

Thank you for your work on the Master Plan for Aging. Representing the California Health Care Foundation (CHCF), which has funded efforts to improve serious illness care and end-of-life care in California for over a decade, I am writing with recommendations that the Master Plan include a focus on the following two areas:

Palliative care for people with serious illness: Palliative care is specialized medical care for people living with a serious illness, focusing on providing relief from the symptoms, stress, and suffering that often accompany serious illness. The goal is to improve quality of life for both the patient and the family. Palliative care is appropriate at any age and at any stage of serious illness. It has been shown to improve quality of life and to reduce avoidable emergency department visits and hospitalizations. A recent [CHCF survey](#) found that when palliative care is described to them, 9 out of 10 respondents say they would want these types of services if they were to face a serious illness. Among older adults with serious illness, a [Kaiser Family Foundation survey](#) found at least a third of respondents said that some key needs are only sometimes, rarely, or never met, including help to manage feelings of anxiety or sadness (40 percent), spiritual support or counseling (37 percent), and getting what they want out of life while sick (34 percent) – all of which are key areas of focus for palliative care.

While access to palliative care has grown in California, many people who could benefit from and are eligible for these services never receive them, in part because of insufficient payment models for palliative care within the Medicare program, but also because of widespread, pervasive misunderstandings among the health care provider community about what palliative care is, who should receive palliative care and when, how it can help and patient and family, how it can help the treating physicians, and how to access these services. In addition, there are insufficient numbers of specialty-trained palliative care providers to serve all those that would benefit, so in addition to building understanding of specialty palliative care, California needs to build the skills and capabilities of all those providers that care for people with serious illness to provide basic elements of palliative care (often called “generalist palliative care” or “primary palliative care”), such as basic pain and symptom management and goals of care discussions. Because of these needs, ***the Master Plan for Aging should include a specific set of strategies around workforce education in palliative care across disciplines but with a primary focus on physicians, including strategies to provide incentives for completing high-quality, comprehensive training.***

Electronic access to medical orders regarding interventions at the end of life: Toward the end of life, when seriously ill or frail people cannot communicate their medical treatment choices, they risk receiving care inconsistent with their wishes. The National POLST (Physician Orders for Life-Sustaining Treatment) Paradigm aims to ensure people get the medical treatments they want, and avoid those they do not want, when they cannot speak for themselves in a medical emergency or due to serious illness. It encourages patients and their health care providers to talk about and document preferences related to potential medical intervention options, considering their diagnosis, prognosis, treatment plan, and goals of care. Older adults prioritize attention to medical wishes: the [CHCF survey](#) found that “making sure my wishes for medical care are followed” was one of the most important factors related to end of life care for respondents aged 65 and above. But during an emergency, when POLST information is needed urgently, it may not be readily available, hindering care or resulting in treatment that is against the patient’s wishes.

Since 2017, four regional POLST registries have been developed in California (two of these began as pilots with funding from CHCF). While these registries provide a valuable service in their local areas, they are limited by inconsistent penetration and use by area health systems and inconsistent access for emergency personnel. They are also limited by the continued use of paper POLST forms across the state, rather than electronically entered POLST information. Paper POLST forms too frequently are missing required elements (like signatures) or contain conflicting medical orders, rendering them invalid; the risk of such errors can be mitigated in the setting of electronic form completion. Because of these gaps, ***the Master Plan for Aging should include strategies to***

expand use of electronic POLST completion and to expand electronic access to POLST across care settings, across the state.

Thank you for your consideration of these recommendations.

Sincerely,

Kate Meyers
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