Information in a Heartbeat: Readiness Assessment for Establishing a POLST Registry in California

The medical treatment that Californians want at the end of life is often out of sync with what they receive. While 70% of Californians say they would prefer to die at home, only 32% do. How can individuals make sure their end-of-life care wishes are known and honored?

Physician Orders for Life-Sustaining Treatment (POLST) allow individuals to articulate their wishes and have more control over their end-of-life care. POLST is a form that captures a conversation between individuals, their family members, and their physician regarding choices for end-of-life treatment.

However, completing a POLST form isn’t enough; it must be easily accessible during a crisis. How will emergency responders know a patient’s treatment wishes if that person’s POLST form or medical record is not available?

One solution is an electronic statewide POLST registry, which would securely store patients’ POLST information and make it accessible by medical personnel at any time.

This brief examines the landscape for a POLST registry in California, looks at models and lessons learned from other states, and outlines possible next steps to successful implementation and adoption of such a registry in this state.

Figure 1. Preferred Location of Death, California, 2011

Note: Segments do not add to 100% due to rounding.

Background

California’s POLST allows individuals to record their choices about life-sustaining treatment, including cardiopulmonary resuscitation, intensity of medical interventions, and artificially administered nutrition. Produced on a bright pink paper for easy recognition and signed by the physician and patient, POLST is a physician order recognized throughout the medical system. POLST is designed for people with a chronic progressive illness or serious health condition, or who are medically frail.

The form is intended to travel with the patient across care settings. “The information contained in a POLST form is as critical to our approach to patient care as information on allergies to medications,” said Tami Gash-Kim, MD, an emergency physician at Marin General Hospital. “It’s the first thing we look for when we see a patient in the end stages of advanced illness.”

After more than 20 years of use in Oregon, where POLST originated, research shows that POLST is a successful process for documenting and honoring end-of-life treatment wishes. A 2014 study of Oregon’s registry data compared treatment wishes listed in POLST forms to location of death and found that the end-of-life wishes outlined in the forms were honored, whether these wishes involved full treatment or limited care. Moreover, in a 2012 Cleveland Clinic Journal of Medicine study, authors found that “POLST more accurately conveys end-of-life treatment preferences for patients with advanced chronic illness and for dying patients than traditional advance directives and yields higher adherence by medical professionals.”

The Coalition for Compassionate Care of California (CCCC), the lead agency for POLST in California, is focused on implementing POLST as a community standard of practice. Formed in 1998, the CCCC is a statewide collaborative of more than 200 medical professionals. POLST complements, but does not replace, advance directives. With an advance directive, individuals can appoint their surrogate — the person they want to speak on their behalf. While an advance directive also allows people to provide a broad outline of their wishes relating to end-of-life care, these documents usually do not address specific treatment issues. Because advance directives are not signed by physicians, they do not carry the weight of a physician order.

POLST is designed for seriously ill individuals, and identifies patients’ specific wishes on specific medical decisions. A POLST is a physician order, and must be honored by emergency responders. These forms are designed to travel with a patient from one medical setting to another.

Advance Directives and POLST: What’s the Difference?

<table>
<thead>
<tr>
<th>ADVANCE DIRECTIVE</th>
<th>POLST</th>
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<tbody>
<tr>
<td>For who?</td>
<td>Every adult</td>
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<tr>
<td>What does it include?</td>
<td>Broad outline</td>
</tr>
<tr>
<td>Names a surrogate?</td>
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</table>

Figure 2. POLST

Source: The Coalition for Compassionate Care of California (CCCC)
www.capolst.org
organizations and individuals — including health care providers, consumers, and regulatory agencies — working together to improve care for seriously ill Californians. CCCC works with more than 25 local POLST coalitions around the state to conduct outreach and education activities in their communities.

Legislative Landscape
In early 2014, legislators in both California’s Assembly and Senate introduced bills to establish a statewide electronic registry for POLST.

Assembly Bill 2452 (AB 2452 Pan) proposed creating a statewide advance health care directive registry that would include POLST forms.6 Administered by the California Secretary of State, this bill would have digitized the state’s existing paper-based advance directive registry and added POLST forms.

Senate Bill 1357 (SB 1357 Wolk) was introduced to create a statewide POLST registry under the auspices of the California Health and Human Services Agency.7 This bill would have required the submission of POLST form data, unless the patient did not want it submitted.

Neither bill was approved by the legislature. AB 2452 was held in Senate Judiciary committee; SB 1357 was held in Senate Appropriations.

In December 2014, Senator Wolk introduced Senate Bill 19, the California POLST Registry Act, which proposes the establishment of a state POLST registry to be operated by the California Health and Human Services Agency. SB 19 is currently under consideration.

Figure 3. Evolution of POLST

1997-1998
Statewide group of health care providers, long term care professionals, state agencies, and consumers proposes ways to improve end-of-life care in nursing homes, starting the task force that would become CCCC.

1990s
POLST was developed to turn patient treatment preferences into actionable medical orders that can be used across care settings.

1990
1995
2000
2005
2010
2015

1997
1998
2004
2009
2012
2013
Early 2014
Late 2014

SB 19 is introduced to establish a POLST registry to be run from the California Health and Human Service Agency.

AB 2452 is introduced to create a statewide advance health care directive registry run from the California Secretary of State to include POLST forms.

SB 1357 is introduced to create a POLST registry out of the California Health and Human Services Department.

The number of local POLST coalitions in California grows to 24. CCCC’s POLST train-the-trainer program reaches over 900 participants.

August 2007
Coalition for Compassionate Care of California (CCCC) manages the creation of a statewide POLST task force and seven local coalitions.

2004
The National POLST Paradigm Task Force (NPPTF) was convened.

2008
AB 3000 legislation passes to create the POLST form in California with approval residing with EMSA.

2013
Oregon launches first statewide POLST registry.

2012
National POLST Paradigm Task Force publishes POLST registry development recommendations and lessons learned.

Source: BluePath Health, Inc.
This grassroots approach is one of the hallmarks of California’s successful POLST adoption. There are more than 1,200 skilled nursing facilities, 393 acute care hospitals, over 7,000 assisted living facilities, and numerous physician offices in California. The most up-to-date data available, from 2011, just two years after POLST was launched, show that more than 100,000 POLST forms had been completed by residents in California’s nursing homes alone.

POLST awareness and use is growing among California’s care providers: A 2010 survey of 546 nursing homes found that 82% of skilled nursing facilities in California have participated in training sessions about POLST. “We are training the nurses in skilled nursing facilities to consult the resident’s completed POLST form for guidance and not call emergency services for a patient that does not want to be transferred to a hospital,” explained Karl Steinberg, MD, certified medical director and current secretary of the California Association for Long-Term Care Medicine.

But because POLST is most appropriate for people with serious illnesses, the general public is largely unaware of this tool.

“The value of POLST is that it reaches across the entire continuum of care: from emergency services...
Why Is Immediate POLST Access Important?

During medical emergencies, providers benefit from immediate access to an individual’s treatment wishes.

Care providers at skilled nursing facilities and hospitals report that managing the paper POLST form to hospitals and nursing homes, all the way to care provided in the home. It gets all health care providers in California working to improve the way that we discuss, document, and honor patients’ treatment wishes,” said CCCC’s Judy Thomas.

California’s Advance Health Care Directive Registry

Since 2000, the California Secretary of State’s Advance Health Care Directive Registry permits a person who has an advance health care directive, or a similar document, to register it with the California Secretary of State. The registration includes information regarding the location of the advance health care directive or a copy of the advance health care directive itself. The intent of this process is to receive and release specified information from a person who has executed a written advance health care directive to authorized individuals like health care providers, and to charge a fee to cover the costs of establishing and maintaining the registry.

This repository of advance directives contains approximately 4,700 forms. California’s current advance directive registry is not searchable, the information cannot be immediately accessed electronically or over the phone, and requests for information can only be made during business hours. Since the registry only includes advance directives, it does not offer information about specific treatment preferences.

The Secretary of State does not conduct any marketing activities for the registry other than the information provided on the website. Secretary of State representatives have indicated that their office is not an obvious place for health care providers to look for the registry.

Figure 4. POLST Registry Technical Overview

Source: BluePath Health, Inc.
across settings of care is a challenge. While the POLST form is meant to travel with patients between care settings, the form can get lost during transfers — or never sent at all.

“If it’s late at night and the family isn’t there, I want to be able to tap into a registry and see what the patient really wants. For a useful registry, the data have to be high quality and absolutely reliable,” explained Larry Stock, MD, of Antelope Valley Hospital.

Access to end-of-life treatment information is especially important for emergency response personnel, who oftentimes do not have access to paper POLST forms. “Because emergency services are decentralized in California, a POLST registry may provide a service that simplifies and centralizes some of our procedures and protocols. A POLST registry would put crucial information about end-of-life treatment right into the hands of our frontline EMTs and paramedics, who can then honor patients’ wishes and their doctors’ orders,” shared Jay Goldman, medical director of ambulance and emergency medicine services for Kaiser Permanente Northern California.

A registry makes POLST information available to health care providers at any location at any time, either by looking up the information online or by contacting a 24-hour call center. It provides a backup system if the paper POLST form or electronic health record (EHR) is unavailable. With round-the-clock phone and electronic access to POLST information, providers would be able to follow an individual’s wishes even during the most stressful times, such as during an emergency department visit.

### POLST Registries: Current Models and Lessons Learned

As of March 2015, 17 states had established POLST programs, sometimes under other names such as Physician Orders for Scope of Treatment (POST), Medical Orders for Life Sustaining Treatment (MOLST), and Medical Orders for Scope of Treatment (MOST), and 25 additional states were developing POLST programs. This brief includes details about the Oregon and New York registries, and information about other POLST registries can be found online at www.polst.org/programs-in-your-state.

A 2012 report of the National POLST Paradigm Task Force, which is comprised of key leaders in the development and spread of POLST in their states and nationally, examined the structure and content of POLST registry systems in seven different states.14 Several key findings emerged:

- Defining the registry’s purpose prior to its development is essential. Questions to address include:
  - What is its proposed function?
  - Who will have access?
  - Where will it be housed?
  - What will it contain?
  - What is the mechanism to ensure timely submission and availability of registry content?

- A mature, widespread POLST program supports rapid adoption of use of a POLST registry.
- Sustainable funding for registry operations is vital to long-term success.
- Strong leadership from an effective statewide POLST coalition, which may be part of a broader effort to improve end-of-life care, is essential to successful POLST program outreach and widespread use of a POLST registry.
- Integrating a registry into existing health care systems (e.g., within a statewide emergency medicine system or health information exchange) increases its use and economizes resources.
- Integrated health systems can serve some functions of a registry within, though not outside, the health system if the electronic medical record is designed to rapidly locate POLST forms.
- How forms are submitted, and by whom, impacts the volume of submission. Develop easy-to-use processes that integrate into the work flow to support form submission.
- The POLST program needs to be firmly established before launching a registry.

Oregon, a leader in POLST adoption, launched its POLST registry in 2009, with the mission to “connect emergency health care professionals with their patients’ POLST orders to facilitate compassionate, desired health care during a crisis; . . . to increase accessibility to POLST orders to support continuity of care across health services platforms; . . . [and to foster] innovation by creating new ways to securely access health information.”15
New York has also established a POLST registry. Oregon’s registry provides a model for successful adoption, and New York offers a model of advanced technology infrastructure.

**Oregon POLST Registry: High Adoption Rate**

**Launched:** 2009

**Overview:** Oregon’s registry is seen by many as the standard-bearer for POLST registries given its length of time in operation and wide use; research demonstrating the impact of POLST could only be done because of the access to POLST forms in the registry.

**Key Elements**

- The Oregon Legislative Assembly House Bill 2009 created the registry within the Oregon Health Authority.
- The registry is a collaborative effort between state entities. State law provides the authority for this state activity and expenditure of funds, the Oregon Health Authority has statutory administrative responsibility, and the Oregon Health Sciences University (OHSU) operates the registry.
- While POLST form completion is voluntary, Oregon requires health providers to submit completed POLST forms to the registry. Forms may be submitted by mail, fax, or secure file transfer, unless the individual chooses not to participate in the registry.
- Providers in Oregon can access the information from the electronic registry at any time by phone. But there is currently no online access to the registry.

The registry focuses solely on POLST forms because the registry users — emergency medical services providers, emergency room and intensive care unit staff — need actionable medical orders. Advance directives do not provide specific medical direction and are not included in the registry.

**Use:** Since 2009, more than 4,600 calls have been made to the Oregon POLST registry hot link, which is open to emergency medical services (EMS), emergency departments, and acute care facilities. “We strive to ensure that the registry is on every emergency responders’ speed dial,” said Susan Tolle, MD, director of the Center for Ethics in Health Care at the Oregon Health and Science University.

The Oregon registry includes over 197,000 POLST forms, more than any other state, of which about 78,000 have been matched to death certificate data and archived. An analysis of 2012 registry data showed that the mean age of individuals with active forms in the registry is 76.7. Use of POLST forms in Oregon is high. Because POLST is most appropriate for individuals with serious illness and limited life expectancy, many of the approximately 34,000 individuals who die each year in this state could benefit from the POLST conversation and completion of a form. Some people appropriate for POLST may cope with serious illnesses for several years. The target market for POLST conversations and form completion may be estimated as a percentage of those who die each year plus those with serious illnesses.

**Impact:** During 2010 and 2011, nearly 18,000 people who died in Oregon had a POLST form in the registry, amounting to 31% of all deaths. When matched with information about place of death, researchers found a strong association between scope of treatment orders on the POLST form and the location of death. For example, 94% of individuals who chose “comfort measures only” died outside a hospital setting, while 44% who chose full treatment died in a hospital.

**What Works**

- The Oregon POLST program, started in 1990, was already in widespread use among stakeholders with a high level of POLST awareness by the time the registry was established.
- Requirement that providers submit all completed forms, unless patients chose not to participate, ensures that the database is populated.
- The registry secured ongoing state funding at its launch, and enhancements have since been funded by both public funding and private grants.
- Locating POLST forms in a single registry allows for research that can demonstrate the impact of POLST on treatment decisions and location of death.
- In 2015, the Oregon POLST registry was linked with OHSU’s electronic health record through specially developed software.

**Areas for Improvement**

- Registry is not accessible via the Internet or other network connections.
New York’s eMOLST Registry: Strong Technology Infrastructure

Launched: 2010

Overview: New York State’s POLST is known as Medical Orders for Life Sustaining Treatment (MOLST) and is available in paper format and online. The online format, first released in 2010, is eMOLST. eMOLST was developed by Excellus BlueCross BlueShield with initial funding from the New York State Department of Health. The registry is currently maintained, funded, and operated by Excellus BlueCross BlueShield.

Key Elements

- eMOLST was established by a private entity working closely with New York State Department of Health, and not through state legislation.
- This web-based application allows eMOLST orders and documentation of the conversation to be accessed from anywhere with Internet access. The state’s eMOLST system is accessible to all users at all times at www.nysemolstregistry.com.
- eMOLST allows health professionals to follow a standard clinical process for the MOLST discussion and guides them through all necessary documentation. The form and documentation elements can be customized to the requirements and laws of any state.
- New York’s MOLST forms can be completed online in eMOLST and are automatically included in the registry. A copy can be printed for the patient.
- Because eMOLST does not require or rely on an EHR system or any other technology besides Internet access, uptake can happen quickly and in all care settings, including in the community. eMOLST is also flexible enough to meet the needs of organizations with well-integrated EHR systems.

Use: eMOLST has thousands of users who access the application and thousands of forms in the registry. Users are from all regions of New York State, including New York City, the Hudson Valley, Upstate and Western New York, the Capital District, and Long Island. Users and forms are added daily.

What Works

- Technology is used to improve the exchange of critical information. Using a web-based platform guarantees instant usability and accessibility in all care settings, and anywhere in the community with Internet access.
- Because eMOLST can be integrated into an organization’s EHR system or HIE, the application can be easily incorporated into the existing provider workflow.
- Quality control measures are built into the system. For example, eMOLST does not allow incomplete forms to be submitted and also prevents providers from creating incompatible medical orders or orders lacking documentation. The eMOLST system immediately notifies providers of errors so they are able to make corrections without losing their work.

Areas for Improvement

- Standardized single-sign-on capabilities are built into the application, allowing for quick basic integration with hospital and nursing home EHR systems, HIEs, and RHIOs.
- In 2015, eMOLST is launching a patient importer process and leveraging optical character recognition technology to allow existing paper MOLST forms to be quickly converted to eMOLST. This addition to the system will report paper-based errors and missing information to providers to allow for corrections in the eMOLST system.

“..."We designed eMOLST as the electronic version of the MOLST form to support and document the end-of-life care conversation between the patient and physician," explained Patricia Bomba, MD, vice president and medical director of geriatrics at Excellus and program director for the eMOLST application. “eMOLST is a tool for providers that guides them through the conversation, capturing patient input accurately and completely in a document that can be shared electronically and printed.”

Areas for Improvement

- eMOLST use is not mandated through legislation or health department action. Health systems may choose to mandate its use within their facilities.
- eMOLST use is driven by systems and facilities that see its value and want to use the application. Systems that are resistant to change in their workflow are not required by legislation or regulation to use the eMOLST application at this time.
A POLST Registry in California: What Do Stakeholders Think

In early 2014, a wide range of health care stakeholders and POLST leaders were interviewed so they could share their perspectives about POLST adoption, the benefits of a statewide registry, and the potential challenges in implementing a registry. Interviewees included users of POLST forms to guide treatment decisions, those responsible for having the POLST conversation, and those completing the form who would also be responsible for submitting the form to the registry. Those interviewed included representatives of hospital emergency departments, acute care facilities, hospices, skilled nursing facilities, emergency medical services, and other care providers. See the appendix for a list of interviewees.

The stakeholders interviewed identified several next steps to support the successful implementation of a statewide POLST registry in California:

- Pilot the registry in a community, with the intent to scale rapidly.
- Develop a technology platform for the registry that supports multiple forms of input and output, from paper to fax to mobile devices.
- Expand existing POLST education infrastructure to include education about the registry.
- Engage state administrative leadership and consider development of an independently operated registry, based on the approaches of other successful California health registries, such as the California Cancer Registry.
- Identify funding sources to build and sustain the registry.

**Pilot the Registry**

Interviewees agreed that piloting the POLST registry would be a critical step toward ensuring that the system works efficiently and effectively for providers and patients across California. They suggested that the pilot be implemented on a future-focused, mobile technology platform and have the ability to scale quickly once it is completed. Stakeholders identified the following goals for a pilot:

- Develop and test product features, including integration with electronic health records and tablet-based input and access.
- Integrate electronic registry submission with current workflows in appropriate facilities, such as skilled nursing facilities and acute care facilities.
- Develop a financing model and commitment from public and private stakeholders.
- Confirm budget assumptions.

Stakeholders talked about the importance of conducting the pilot in a community that is ready for such an effort, and that has the following characteristics:

- Providers committed to participating in registry development efforts.
- An active POLST coalition to provide education and to promote adoption in the local community.
- A population that is able to generate a reasonable number of POLST forms, to populate the registry within the pilot timeframe.

**Develop a Future-Focused Technology Platform**

Interviewees discussed the ideal technology platform for the registry and stressed that it must be flexible to enable updates based on regulatory changes and link to other public registries to support population health and other research needs.

Key technology elements identified for a modern, mobile registry platform include the following:

- Support for web-based data entry as well as input from paper-based documents and output to paper. Electronic data entry is critical for controlling data quality, and input from and output to paper are still a necessity for many users.
- Use of tablets and smartphones. With more than 83% of providers using smartphones and tablets, providing mobile device support is an important component of stakeholder adoption.22
- Offer cloud-based access so that any provider with Internet connectivity can access the registry.

Stakeholders highlighted the importance of having the registry’s technology support the workflow of its users. They pointed to New York’s eMOLST form, a portion of which can be filled out by a non-physician, saved, and then completed and signed electronically.
by a physician. The form’s feedback system won’t allow non-physicians to complete any part of the form that requires physician completion. In this way, the electronic system mimics the paper workflow that has already been adopted by providers.

Two technical challenges that were identified include how individuals and providers will sign the electronic POLST forms to validate them, and what kind of system to implement for the unique identification of individuals with a form in the registry. New York’s eMOLST allows for digital signatures and also assigns a unique MOLST number identifier to each patient. While the provisions of the California Uniform Electronic Transactions Act do not prohibit the use of electronic signatures for POLST, more legal analysis is needed to ensure that electronic signatures can be used. In addition, the registry requires a robust patient matching system to ensure that providers can accurately and reliably match patients to their most recent POLST form.

Educate Stakeholders
Stakeholders emphasized that a strong outreach and education effort targeting both providers and patients will be necessary to ensure widespread adoption. The CCCC’s statewide and grassroots infrastructure was acknowledged as a ready-made distribution framework for reaching the appropriate consumer and provider audiences with messages on the requirements, use, and benefits of a statewide POLST registry.

Stakeholder membership organizations, such as the California Association of Health Facilities, were also identified as potential venues for reaching patients and providers. A state partnership with the POLST Task Force was discussed as an important way to reach these membership groups to speed adoption and increase the reach and impact of the registry.

Stakeholders acknowledged the diversity of emergency response providers in California, and the flexible approach to integration and adoption that will be required of EMS once a statewide registry is in place. Because communities typically have multiple fire substations, 911 responders, and medical transporters that operate under largely independent local policies and procedures, a POLST registry will be most successful if it is integrated into each of these unique workflows. Stakeholders expressed confidence about overcoming the challenges they recognized that are likely to arise with EMS integration.

Develop Expectations and Rules About POLST Registry Use
Oregon’s registry development and adoption was cited as a clear example of how a state requirement led to adoption. Stakeholders agreed that regulation will be a key driver for success in California as well. “We need a mandate, or something with a regulatory feel, to accelerate the adoption of new steps into our workflow,” said Jocelyn Montgomery, RN, of the California Association of Health Facilities, a long term care association.

Stakeholders also confirmed that state-supported regulation should focus on requiring providers to submit completed and signed POLST forms to the registry. They agreed that it is just as important to allow patients who are completing the forms to decide not to have their POLST forms submitted to the registry.

Engage State Leadership in Pilot and Statewide Spread Stages
Many stakeholders interviewed believe that strong state leadership, stakeholder engagement, and a requirement to populate the POLST registry will be required to drive adoption. “The hard work for this registry is not the software. The hard work is leadership and stakeholder involvement,” explained Robert Moore, MD, of Partnership HealthPlan of California.

Interviewees recognized that a statewide effort, particularly one with a regulatory requirement, will need strong state executive and legislative engagement. Initiating and adopting a California POLST registry will require a multi-stakeholder effort, similar to the initial POLST education effort, with goals and outcomes clearly defined.

Consider Operating Models
The administration and operation of a POLST registry could be provided through an independent organization or be a governmental function. Oregon is an example of a registry run by a state entity, OHSU. New York is an example of a registry run by a non-governmental entity, Excellus BlueCross BlueShield. In California, several statewide health registries were established to support the mission and goals of specific government agencies and departments while under the operation and administration of independently operated organizations (see Figure 5 on the following page).
Explore Funding to Build and Sustain the Registry

Interviewees agreed that public and private funding sources should be explored to sustain the registry. The launch of Oregon’s registry, for example, was funded through its state budget. The registry’s general administration continues to be supported through the state’s general fund, and research and outreach efforts are funded through private sources.

In addition to state funding, there are several federal programs for health information technology investments that could be explored to support the development of a POLST registry. Stakeholders concurred that plans, providers, and state leaders should work together to explore and maximize access to these opportunities.

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<th>GOVERNMENT ORGANIZATION</th>
<th>OPERATOR</th>
<th>PURPOSE</th>
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<td>California Cancer Registry</td>
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<td>UC Davis Institute for Population Health Improvement</td>
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<td>California Department of Motor Vehicles</td>
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<td>Controlled Substance Utilization Review and Evaluation System (CURES)</td>
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Next Steps

A statewide POLST registry will ensure that in times of crisis, emergency responders can immediately access treatment wishes so that people get the treatment they want — and equally important — they do not get the treatment they do not want.

What are the next steps?

People and partnerships. Strong leadership and a broad, committed, and sustainable coalition are common themes among successful POLST programs, as well as successful registries. California already has much of the necessary structure and leadership in place with its existing POLST program. The state will need to identify a capable technology partner. There may also be a consulting role for groups that have experience with successful POLST registry systems.

Voluntary and mandatory. The POLST itself is rooted in the belief that the form’s completion should always be voluntary for patients, but that it should be mandatory for providers to take reasonable steps to ensure that the POLST form is honored. A registry system should follow the same format: voluntary for patients, but mandatory that providers submit the forms to the registry, unless the patient chooses otherwise. One of the primary reasons the Oregon registry has been so successful is the provider mandate. Without such a requirement, the registry would likely not be a reliable resource, as many forms would never be submitted.

Legislation. Enacting legislation would make it mandatory for providers to submit completed POLST forms to a registry, unless the patient elects not to have the form submitted.

Technology. Because of California’s size and complex health care system, existing registry systems may not meet this state’s needs for a transactional registry, where data can be both submitted and retrieved in real time. A system that is developed should be flexible to evolve as health-related IT evolves. It should be developed to adapt with the current workflow of health care providers, and dovetail with the larger community-based grassroots approach of POLST.

Governance structure. California’s POLST program has long operated under a successful public-private partnership model. The California Emergency Medical Services Authority is the official home of the POLST form and approves the form’s content and any revisions. The nonprofit Coalition for Compassionate Care leads the coordination and delivery of POLST education to health care providers, oversees stakeholder engagement activities, and coordinates local implementation efforts. The two organizations work cooperatively to promote POLST.
About the Authors
BluePath Health is a California-based consulting firm that partners with government agencies, public health organizations, health information technology companies, providers, and payers to develop policies and strategies that improve the delivery of patient care and build community health.

The Coalition for Compassionate Care of California is a statewide collaboration of health care providers, consumers, and regulatory agencies working to improve care of seriously ill Californians.

About the Foundation
The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

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Appendix: Interviewees

California Ambulance Association
  June Iljana, executive director

California Association for Nurse Practitioners
  Karen Ayers, ACNP

California Association of Health Facilities
  Jocelyn Montgomery, RN, clinical affairs program director

California Association of Long-Term Care Medicine
  Karl Steinberg, MD, CMD

California Emergency Medical Services Authority
  Sean Trask, chief of EMS personnel
  Lisa Witchey, manager, EMS Personnel Standards

California Hospital Association
  Patricia Blaisdell, vice president, Post-Acute Care Services

California Medical Association
  Alicia Wagnon, legal counsel

Center for Medicare & Medicaid Services
  Betsy Thompson, chief medical officer, CMS Region IX

Coalition for Compassionate Care of California
  Judy Thomas, JD, chief executive officer

Emergency Medical Services Administrators’ Association of California
  Dan Burch, president

Excellus BlueCross BlueShield
  Patricia Bomba, MD, vice president and medical director, Geriatrics

HealthInsight
  Deepthi Rajeev, biomedical informaticist

Inland Empire Palliative Care Coalition
  Tarek Mahdi, MD, chair

Kaiser Permanente
  Jay Goldman, MD, ED physician, EMS liaison

Mendocino POLST Coalition
  Mark Apfel, MD

Oregon Health & Science University
  Susan Tolle, MD, director of the Center for Ethics in Health Care

Oregon POLST
  Jenny Cook, project liaison
  Dana Zive, senior instructor

POLST Task Force, POLST Registry Committee
  Robert Moore, MD, MPH, Partnership HealthPlan of California

UC Davis, Institute for Population Health Improvement
  Rim Cothren

UC Davis School of Medicine
  Michael Hogarth, MD, associate professor

Utah Commission on Aging
  Anne Palmer, executive director

Utah Department of Health
  Janice Houston, director, Bureau of Vital Records

Vynca
  Ryan Van Wert, MD, founder

West Los Angeles POLST Coalition
  Poonam Bhatla

West Virginia University
  Evan Falkenstine, data administrator
  Cindy Jamison, program manager, West Virginia Center for End-of-Life Care

Yolo POLST Coalition
  Joanne Hatchett, MSN, FNP
  Jeffrey Yee, MD, Dignity Health
Endnotes


4. Bomba, “POLST.”

5. AB 3000 amended Section 4780-4785 of the Probate Code.

6. For more information on AB 2452, see www.leginfo.ca.gov.

7. For more information on SB 1357, see www.leginfo.ca.gov.

8. For number of skilled nursing facilities, see “Total Number of Skilled Nursing Facilities,” Kaiser Family Foundation, www.kff.org; for number of acute care hospitals, see California Hospitals: Buildings, Beds, and Business (California HealthCare Foundation, January 2013), www.chcf.org; for number of assisted living facilities, see The Right Place: An Overview of Supportive Housing Options for Seniors and People with Disabilities (California HealthCare Foundation, September 2013), www.chcf.org.

9. 2011 data reports, California Minimum Data Set, Section S.


12. Phone conversation with staff person at the administrative office of the Secretary of the State.

13. Ibid.


17. Oregon POLST Registry.

18. Fromme et al., “Association.”


20. Fromme et al., “Association.”
