



## Fiscal Impact of the POST Program

**Bottom Line:** The goal of the POST Program is to honor treatment preferences of those with advanced progressive illness or frailty. The research indicates the POST Program is achieving this goal and concomitantly preventing unwanted expensive hospitalizations.

<http://www3.interscience.wiley.com/journal/117995531/home?CRETRY=1&SRETRY=0>

### The full statement of The National POLST Paradigm Task Force

In 1990 in Oregon the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm began to honor the medical treatment preferences of persons with advanced progressive illness. The system created by the paradigm helps elicit, communicate, and respect an individual's values through portable medical orders. The POLST Paradigm has different names in different states. In West Virginia, we call the program the Physician Orders for Scope of Treatment (POST) program, and the observations made in this article apply to it.

A number of states have implemented the POLST Paradigm and a majority of states have expressed interest in doing so. As the initiative grows, some wonder if the POLST Paradigm might partially mitigate the costs of health care near the end of life by preventing unwanted expensive life-sustaining medical treatments. Research has not specifically been done to establish the fiscal impact of the POLST Paradigm. However, extrapolations can be made from relevant research.

Based on individual preferences of persons with advanced illness expressed as orders on POLST Paradigm forms, a majority of patients choose to forgo some types of treatments and/or hospital transfer.<sup>1,2,3</sup> Of those patients with orders to forgo resuscitation and requesting comfort measures only, the rate of in-hospital death was 5% compared to a national average of 32%.<sup>4,5,6</sup>

A 3-state evaluation of the POLST Paradigm in nursing facilities (including in West Virginia) found that 98% of residents with POLST forms have orders regarding hospitalization, feeding tubes, and antibiotics, in comparison to just 16% of residents with traditional orders. Moreover, residents with POLST forms reflecting preferences for *Comfort Measures Only* were much less likely to receive hospitalization and other life-sustaining treatments than residents with POLST Paradigm orders for *Full Treatment*.<sup>7</sup>

Recently collected data from the death certificates and medical records of deceased residents of La Crosse County, Wisconsin demonstrate that with the use of POLST forms there was a six-fold increase in documented preferences not to return to the hospital for acute treatment compared to the pre-POLST era when only advance directives were available. Moreover, with POLST forms the request not to be hospitalized was honored 99% of the time compared to 78% of the time when only advance directives were used to record patient preferences.<sup>8</sup>

An ideal health care system would honor individual preferences while allocating health care resources efficiently. Although these needs are not mutually exclusive (and usually coincide for individual patients), the Task Force emphasizes that the goal of the POLST Paradigm is to honor treatment preferences of those with advanced progressive illness or frailty. The research indicates the POLST Paradigm is achieving this goal and concomitantly preventing unwanted expensive hospitalizations.

### References

1. Hickman, SE, Nelson, CA, Moss, A, Hammes, BJ, Terwilliger, A, Jackson, A, Tolle, SW. (2009). Use of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program in the Hospice Setting. *Journal of Palliative Medicine*, 12, 133-141.
2. Hickman SE, Tolle SW, Brummel-Smith K, Carley MM. (2004). Use of the POLST (Physician Orders for Life-Sustaining Treatment) Program in Oregon Nursing Facilities: Beyond Resuscitation Status. *Journal of the American Geriatrics Society*, 52, 1424-1429.
3. Lee MA, Brummel-Smith K, Meyer J, Drew N, London MR. (2000). Physician Orders for Life-Sustaining Treatment (POLST): Outcomes in a PACE Program. *Journal of the American Geriatrics Society*, 48, 1219-1225.
4. Tolle SW, Tilden VP, Dunn P, Nelson C. (1998). A Prospective Study of the Efficacy of the Physician Orders for Life Sustaining Treatment. *Journal of the American Geriatrics Society*, 46, (9), 1097-1102.
5. Fromme EK, Bascom PB, Smith MD, Tolle SW, Hanson L, Hickam DH, Osborne ML. (2006). Survival, Mortality, and Location of Death for Patients Seen by a Hospital-Based Palliative Care Team. *Journal of Palliative Medicine*, 9(4):903-911.
6. Zhao Y, Encinosa W. The Costs of End-of-Life Hospitalizations, 2007. Statistical Brief #81, Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality. November 2009, revised April 2010. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb81.pdf> (last accessed April 29, 2010).
7. Hickman SE, Nelson CA, Perrin NA, Moss AH, Hammes BJ, Tolle SW. (July 2010 in press). A Comparison of Method to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices versus the Physician Orders for Life-Sustaining Treatment (POLST) Program. *J Am Geriatrics Society*.
8. Hammes BJ, Rooney BL, Gundrum JD. (July 2010 in press). A Comparative, Retrospective, Observational Study of the Prevalence, Availability, and Utility of Advance Care Plans in a County that Implemented an Advance Care Planning Micro-System. *J Am Geriatrics Society*.

[www.wvendoflife.org](http://www.wvendoflife.org)

Toll-free number