Special Audio Report Transcript

Headline: New Study Linking End-of-Life Directives With Hospitalization Has Implications for California

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Text:

A new study has found that nursing home patients who participate in a program that lets them record their end-of-life treatment wishes are much more likely to get those wishes met. This is a special report for *California Healthline*, a daily news service of the California HealthCare Foundation. I'm Mina Kim.

The Physician Orders for Life-Sustaining Treatment program, or POLST, allows terminally ill or nursing home patients to specify the type of end-of-life care they want. A new study released in July found that patients with a POLST were 59% less likely to get unwanted hospitalizations and medical interventions. Kenneth Brummel-Smith is chair of the Department of Geriatrics at Florida State University College of Medicine and a consultant to the study.

(Brummel-Smith): "What this study does is it compares people in the same institution who have a POLST and who don't have a POLST. So it really does give us a chance to answer the question, does having a POLST make a difference, and it appears it makes a pretty significant difference."

The study, for example, found 95% of people with a POLST got the medical interventions they wanted related to antibiotics versus 3% of patients without a POLST. On the use of feeding tubes it was 92% versus 6%. The study looked at 90 nursing homes in three states, though not in California, which only began using the tool a few years ago. Brummel-Smith was one of the pioneers in developing the Physician Orders for Life-Sustaining Treatment at Oregon Health Science University in 1990, in response to concerns that Do Not Resuscitate Orders and other advance directives weren't doing the job.

(Brummel-Smith): "The main problem is that a lot of people don't complete advance directive forms, like living wills….And so you're having to play catch up during a very emotional and stressful time."

Brummel-Smith says the key to the POLST program's effectiveness is that it's on the doctor to initiate the conversation, and the options for interventions are more comprehensive. Another key factor is that it's a standard form that

gets transferred across care sites like from the nursing home to the hospital. Jeffrey Yee is chief of General Medicine for Woodland Healthcare, a hospital near Sacramento that has been using POLST for more than three years.

(Yee): "Through the years I think we see a greater and greater fragmentation of medical care and when a community embraces POLST it helps to unify that care and helps to unify the different aspects of care that our frail patients are being subjected to."

Yee says similar to the study's findings, POLST has helped patients get their preferred treatments at his hospital, among other benefits.

(Yee): "It's been very very helpful, it's really changed how I interact with my patients certainly, and I think it's really changed how other physicians interact with the patients who have POLST."

About 250 nursing homes, hospitals and other care facilities in California have adopted POLST. But Yee says he has had some resistance. Some patients have been concerned that a physician could override a patient's wishes, others have worried that if they indicated they didn't want the full course of lifesaving treatment, the overall care they received would decline.

(Yee): "One of the biggest barriers we ran into was the perception that this was a process just to be cost savings, and that was not our intent at all. This was not to be an economic lever, but this was really to be a process by which we can help honor patient choices."

Judy Citko is executive director of the Coalition for Compassionate Care of California, a nonprofit that trains medical providers to talk with patients and their families about end-of-life care, and works to implement POLST broadly throughout the state. She says a requirement that both physicians and patients sign the POLST has helped alleviate some fears, but structural challenges remain such as giving physicians the time and expertise they need to have end-of-life conversations effectively.

(Citko): "Our health care system is designed to reward for procedures and interventions and it's not designed to reward for information and conversation."

Citko says other challenges have been the vast size and diversity of California. She says the group is developing a curriculum to address cultural differences in end-of-life conversations. And medical schools are starting to make it part of their curriculum. But Citko says the biggest change that needs to happen is an overall shift in mindset to prioritizing end-of-life conversations and devoting the needed resources and staff if California is to reap the benefits the new study suggests.

(Citko): "We are as a society spending a lot of money on care toward the end of life and people are not getting care that's consistent with what they want."

This has been a special report for *California Healthline*, a daily news service of the California HealthCare Foundation. If you have feedback or other issues you'd like to have addressed, please e-mail us at CHL@CHCF.org. I'm Mina Kim, thanks for listening.