Practitioner. NPs provide expanded nursing services including diagnosing, prescribing, ordering tests and managing common acute illnesses and chronic conditions. |
| **Plan of Care:** | An interprofessional documentation tool that outlines the care for the adult, and reflects their needs and goals which all health care team members need to consider in their interactions with the adult. |
| **Public Guardian and Trustee (PGT):** | A corporation established under the Public Guardian and Trustee Act which includes a mandate to serve adults requiring assistance in decision-making through protection of their legal rights, financial interests and personal care interests. |
| **Representation Agreement:** | Two types of agreements (Section 7RA or 9RA) in which a capable adult names their representative to make health care treatment decisions and other decisions on their own behalf when incapable. Scope of authority is dependent on the type of agreement as well as the scope of decisions laid out by the capable adult. |
| **Representative:** | A person 19 years or older who is named by a capable adult in a Representation Agreement to make health care treatment decisions and other decisions on their behalf when no longer capable of providing consent decisions. |
| **Substitute Decision Maker (SDM):** | A capable adult with authority to make health care treatment decisions on behalf of an incapable adult. There are three types of SDMs: Committee of Person/Personal Guardian; Representative; and Temporary Substitute Decision Maker. |
| **Temporary Substitute Decision-Maker (TSDM):** | In the absence of an available Representative, an adult is chosen in ranking order by the HCP as per the *Consent Act*. The Health Care Providers' Guide to Consent to Health Care is another resource. The selected TSDM will be qualified, willing and available to make health care treatment decisions on behalf of the incapable adult when substitute consent is needed. A TSDM appointment is time-specific and applies only to the health issue at hand, and is not authorized to make health care treatment decisions in advance of a proposed treatment being offered by the MRP. |
| **Un-witnessed Arrests:** | An arrest is considered un-witnessed when the adult is found with no vital signs, unresponsive pupils, no spontaneous attempts at respiration and no other agonal movements (e.g. attempts to swallow), and where there are no clues of any kind to indicate when the actual cessation of consciousness occurred. |

## APPENDIX B – MOST Form Guide for Use

[MOST Form Guide for Use]



STOP **IMPORTANT REMINDERS:** Check the following information before sending to MOST Data Entry Office

Adult must be at least 19 years old.

The form must have 3 identifiers: legal name, DOB, PHN or account number.

Ensure information is legible.

Interior Health

MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)

Legal Name ______ Last Name / First Name

Date of Birth ______ dd/mm/yyyy

PHN ______

There must be a MOST designation for the form to be processed.

Select ONE designation only.

| PART 1 – RESUSCITATION STATUS & MEDICAL TREATMENTS Most Responsible Practitioner (MRP) (Physician and/or Nurse Practitioner) to initial in the box beside the chosen resuscitation status/treatments *(choose only ONE designation)* | | |
|---|---|---|
| | M1 | **Supportive care, symptom management and comfort measures only**: Allow a natural death. Care is for physical, psychological and spiritual preparation for an expected or imminent death. Do not transfer to higher level of care unless to address comfort measures that cannot be met in current location. |
| | M2 | **Medical treatments within current location of care excluding critical care interventions, cardiopulmonary resuscitation (CPR), intubation, and/or defibrillation. Current location:** ______ Allow a natural death. Transfer to higher level of care only if adult's medical treatment needs cannot be met in current location. Goals of care and interventions are for cure or control of symptoms of illness that do not require critical care interventions, CPR, defibrillation and/or intubation. |
| | M3 | **Medical treatments including transfer to higher level of care but excluding critical care interventions, CPR, defibrillation and/or intubation:** Allow a natural death. Medical treatments are for cure or control of symptoms of illness. Transfer to a higher level of care may occur if required for diagnostic and treatment. |
| | C0 | **Critical care interventions excluding CPR, defibrillation and intubation:** Adult is expected to benefit from and is accepting of any medically appropriate investigations and interventions that are offered **except CPR, defibrillation and intubation.** |
| | C1 | **Critical care interventions including intubation, but excluding CPR and defibrillation:** Adult is expected to benefit from and is accepting of any medically appropriate investigations and interventions that are offered **except CPR and/or defibrillation.** |
| | C2 | **Critical care interventions including CPR, defibrillation and/or intubation:** Adult is expected to benefit from and is accepting of any medically appropriate investigations and interventions that are offered. |

| PART 2 – SPECIFIC INTERVENTIONS *(if applicable, refer to details in completed Patient Consent Record)* | | | | | |
|---|---|---|---|---|---|
| Blood/Products | ☐ YES ☐ NO | Nutritional Support | ☐ YES ☐ NO | Dialysis | ☐ YES ☐ NO |
| Non-Invasive Ventilation | ☐ YES ☐ NO | Other | | | |

| PART 3 – SUPPORTING DOCUMENTATION *(check all documents reviewed)* | | | |
|---|---|---|---|
| ☐ Previous MOST Form<br>☐ No CPR Form (B.C.) | ☐ Plan of Care<br>☐ Advance Directive | Representation Agreement<br>☐ Section 9 ☐ Section 7 | ☐ Other |

| PART 4 – CONSULTATIONS *Refer to consent process on reverse (check all individuals consulted)* | | |
|---|---|---|
| ☐ Capable Adult<br>☐ Personal Guardian (Committee) *(name)* | ☐ Representative *(name)*<br>☐ Temporary Substitute Decision Maker *(name)* | ☐ Inter-professional health care te...<br>☐ Adult incapable/ SDM unavailable |

Ensure the MRP's name is legible as this must be entered into Meditech.

The form must be signed by the MRP.

This is an MRP order and, as such, cannot be processed without a MRP signature.

**SUMMARY OF MRP ORDER (Physician and/or Nurse Practitioner)**

As the MRP I have considered the documents noted in Part 3 and discussed the benefits, consequences and preferences o... above Order with the individual(s) noted in Part 4.

| Name of MRP (please print) | | College ID# | Signature |
|---|---|---|---|
| Date (dd/mm/yyyy) | Time (24:00) | MRP Office Phone # | Adult Location |
| *Sent to MOST Data Entry Office* | | Date (dd/mm/yyyy) | Initials |

**REVALIDATION OF MRP ORDER**

| ☐ MOST FORM Revalidation (No Change) | Date (dd/mm/yyyy) | Name of MRP (print) | College ID# | MRP Signature |
|---|---|---|---|---|
| *Sent to MOST Data Entry Office* | | Date (dd/mm/yyyy) | Initials | |

*Send to MOST Data Entry Office at 1-855-980-6180 (toll free)*

IF RECEIVED IN ERROR, NOTIFY INTERIOR HEALTH INFORMATION PRIVACY & SECURITY TOLL FREE AT 1-855-980-5020

829641 May 15-19 page 1 of 1

**The MOST form will not be processed electronically if any of this information is missing, not legible or not completed properly**

## APPENDIX C: SUMMARY OF PROCESS TO DETERMINE MOST DESIGNATION

(# Reverse side of Form # 829641)