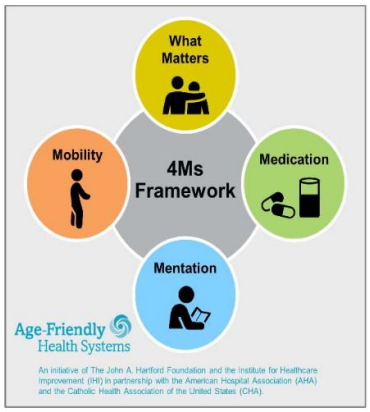
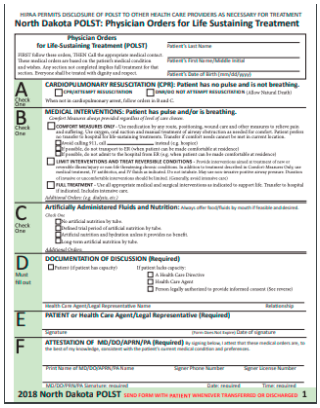


What Matters, Beyond POLST

Jon Berg, MD, CMD
Jacque Gray, PhD
Nancy Joyner, MS, CNS-BC, APRN, ACHPN®


North Dakota POLST: Physician Orders for Life Sustaining Treatment

Physician Orders for Life-Sustaining Treatment (POLST)

A CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

B MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

C Artificially Administered Fluids and Nutrition:

D DOCUMENTATION OF DISCUSSION (Required)

E PATIENT or Health Care Agent/Legal Representative (Required)

F ATTESTATION OF MD/DO/APRN/PA (Required)

2018 North Dakota POLST SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED 1

Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

Project ECHO®
University of North Dakota
School of Medicine and Health Sciences

Disclaimers

- None

Objectives

1. Define Advance Care Planning (ACP) and identify where POLST fits.
2. Identify why “What Matters” conversations matter the most.
3. Determine what cultural factors impact “What Matters” conversations.

Advance Care Planning: *Definition*

A person-centered, ongoing process of communication that facilitates individuals' understanding, reflection and discussion of their goals, values and preferences for future healthcare decisions.

Respecting Choices®
Gunderson Health System
http://www.gundersenhealth.org/respecting-choices

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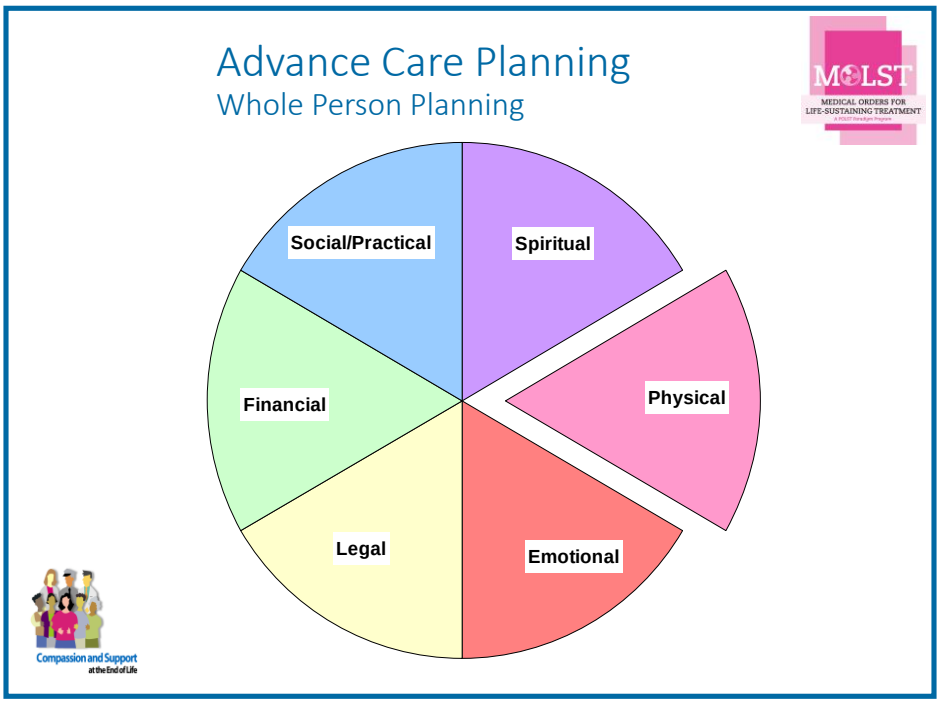


Advance Care Planning: *No Easy Talk*

Perspective: Individuals/Families

- Don't want to talk about death
- Culture and ethnicity
- Lack of awareness and importance of ACP
- Not understanding the significance of condition
- Unclear treatment options and decisions
- Family conflict
- No designated health care agent

Perspective: Delivery of Person-Centered Care

- Experience multiple transitions near end of life → high rates of preventable hospitalizations
- Increasing demand for family caregiving → personal care, household tasks, medication management → burden
- Delayed referral to palliative care → access

Advance Care Planning: *No Easy Talk*

Reference: IOM (Institute of Medicine). 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life.* Washington, DC: The National Academies Press.

Advance Care Planning: *No Easy Talk*

Perspective: Clinician-Patient Communication and Advance Care Planning

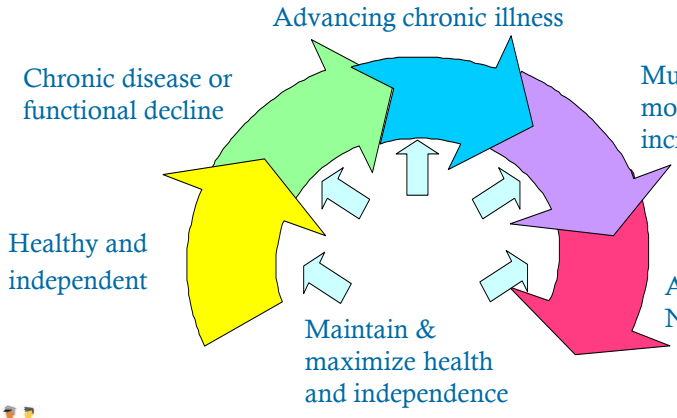
- Most people near end of life (EOL) unable to make own decisions → advance care planning essential
- People with EOL-care focus on alleviation of pain and suffering → need for medical orders
- Frequent conversations necessary to avoid unwanted treatment → improved ACP communication needs

Reference: IOM (Institute of Medicine). 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life.* Washington, DC: The National Academies Press.

Advance Care Planning

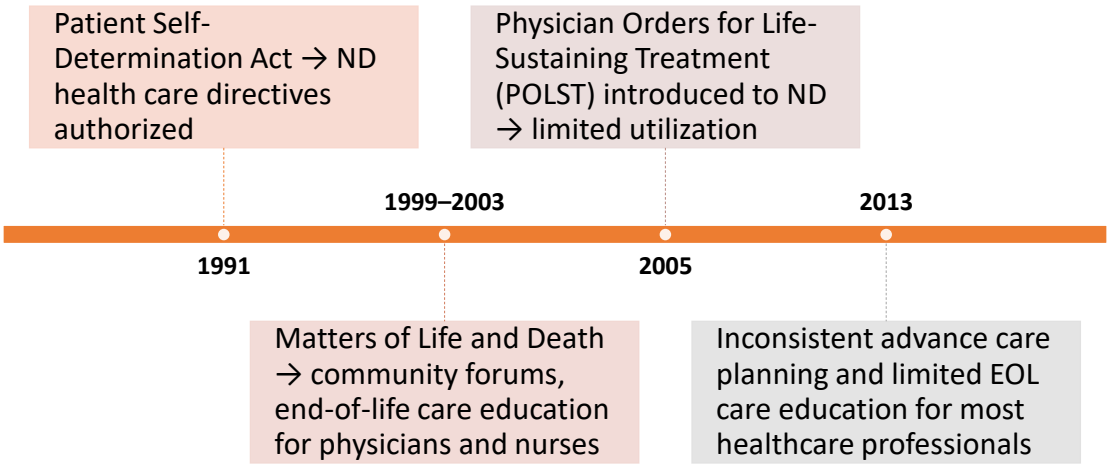
MOLST
MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT

Compassion, Support and Education along the Health-Illness Continuum

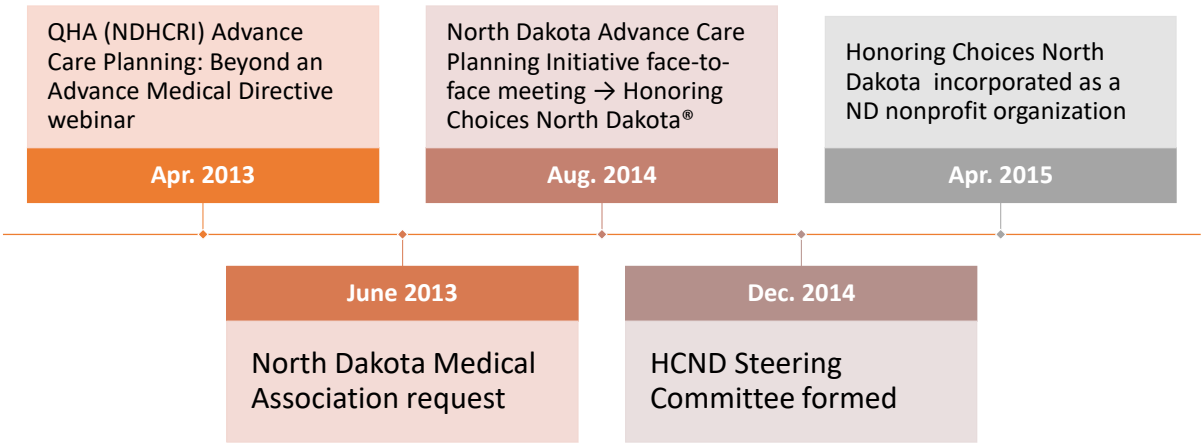


Compassion and Support at the End of Life
CompassionAndSupport.org

Advance Care Planning: *The History*



Advance Care Planning: *The History (cont)*



What is POLST?

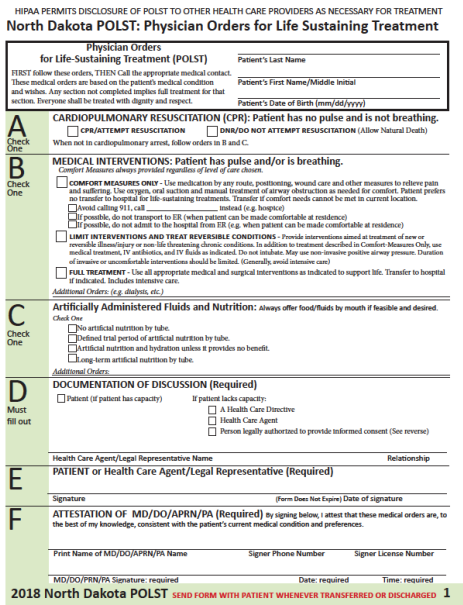
What is POLST?

Medical Order

Signed by the patient or their Agent

Signed by a Physician or Advanced Practice Provider

PORTABLE from one facility to another and honored by EMS



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

North Dakota POLST: Physician Orders for Life Sustaining Treatment

Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, THEN Call the appropriate medical contact. These medical orders are based on the patient's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name

Patient's First Name/Middle Initial

Patient's Date of Birth (mm/dd/yyyy)

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.**

☐ **CPR/ATTEMPT RESUSCITATION** ☐ **DNR/DO NOT ATTEMPT RESUSCITATION** (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C.

B Check One — **MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.**

Comfort Measures always provided regardless of level of care chosen.

☐ **COMFORT MEASURES ONLY** - Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

☐ Avoid calling 911, call _____ instead (e.g. hospice)

☐ If possible, do not transport to ER (when patient can be made comfortable at residence)

☐ If possible, do not admit to the hospital from ER (e.g. when patient can be made comfortable at residence)

☐ **LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS** - Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions. In addition to treatment described in Comfort Measures Only, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Duration of invasive or uncomfortable interventions should be limited. (Generally, avoid intensive care)

☐ **FULL TREATMENT** - Use all appropriate medical and surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care.

Additional Orders: (e.g. dialysis, etc.)

C Check One — **Artificially Administered Fluids and Nutrition:** Always offer food/fluids by mouth if feasible and desired.

Check One

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

☐ Artificial nutrition and hydration unless it provides no benefit.

☐ Long-term artificial nutrition by tube.

Additional Orders:

D Must fill out — **DOCUMENTATION OF DISCUSSION (Required)**

☐ Patient (if patient has capacity)

If patient lacks capacity:

☐ A Health Care Directive

☐ Health Care Agent

☐ Person legally authorized to provide informed consent (See reverse)

Health Care Agent/Legal Representative Name — Relationship

E — **PATIENT or Health Care Agent/Legal Representative (Required)**

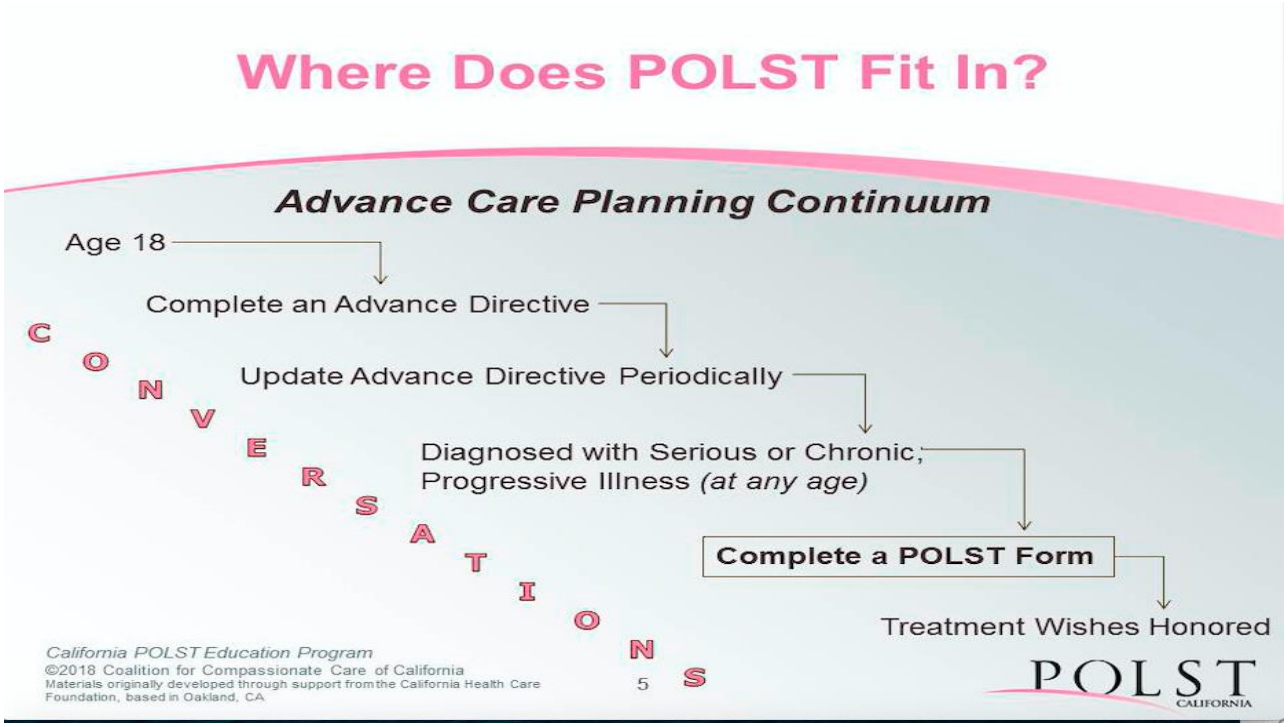
Signature (Form Does Not Expire) Date of signature

F — **ATTESTATION OF MD/DO/APRN/PA (Required)** By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's current medical condition and preferences.

Print Name of MD/DO/APRN/PA Name — Signer Phone Number — Signer License Number

MD/DO/PRN/PA Signature: required — Date: required — Time: required

2018 North Dakota POLST SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED 1



Comparing POLST Form to Healthcare Directive

	Healthcare Directive	POLST Paradigm Forms
Population	All adults >18 y.o.	Any age, serious illness, at end of life or frailty
Time Frame	Future care/future conditions	Current care/current conditions
Where Completed	Any setting, not necessarily medical	Medical setting
Resulting Product	Healthcare agent appointed and/or statement of preferences	Medical orders based on shared decision making
Healthcare Agent Role	Cannot complete	Can consent if patient lacks capacity
EMS Role	Does not guide EMS	Guides EMS as a medical order
Portability	Patient/Family Responsibility	Healthcare Professional Responsibility
Periodic Review	Patient/Family Responsibility	Healthcare Professional Responsibility

Why "What Matters" Matters MOST?

Why "What Matters" Matters Most?

- For older adults
  - Variation in "What Matters" Most
  - Feel more engaged and listened to
  - Avoids unwanted treatment while receiving wanted treatment
  - Comfort care Always, not just Only
- For Health systems
  - Better patient experience scores & retention
  - Avoids unnecessary utilization
- For Everyone (patients, families, caregivers, providers, health systems)
  - Everyone is on the same page
  - Improved relationships
  - It is the basis of everything else

Beyond POLST- What Matters

"It is more important to know what sort of person has a disease than to know what sort of disease a person has."

Hippocrates (ca. 460 BC - ca. 370 BC)

Patient Perspective

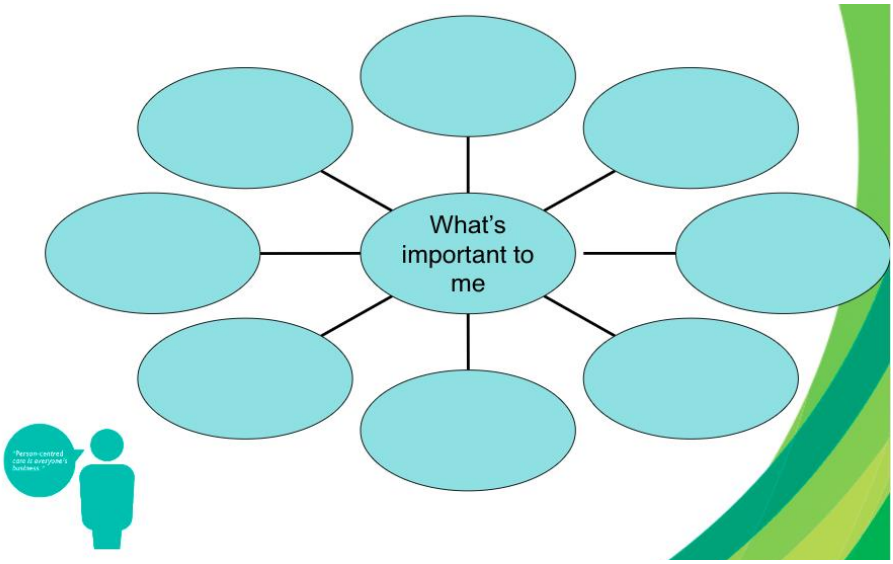
Flipping Health Care Concepts

- Change form “What’s the Matter” to “What Matters to You?”
- Flip the balance
- Let down the barriers that separate us ‘staff’ and ‘patients’
- Changing expectations
- Truly collaborating

Roy’s Story

- 88 years old with diabetes and hypertension
- Admitted to nursing home after hospitalization after a fall
- Tells staff he wants to go “Home”
- Complains about staff interventions
- What Mattered Most to Roy

What's Important to Me?



Patient Voices

- Who do you want involved?
- Ceremonies?
- History of conditions (ex COVID-19)?
- How much technology?

What Really Matters? (Patient Voices Summarized)

- Being kept informed by staff
- Getting the staff to listen to me
- Having my wishes honored
- To know my choices
- Being treated for my age
- See me, not my illness
- With people my own age
- Not in the hospital any longer than necessary
- Friendly and caring staff

Clinician's Responsibilities

How to Ask "What Matters"

- Who do you want to be included in the conversation?
- What should I know about you that may not be on your medical record?
- What does a good day look like to you ? (end-of-life)
- What do you want to be doing six months from today that you are not able to do now? (procedure)
- Is there anything you are worried or concerned about? (discharge)
- What will success look like to you? (surgery)

Asking "What Matters": Our ALWAYS Event

Before: Clinician Directed

- Manage signs & symptoms
- Implement diet restriction
- Further testing without change

Now: Patient Guided

- Be Able to join my ROMEO Group (Retired Old Men Eating Out)
- Eat and drink what I want when I want

What to Discuss?

- What is important to you today?
- What brings you joy?
- What gives your life meaning?
- What makes you happy?
- What makes life worth living?
- What do you worry about?
- What are some goals you hope to achieve in the next six months or before your next birthday?
- What are some goals you hope to achieve in the next six months or before your next birthday?
- What would make tomorrow a really great day for you?
- What else would you like us to know about you?
- How do you learn best? For example, listening to someone, reading materials, watching a video.

Checklist for Culturally Appropriate "What Matters" Conversations

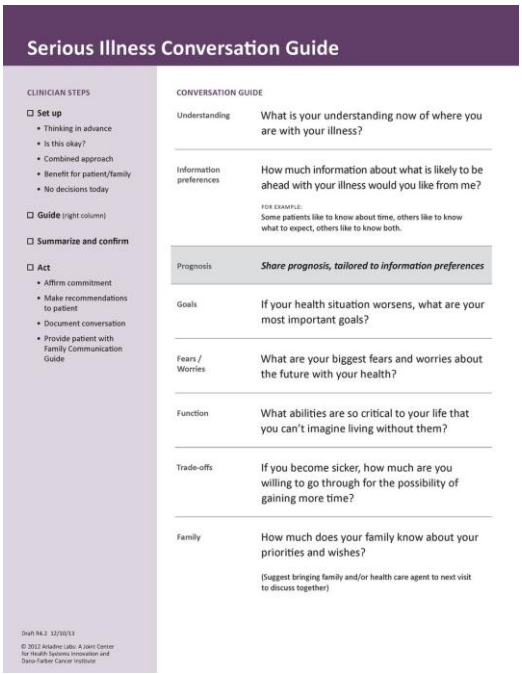
- Learn the preferred term for their cultural identity
- Determine appropriate degree of formality-how to address
- Determine preferred language. Include an interpreter/materials
- Be respectful of nonverbal communication
- Address issues linked to culture- lack of trust, fear (medical experience, side effects, Western medicine)
- Review history- trauma, violence, survivors of racism (very sensitive)
- Recognize health beliefs- alternative therapies
- Consider decision-making factors and individual autonomy

(Reference: IHI toolkit, 2014)

Discussion Goals of Care and Treatment Options

- What is the one thing about your health care you most want to focus on so that you can do [fill in desired activity] more often or more easily?
- What are your most important goals now and as you think about the future with your health?
- What concerns you most when you think about your health and health care in the future?
- What are your fears or concerns for your family?
- What are your most important goals if your health situation worsens?
- What things about your health care do you think aren't helping you and you find too bothersome or difficult?
- Is there anyone who should be part of this conversation with us?

Serious Illness Conversation Guide



Serious Illness Conversation Guide

CLINICIAN STEPS

- ☐ **Set up**
  - Thinking in advance
  - Is this okay?
  - Combined approach
  - Benefit for patient/family
  - No decisions today
- ☐ **Guide** (right column)
- ☐ **Summarize and confirm**
- ☐ **Act**
  - Affirm commitment
  - Make recommendations to patient
  - Document conversation
  - Provide patient with Family Communication Guide

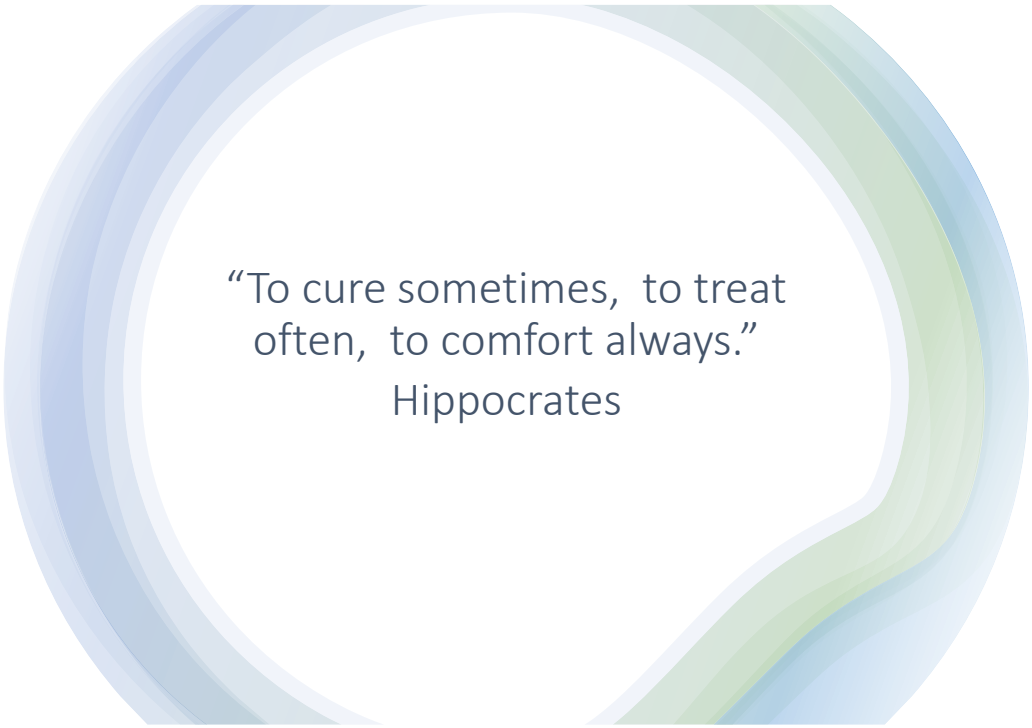
Draft 9A.2 12/10/13

CONVERSATION GUIDE

Understanding	What is your understanding now of where you are with your illness?
Information preferences	How much information about what is likely to be ahead with your illness would you like from me? FOR EXAMPLE: Some patients like to know about time, others like to know what to expect, others like to know both.
Prognosis	***Share prognosis, tailored to information preferences***
Goals	If your health situation worsens, what are your most important goals?
Fears / Worries	What are your biggest fears and worries about the future with your health?
Function	What abilities are so critical to your life that you can't imagine living without them?
Trade-offs	If you become sicker, how much are you willing to go through for the possibility of gaining more time?
Family	How much does your family know about your priorities and wishes? (Suggest bringing family and/or health care agent to next visit to discuss together)

Conclusions

- Advance Care Planning (ACP) is important for conversations about "What Matters".
- We identified where POLST fits
- "What Matters" conversations give the healthcare team a roadmap.
- There are multiple cultural factors that impact "What Matters" conversations.



References Resources

- Honoring Choices ND website
- IHI Age Friendly Health Systems website
- IHI Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults (2019)
- IHI "Conversation Ready": A Framework for Improving End-of-Life Care (2019)
- IHI, "What Matters" to Older Adults Toolkit (2019)
- National POLST for Professionals website
- Serious Illness Conversation Guide (Ariadne Labs) (2015)

2020 POLST and ACP Conversations in ND

- Honoring Choices® North Dakota- POLST
- POLST Awareness, Education and Implementation Seminars
- ND POLST CME
- COVID-19 and POLST
- COVID and Conversations

For More Information

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