JANUARY/FEBRUARY 2022

HONORING CHOICES® NORTH DAKOTA (HCND)

A non-profit organization with the initiative to improve advance care planning across the state

IN THIS NEWSLETTER

NEW YEAR, SAME PURPOSE

Happy New Year and Warm Wishes!

We hope this newsletter finds you healthy and in opportunistic spirits as we enter the new year. Thank you for your dedication to your patients and your communities. Your tireless efforts to continue to provide quality of care during these unprecedented times have not gone unnoticed.

Over the past few years, there has been a lot of "behind the scenes" action underway at Honoring Choices® North Dakota. We want to take this moment as an opportunity to share with you our past accomplishments, our current projects, and our future goals for this year and and for years to come. We invite you to join in our commitment to standardize the process of advance care planning (ACP) across the state of North Dakota through advocation and education. By gaining a greater understanding of ACP, familiarity of associated documents (e.g., health care directive, POLST form), and learning about various resources available, we hope that you will share and promote the importance of ACP to your colleagues as well as your loved ones.

ABOUT US

Honoring Choices® North Dakota is a collaborative group of statewide community partners who have a shared vision of creating a culture across North Dakota where continuous (on-going) advance care planning is the standard of care and every individual's informed preferences for care are documented and upheld.

VISION

The health care choices a person makes become the health care the person receives

GOALS

To assist communities develop a successful advance care planning process

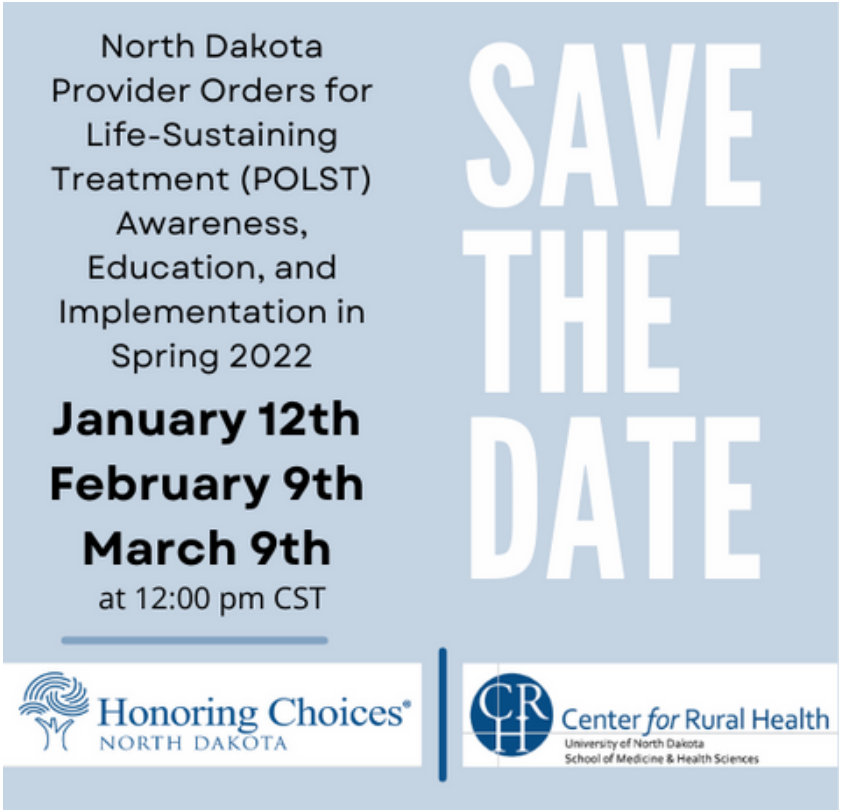
OBJECTIVES

- Promote advance care planning through community and professional outreach and education
- Promote standardization of advance care planning
- Establish base of financial support

HCND partners believe

Quality of care is realized when it meets the person's needs and upholds their care preferences

To register:
https://und.zoom.us/meeting/register/tJwvcuuvpjguGtd_oQOu7W_PGp0bNeKWM30Z



HCND Highlights

2015 - NOW

2015 - 2016

Honoring Choices® North Dakota Board of Directors was created

2016 - 2019

HCND provided training opportunities through Respecting Choices® First Steps® to become an ACP Facilitator

HCND created policies and action plans

2016 - CURRENT

Numerous articles, publications, and presentations

Development of short- and long-form advance directives

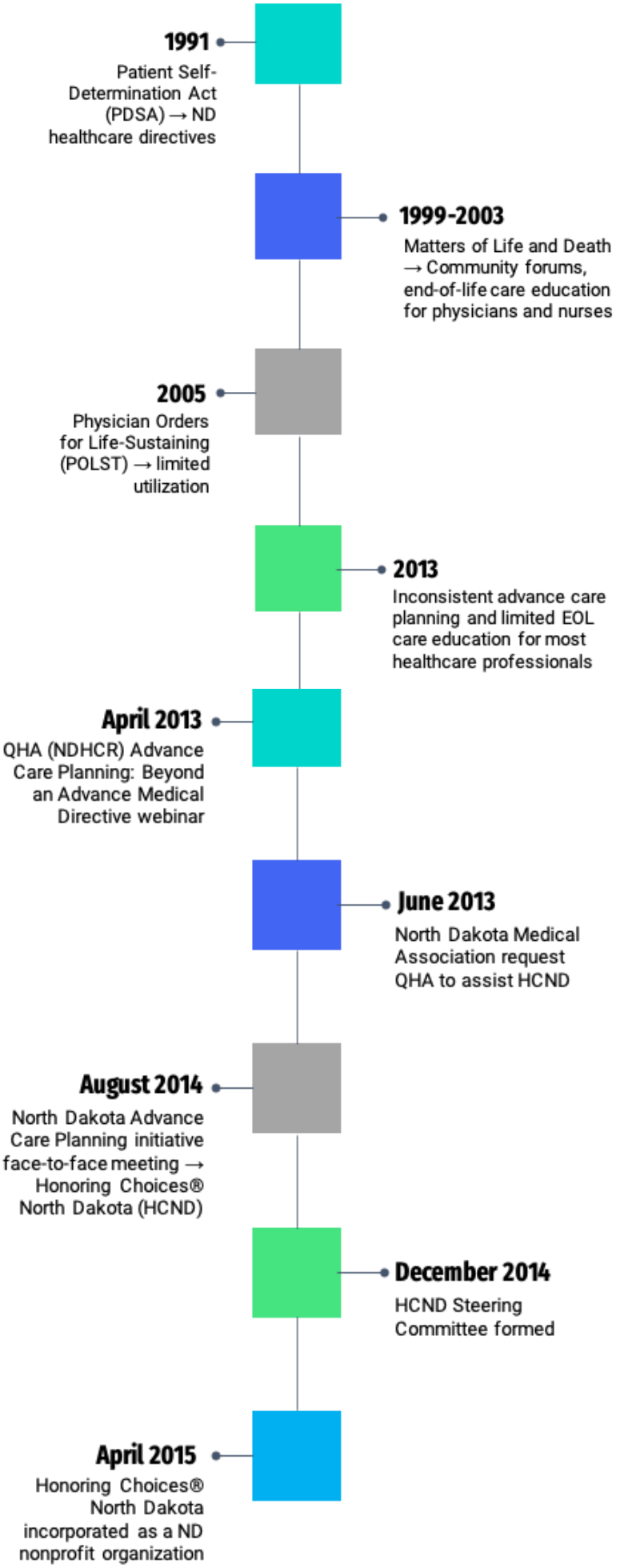
Website and Outlook email provided through affiliation with Quality Health Associates of North Dakota (QHA-ND)

Partnership with ND Palliative Care

Support from Center for Rural Health (CRH)

HCND has endorsed National Healthcare Decisions Day (NHDD) in years past. On April 16, 2021, the Governor Burgum of North Dakota signed a proclamation for NDHH

History of Advance Care Planning in North Dakota



WHAT IS ADVANCE CARE PLANNING (ACP)?

“Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness” (Sudore, 2017, p. 2)

ADVANCE DIRECTIVE

“Advance directives are legal documents that allow patients to put their healthcare wishes in writing, or to appoint someone they trust to make decisions for them, if they become incapacitated” (Miller, 2017, p. 2)

POLST

WHAT IS POLST?

"POLST is part of advance care planning intended for people who are seriously ill or who have advanced frailty. It starts with a talk between the person and their health care provider and can lead to a portable medical order, or POLST form" (National POLST, 2021)

WHAT IS A POLST FORM?

"A POLST form is a portable medical order. The POLST form is how patients who are seriously ill or have advanced frailty tells all health care providers what they want during an emergency and what their goals of care are given their current medical condition" (National POLST, 2021)

MEET THE BOARD

Nancy Joyner, MS, CNS-BC, APRN, ACHPN®

President of Honoring Choices® North Dakota

Organization: Nancy Joyner Consulting & Center for Rural Health (CRH)
Positions: APRN, Palliative Care Clinical Nurse Specialist, ND POLST Program Coordinator, CRH Outreach Specialist
Location: Grand Forks
email: nancy.joyner@honoringchoicesnd.org

Courtney Koebele, JD

Organization: North Dakota Medical Association
Position: Executive Director
Location: Bismarck

Michelle Lauckner, RN

Organization: Quality Health Associations
Position: Quality Improvement Advisor
Location: Minot

Hannah Murphy, RN

DNP Student - North Dakota State University
HCND Fargo Healthcare Representative
Location: Fargo

Dr. Edith Okoye, MD

Organization: Sanford Health
Position: Hospitalist
Location: Bismarck

Karli Olson, RN, CCRN

DNP Student - University of Mary
HCND Western ND State Representative
Location: Wildrose

MEET THE BOARD

Rebecca Quinn, LMSW, CBIST

Organization: Center for Rural Health
Position: Program Director
Location: Grand Forks

Marcie Schulz, MBA, MSN, RN

Organization: Good Samaritan
Position: Director of Nursing
Location: Bismarck

Rev. Sara Schwarz, MA

Organization: Hospice of the Red River Valley
Positions: Chaplain, Spiritual Care, ACP Facilitator & Instructor
Location: Bismarck

Lisa Tocchio, RN

Organization: Blue Cross Blue Shield
Position: Director of Population Health and Health Integration
Location: Fargo

Kristi Ulrich

Community Representative
Positions: Business Management, Photography, Event Management, Media relationships, and Corporate Communications of Nonprofit Organizations
Location: Fargo

Jody Ward, MS, RN, APHN

Organization: Center for Rural Health
Position: Program Director
Location: Minot

Maryn Young, PMHNP-BC, FNP-BC

Organization: Presentation Medical Center SMP Health System
Position: APRN in Clinic Services
Location: Rolla

HCND Project: Increased Awareness, Education, and Implementation of Advance Care Planning with Patients Living with Cancer

Over the past six years, there has been a lot of discussion about increasing palliative care services across the state of North Dakota due to a lack of education and awareness of palliative care services. Even though palliative care is one of the fastest growing trends in healthcare care, it is often largely misunderstood.

To overcome challenges associated with ACP and palliative care in North Dakota, Objectives 15 and 16 of the North Dakota Cancer Control Plan focus on increasing awareness of palliative care for the general public and healthcare providers as well as improving access to quality palliative care services. These objectives are also inline with the National Comprehensive Cancer Network (NCCN) Advance Care Planning (PAL-29) Guideline of 2021, as it focuses on engaging in adequate ACP, reducing patient/family/caregiver distress, and optimizing quality of life.

ACP amongst patients with cancer is a heavily weighted topic. In an interview with Dr. Michael G. Cohen, a gynecological fellow at the University of Pittsburgh Magee-Women's Hospital, he remarked, "These providers are basically having these conversations too little too late. And often these conversations only come up in crisis moments" (Moretti, 2021, para, 14).

In a secondary analysis of a randomized controlled trial of primary palliative care in patients with advance cancer, Cohen and colleagues (2021) found that hope is not decreased after engaging in ACP, whether in the form of a conversation or completing an advance directive. The researchers discovered that hope was increased in patients who engaged in ACP and these findings may provide clinicians with reassurance about the importance of engaging in these challenging yet important conversations (Cohen et al., 2021).

Last November, Nancy Joyner, a Palliative Care Clinical Nurse Specialist and the President of HCND, presented at an American Cancer Society Cancer Action Network about statewide palliative care services and HCND. Moreover, HCND received a grant from the North Dakota Department of Health (NDDoH) to conduct outreach and education on palliative care and advanced care planning (ACP) with providers across ND and distribute ACP resources to providers.

The project is running from December 1, 2021 through June 29, 2022. The objectives for this project include:

- Conducting outreach and education on palliative care and advanced care planning (ACP) with healthcare care professionals across ND
- Distributing advance care planning (ACP) resources to professionals
- Inclusion of current statewide ACP facilitators
- Providing an advanced care planning facilitator training

By increasing ACP and palliative care education across the state, the overarching goals are to increase the number of ACP conversations and completed advance directives (ADs) for patients living with cancer in ND, increase the number of ACP facilitators in the state, and increase awareness of HCND to all healthcare professionals across ND.

If you are an interested healthcare professional and could assist us with ACP facilitation with patients living with cancer, please complete this form and/or share it with your colleagues who could assist: https://forms.gle/G8ew1DMNFRZS3y7h9

The American Cancer Society estimates at least 38,430 of our 779,094 North Dakotan residents are living with cancer (4.9%). There were an estimated 4,200 new cases of cancer in the year 2021.

VISIT OUR WEBSITE

Please visit our website, **www.honoringchoicesnd.org,** to access multiple resources to aid in ACP and completing legal documents (e.g., POLST forms and healthcare directives) as well as to learn more about effectively implementing ACP to ensure patients' wishes and medical preferences are documented and disseminated appropriately.

LIKE AND FOLLOW US ON FACEBOOK

CONNECT WITH US ON LINKEDIN

NORTH DAKOTA POLST

This form was developed in 2018 and provides step-by-step instructions for the provider to complete in addition to the patient and/or healthcare agent/legal representative

HEALTHCARE DIRECTIVES

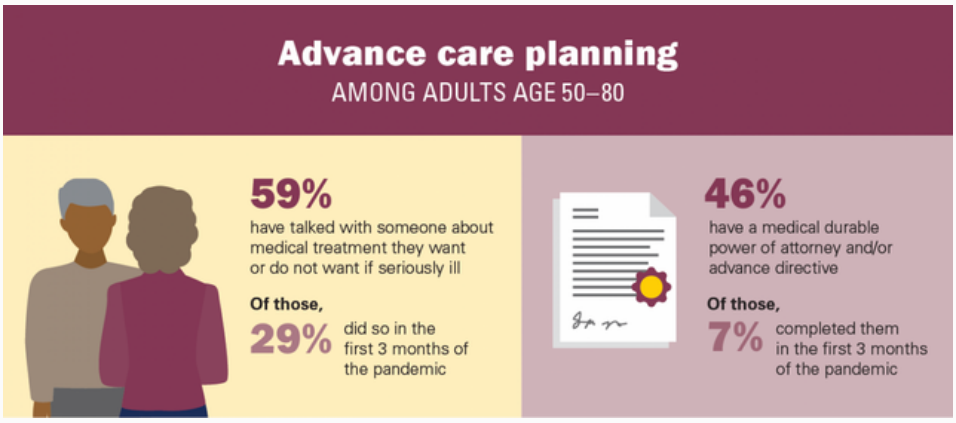
Two forms available:

- Short-form: most applicable for healthy adults, ages 18-40 years
- Long-form: comprehensive document for individuals of all ages

PATIENT INFORMATION

Numerous patient handouts discussing different terms associated with ACP, the Basics of CPR, a printable wallet card, and much more!

COVID-19 and Advance Care Planning:
What We Know and How We Can Improve



The statistics are derived from the National Poll on Healthy Aging at the University of Michigan's Institute for Healthcare Policy and Innovation. (Perumalswami et al., 2021)

> "[T]he COVID pandemic has upended both traditional healthcare and ACP and forced healthcare providers to rethink and restructure the delivery of care."
>
> (Sokas et al., 2020, para. 8)

Additional COVID-19 and ACP resources:

the conversation project

Serious Illness Conversation Guide

Institute for Healthcare Improvement

VITAL talk

ARIADNE LABS

The Conversation Project® | **VITAL talk** | **The Serious Illness Project**

"ACP can improve patient well-being, experience, and quality of care by aligning care with what matters most to patients and avoiding burdensome and unwanted treatments at the end of life. Given the speed with which the virus is spreading, uncertainty about its short- and longterm consequences, and the disproportionate negative impact on specific populations (for example, older adults, patients with underlying medical conditions, and persons of color), we face an enormous volume of patients who would benefit from empathic ACP conversations with their clinical teams" (Paladino et al., 2021, para. 3)

For more information, visit www.honoringchoicesnd.org

ADVANCE CARE PLANNING UNDER MEDICARE

In January of 2016, the Centers for Medicare and Medicaid Services (CMS) adopted time-based current procedural terminology (CPT) codes that reimburse healthcare providers who engage in advance care planning conversations with Medicare beneficiaries. The codes are used to report face-to-face services between a qualified healthcare professional and a patient, family member, and/or healthcare agent. ACP discussions may include but are not limited to the patient's wishes and preferences for future medical treatment in the event that they lose capacity to maker their own decisions as well as completing legal documents, such as healthcare directives and POLST forms.

CPT codes for ACP: 99497 and 99498

"Advancing patient-centered care through meaningful conversations and shared decision making encourages patients to plan and make informed choices about their current and future healthcare"

(Simmons-Fields et al., 2020, p. 426)

HONORING CHOICES®
NORTH DAKOTA

WHY NOW?

92% of people think it is important to talk about wishes for end-of-life care but *only* 32% have their wishes in writing

The Conversation Project, 2018

ADVANTAGES OF ACP

- Improved compliance with end-of-life wishes
- Improved patient and their families' satisfaction with care
- Reduction of anxiety, depression, and family stress
- Reduction of chances of dying in the hospital
- Decreased cost of care

THANK YOU!

Again, thank you for your continued dedication for the health and safety of our patients!

QUESTIONS OR COMMENTS?

If you or members of your healthcare team would like to learn more about ACP, educational materials and offerings, or training opportunities to become an ACP Facilitator, please go to our website or email HCND's President, Nancy Joyner, at: nancy.joyner@honoringchoicesnd.org