April 26, 2017

Mr. Jamie Mack  
Division of Public Health  
Jesse Cooper Building  
417 Federal Street  
Dover, DE 19901  

RE: 20 DE Reg. 770 [DPH DMOST Regulation (4/1/17)]

Dear Mr. Mack:

The State Council for Persons with Disabilities (SCPD) has reviewed the Division of Public Health’s (DPH’s) proposal to adopt a brief amendment to its regulations covering Delaware Medical Orders for Scope of Treatment (DMOST). The proposed regulation was published in the April 1, 2107 Register of Regulations.

Section 2.1.1 would be amended to clarify that the DMOST form’s identification section must include the patient’s address of record, phone number, and gender. The form (attached) already included these fields but the regulation did not require their inclusion. The proposed amendment is benign and essentially a “housekeeping” initiative.

The SCPD is endorsing the proposed regulation.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our position on the proposed regulation.

Sincerely,

Jamie Wolfe, Chairperson  
State Council for Persons with Disabilities  

cc: Ms. Karyl Rattay, DHSS-DPH  
Mr. Brian Hartman, Esq.  
Developmental Disabilities Council  
Governor’s Advisory Council for Exceptional Citizens  

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DELAWARE MEDICAL ORDERS FOR SCOPE OF TREATMENT (DMOST)

- FIRST, follow the orders below. THEN contact physician or other health-care practitioner for further orders, if indicated.
- The DMOST form is voluntary and is to be used by a patient with serious illness or frailty whose health care practitioner would not be surprised if the patient died within next year.
- Any section not completed requires providing the patient with the full treatment described in that section.
- Always provide comfort measures, regardless of the level of treatment chosen.
- The Patient or the Authorized Representative has been given a plain-language explanation of the DMOST form.
- The DMOST form must accompany the patient at all times. It is valid in every health care setting in Delaware.

<table>
<thead>
<tr>
<th>Print Patient’s Name (last, first, middle)</th>
<th>Date of Birth</th>
<th>Last four digits of SSN</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Address</td>
<td>Phone Number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A. Goals of Care (see reverse for instructions. This section does not constitute a medical order.)

B. Cardiopulmonary Resuscitation (CPR) Patient has no pulse and/or is not breathing
   - Attempt resuscitation/CPR
   - Do not attempt resuscitation/DNAR

C. Medical Interventions: Patient is breathing and/or has a pulse
   - Full Treatment: Use all available medical and surgical interventions, including intubation and mechanical ventilation in an intensive care setting, if indicated, to support life. Transfer to a hospital, if necessary.
   - Limited Treatment: Use appropriate medical treatment, such as antibiotics and IV fluids, as indicated. May use oxygen and non-invasive positive airway pressure. General treatment, avoid intensive care.
   - Transfer to hospital or medical interventions.
   - Transfer to hospice, comfort measures, cannot be met in current setting.

D. Treatment of Symptoms/Comfort Measures
   - Use only medications, including pain medication, by any route, position, suctioning, sedating care, and other measures to keep clean, warm, dry, and comfortable. Use oxygen, suctioning, and tracheal treatment only to the extent as needed for comfort.
   - Use antibiotics only to promote comfort, not to cure infection as needed for comfort.
   - Other Orders:

E. Artificaly Administered Fluids and Nutrition
   - Long-term artificial nutrition
   - Defined trial period of artificial nutrition: Length of trial: _______
   - No artificial nutrition
   - Hydration only
   - None (check one box)
   - Printed Name & phone number
   - Signature

F. Orders Discussed With:
   - Guardian
   - Surrogate (per DE Surrogacy Statute)
   - Other
   - Agent under healthcare POA/ahcd
   - Parent of a minor

Print Name of Authorized Representative  Relation to Patient  Address  Phone #
If I lose capacity, my Authorized Representative may change or void this DMOST
If not, my designated health care provider may not change or void this DMOST
Patient Signature

SIGNATURES: Patient/Authorized Representative/Parent (mandatory) I have discussed this information with my Physician / APRN / PA

Signature  Date  Time

Print Name

Print Address

License Number  Phone #
DIRECTIIONS FOR HEALTH-CARE PROFESSIONALS

COMPLETING A DMOST FORM

- Must be signed by a Licensed Physician, Advance Practice Registered Nurse, or Physician's Assistant.
- Use of original form is highly encouraged. Photocopies and faxes of signed DMOST forms are legal and valid.
- Any incomplete section of the DMOST form indicates the patient should get the full treatment described in that section.

REVIEWING A DMOST FORM -- It is recommended that a DMOST form be reviewed periodically, especially when:

- The patient is transferred from one care setting or care level to another,
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

MODIFYING AND VOIDING INFORMATION ON A COMPLETED DMOST FORM

A patient with decision-making capacity can void a DMOST form at any time in any manner that indicates an intent to void.

Any modification to the form voids the DMOST form. A new DMOST form may be completed with a health care practitioner.

Forms are available online at www.delaware.gov.

SECTION A This section outlines the specific goals that the patient is trying to achieve by this treatment plan. Health care professionals shall share information regarding prognosis with the patient in order to assist the patient in setting achievable goals. Examples may include:

- Longevity, cure, remission or prolongation of life
- To live long enough to attend an important event (wedding, birthday, graduation)
- To live without pain, nausea, constipation, or other symptoms
- Eating, driving, gardening, enjoying time with family, or other activities

SECTION B This is a medical order. Mark a selection for the patient's preferences regarding CPR.

SECTION C This is a medical order. When limited treatment is selected, also indicate whether the patient prefers or does not prefer transfer to a hospital for additional treatment. Examples may include:

- IV medication to enhance comfort may be appropriate for the patient who has indicated "symptom treatment only."
- Non-invasive positive airway pressure indicates continuous positive airway pressure (CPAP) and bi-level positive airway pressure (Bi-PAP).
- The patient will always be provided with comfort measures.
- Patients who are already receiving long-term mechanical ventilation may indicate treatment limitations on the "Other Orders" line.

SECTION D This is a medical order. Mark a selection for the patient's preferences regarding nutrition and hydration. Check one box.

- Oral fluids and nutrition should always be offered if feasible and consistent with the goals of care.

SECTION E This section documents with whom the medical orders were discussed, the name of any healthcare professional who assisted in the completion of the Form, the name of any authorized representative and if the authorized representative may not modify/void the Form.

SECTION F To be valid, all information in this section must be completed.

HIPAA PERMITS DISCLOSURE OF DMOST FORMS TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT.

SEND FORM WITH PATIENT, WHENEVER MOVED TO A NEW SETTING.