September 3, 2024

Summer 2024 Newsletter: Essential Insights from the Palliative Care Committee

GEORGIA Hospice & Palliative Care ORGANIZATION

Dear Friends and Colleagues,

As summer graces us with its warmth, we're excited to bring you the latest edition of our newsletter, filled with important updates and resources from GHPCO's Palliative Care Committee. Our mission remains steadfast: to empower Georgians with serious illnesses by ensuring they are well-informed about their healthcare rights and options.

In this issue, we're thrilled to feature valuable contributions from our esteemed collaborators, Dr. Lal, Natasha Fowlks, and the compassionate team at Hospice Atlanta. We'll explore how you can take charge of your medical decisions and navigate the complexities of healthcare planning. Our focus will be on demystifying the POLST form, clarifying how it differs from Advanced Care Planning, and providing actionable insights from industry experts.

Additionally, we'll share inspiring patient stories that highlight the profound impact of informed decision-making in palliative care.

Thank you for your continued dedication to this crucial work. Together, we can make a difference in the lives of those we serve.

Warm regards,
Paula Sanders & Hannah Joyner
CEO & Membership and Event Coordinator
GHPCO Palliative Care Committee

GEORGIA Hospice & Palliative Care ORGANIZATION

GHPCO Newsletter Summer 2024

GHPCO's Mission:

To promote quality hospice and palliative care throughout Georgia by providing information, education and advocacy

Dear Friends/Colleagues, At GHPCO, our Palliative Care Committee is dedicated to empowering all Georgians with serious illnesses by keeping them informed about their healthcare rights and options. In this newsletter, we'll guide you through how you can take charge of your medical decisions. We'll break down what a *POLST form* is and clarify how it differs from *Advanced Care Planning*. Additionally, industry experts will offer their insights, and we'll share patient stories to highlight this vital aspect of healthcare.

~ Natasha Fowlks
Visiting Nurse Health System | Hospice Atlanta

WHAT IS A POLST?

The Physician Order for Life Sustaining treatment (POLST), is a form that outlines patient's choices for end-of-life care based on what they've told their doctor or written in an Advanced Directive. It is filled out by the doctor and the patient or their representative.

The Georgia Department of Public Health adapted the POLST form for statewide use and is available at https://dph.georgia.gov/POLST. It is recommended that the form be printed on hot pink paper, but it is not required. This is meant to be easily located by EMS in case of an emergency. This order should be transferable between hospital systems as it is portably with the patient across care settings. It is recommended for the form to be reviewed during care transitions to ensure goals have not shifted.

WHO SHOULD HAVE A POLST?

The form is designed for those who have a chronic medical condition and/or are seriously ill with a prognosis of less than one year. Completion of the form is voluntary and does not replace an Advanced Directive, but rather, compliments it. If patient's do not have the ability to sign the form, their authorized agent (legal next of kin or surrogate medical decision maker) can do so.
The POLST form documents the patient's election on the following:

- CPR—To Allow natural death vs Full resuscitation (CPR)
- Identifies medical interventions that a patient may want to forego or elect to receive
- Reviews the use of antibiotics and artificial nutrition and hydration

POLST GEORGIA

POLST

- Facts History
- Benefits
- How to complete one

To learn more about POLST:

POLST Form:

Georgia Department of Public Health

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

Patient's Name _____ _____ _____
(First) (Middle) (Last)

Date of Birth _____ **Gender**: Male ☐ Female ☐

A **CODE STATUS** Check One	**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.** ☐ **Attempt Resuscitation (CPR).** ☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.** *** Signature of a concurring physician is needed for this section to be valid **if** this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.* **When not in cardiopulmonary arrest, follow orders in B, C and D.**
B Check One	**MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.** ☐ **Comfort Measures**: Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment.* ☐ **Limited Additional Interventions**: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. *Transfer to hospital if indicated. Generally avoid intensive care unit.* ☐ **Full Treatment**: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.* Additional Orders (e.g. dialysis):
C Check One	**ANTIBIOTICS** ☐ No antibiotics: Use other measures to relieve symptoms. ☐ Determine use or limitation of antibiotics when infection occurs. ☐ Use antibiotics if life can be prolonged. Additional Orders:
D Check One In Each Column	**ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS** **Where indicated, always offer food or fluids by mouth if feasible** ☐ No artificial nutrition by tube. ☐ Trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. Additional Orders: ☐ No IV fluids. ☐ Trial period of IV fluids. ☐ Long-term IV fluids. Additional Orders:

DISCUSSION AND SIGNATURES

The basis for these orders should be documented in the medical record. To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable Georgia law.

Physician Name: License No.: State:	Physician Signature:	Date: Phone:
Concurring Physician Name (*if needed; see III.i. on back of form*): License No.: State:	Concurring Physician Signature (if needed):	Date: Phone:
Patient or Authorized Person Name: ****authorized person may NOT sign if patient has decision making capacity*	Patient or Authorized Person Signature:	Date: Phone:

Relationship to Patient (check all that apply):
☐ Self ☐ Health Care Agent ☐ Spouse ☐ Court-Appointed Guardian ☐ Son or Daughter ☐ Parent ☐ Brother or Sister

POLST form for statewide usage and it is available at www.gapolst.org. It is recommended that the form be printed on hot pink paper, but it is not required.

BENEFITS OF POLST

HISTORY · OF POLST

ADVANCED DIRECTIVES

Benefits of POLST

- Ensure patients receive care homogeneous with their values and beliefs. Reduce suffering.
- Prevent unwanted treatment.
- Avoid unnecessary hospital admissions.
- Transferable to all healthcare settings.
- The POLST order is dynamic and can be changed to fit changing needs.

History of POLST

Oregon, 1991 Following the realization that patients end of life wishes were not consistently being honored and Advance Directives being inadequate for those with serious illness, medical ethicists in Oregon knew they needed something more. Thus , they developed a program to respect the wishes of those receiving end of life and emergency treatment. After years of fine tuning and evaluation, the program became know as the Physician Orders for Life-Sustaining Treatment. In 2004, the National POLST Advisory Panel was formed to initiate quality standards for the forms and programs to aide the states in evolving POLST into a “Paradigm.”

Advanced Directives

Advance Directives are legal documents that lay out steps and instructions for medical care to go into effect once a patient becomes incapacitated. **Living Wills** are an type of an Advance Directive. A Living Will preserves your wishes in writing and is typically completed with legal council. You record what you want to happen with your future care. **Advanced Directives** help delineate Durable Power of Attorney (hPOA) for Health Care. This POA is created specifically to tell your healthcare providers who should speak for you if you lose capacity due to serious illness to help guide and make medical decisions on your behalf,. With the Durable POA documents, you appoint an individual to make the medical decisions. Whereas the **Living Will,** you have all your wishes indicated in writing. Completion of these documents helps avoid leaving family and friends with making difficult choices.

HOSPICE ATLANTA
VISITING NURSE HEALTH SYSTEM

INSIGHTS FROM A LICENSED CLINICAL SOCIAL WORKER

As a medical social worker, advanced care planning and end-of-life conversations involve navigating emotional, cultural, and ethical complexities. Building trust is crucial, as patients and families face fear, grief, and uncertainty. Social workers must balance honesty about prognosis with sensitivity, respecting diverse beliefs and values while preserving patient's rights. We social workers, facilitate discussions about advanced care planning and hospice care, ensuring patients' wishes are honored. These conversations require active listening, empathy, and nonjudgmental support. Social workers also address family dynamics, providing counseling and mediating conflict or providing resources. We hope that with open communication, we help patients and families achieve a sense of peace and preparedness during this difficult time.

One of the tools social workers utilize is the *Physician Orders for Life Sustaining Treatment* (POLST). As compassionate advocates, we guide families and patients through the emotionally challenging process of making informed decisions about future medical care. We explore conversations that include patient's values, preferences, and goals. The POLST form includes decisions and electing preferences such as resuscitation, intubation, and artificial nutrition. Unlike traditional advance directives, which are often more general, POLST forms provide specific instructions that healthcare providers must follow. Social workers educate patients about the POLST options, helping them understand the implications of their choices in various settings and situations.

Social workers conduct in-depth discussions with patients and families, addressing many of their anticipated fears, hopes and cultural beliefs. We help clarify the patient's wishes, ensur ing that they are accurately reflected in the POLST. The hope is that this process empowers patients and alleviates the burden on family members who might be uncertain about their loved ones preferences.

Communication and trust are key factors when having these intimate conversations with family members. It is important to collaborate with the medical team, if families and patients have additional questions surrounding their diagnosis or prognosis. This ensures patients and families are able to make informed decisions. It is important to provide emotional support, empathy and to listen to families preferences, but to also listen to their fears as they are anticipating loss. Through this process, we hope to ensure that patient's receive the care that's aligned with their goal to preserve dignity and quality of life in their final days.

~ Janet Yo, LCSW
Hospice Atlanta

The end of life deserves as much beauty, care and respect as the beginning.

-Anonymous

Life After Death:
Bereavement Professional Perspectives on Life After the Death of a Loved One

The death of someone we love can be life-shattering. As a Grief Specialist and a Hospice Bereavement Coordinator, I'm trusted with the fragments: helping the bereaved pick up the pieces and put them back together into something new. Whether thick pieces, thin pieces or 'can't-quite-see-it" pieces, emotional cleanup is hard work. Even more so, however, when patients don't have a DNR, or their signed DNR is unavailable in a crisis.

To DNR or not to DNR?

That is the question our death-aversive society takes too lightly. The 'DNR Talk' often creates offense; "Why not do everything possible?" most think, deceived by media portrayals of magic white paddles that effortlessly restore flat-lines to gently beeping hills and valleys. Those familiar with 'life saving measures,' however, know a very different reality. Phil, a current client, permitted me to share his account:

"When my wife [Dee] was previously admitted to a midtown hospital, her signed DNR [was] entered into her medical record. 18 months later, we returned for what we thought would be a routine breathing treatment. Dee went into rapid respiratory failure. They told me her death was imminent and asked if I wanted 'life saving measures' to commence. It was so sudden and unexpected; I was in shock. I [told them] her advanced directives were in her medical record, but they couldn't find them. I had to make a quick decision [and] called one of her daughters. Unable to remember [Dee's] wishes, we approved 'life saving measures.' The medical team was excellent, but the measures were violent. Dee was 76. None of the measures worked. I'm sure she was dead before they started, and [that] every bone in her ribcage was broken by the compressions. After 30 minutes, they pronounced her dead and left. She had been intubated and they could not remove the plastic tube in her mouth. That was my last impression of Dee before her viewing at the funeral home."

In hindsight, Phil says, "It was a terrible mistake and horrible to watch... I would never have authorized that had I known the reality. I have subsequently let everyone in my extended family know about my DNR."

Sadly, Phil's experience is not uncommon. Misconceptions around the implications of not signing a DNR continue to persist. It's essential that patients and families are candidly informed. Resources like the Physician Orders for Life Sustaining Treatment (POLST) help healthcare professionals introduce these topics and educate others. Not only does this ensure patients can die with as much comfort and dignity as possible, it is also an important step in protecting families psycho-emotionally, and establishing a healthy starting point for processing and working through loss.

~ Chandelle Carter, CCM
Grief Specialist, Bereavement Coordinator
Hospice Atlanta

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RESOURCES

National POLST Coalition c/o

Louisiana Health Care Quality Forum

8550 United Plaza BLVD Ste. 301
Baton Rouge, LA 70809
Polst.org
natlpostcollaborative@gmail.com

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contact@ghpco.org

Interested in becoming a Palliative Care Committee Member? Please contact us at admin@ghpco.org

Legal Considerations

In 2015, The US Senate passed Bill 109 to clarify the use and effectiveness of POLST forms. While much of the details of the bill have been reviewed already, it is important to reiterate that this form is portable across care settings (such as transitions from the hospital to hospice). Importantly, all health care providers and facilities that utilize guidance based on the decisions delineated in the form, who act in good faith, are protected from liabilities. Furthermore, the bill helped equate terms such as allow natural death and do not resuscitate to ensure patients' end of life wishes are being honored.

Advanced Directives	VS	POLST
For anyone over 18 years of age		To be used for patients with a prognosis of less than 1 year and/or at risk of losing capacity
Completed by the individual		Completed by a physician and patient/ surrogate
Broad treatment preferences		Specific Orders
Signed by patient and two witnesses		Signed by MD and patient/surrogate

Thank you for your interest and continued support of GHPCO!

Follow our Facebook Page and Instagram for updates, news, and current events!

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