What Matters, Beyond POLST
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Disclaimers
• None
Objectives

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

"The name Honoring Choices North Dakota is used under license from East Metro Medical Society Foundation."
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*

**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


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Advance Care Planning: The History

1991
- Patient Self-Determination Act → ND health care directives authorized

1999–2003
- Physician Orders for Life-Sustaining Treatment (POLST) introduced to ND → limited utilization

2005
- Matters of Life and Death → community forums, end-of-life care education for physicians and nurses

2013
- Inconsistent advance care planning and limited EOL care education for most healthcare professionals

Advance Care Planning: The History (cont)

Apr. 2013
- QHA (NDHCRI) Advance Care Planning: Beyond an Advance Medical Directive webinar

Aug. 2014
- North Dakota Advance Care Planning Initiative face-to-face meeting → Honoring Choices North Dakota®

Apr. 2015
- Honoring Choices North Dakota incorporated as a ND nonprofit organization

June 2013
- North Dakota Medical Association request

Dec. 2014
- HCND Steering Committee formed
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
Comparing POLST Form to Healthcare Directive

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

- 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
• 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

[Image of Serious Illness Conversation Guide]

Understanding
What is your understanding now of where you are with your illness?

Information needs
How much information about what is likely to be ahead with your illness would you like from me?

Share progress and preferences
Goals
If your health situation worsens, what are your most important goals?

Wants / Worries
What are your biggest fears and worries about the future with your health?

Future
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?

Recall
How much does your family know about your priorities and wishes?

Support bringing family and for healthcare agent to meet with to discuss together.
To do nothing is also a good remedy.

Hippocrates

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.
"To cure sometimes, to treat often, to comfort always."
Hippocrates

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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