Recommendations for Integrating Physicians Orders for Life Sustaining Treatment (POLST) Forms with Electronic Health Records

It is critical for health care professionals to have access to POLST Forms during a medical emergency when the patient lacks capacity. Electronic health/medical record systems (EHRs) create the ability for POLST Forms to be immediately accessible. As EHRs are being increasingly adopted, health care facilities must consider how best to integrate POLST Forms with their EHRs.

There are two formats to consider when integrating POLST within an EHR. The first is completing a paper POLST Form and then uploading and storing a copy within an EHR. The second is creating an electronic POLST (ePOLST) where the POLST Form is completed electronically with a copy printed for the patient to keep. Because of the flexibility in form completion, increased accessibility to educational materials and improved ability for quality assurance activities, the National POLST Paradigm Task Force (NPPTF) strongly encourages facilities to utilize electronic completion of POLST, but should utilize, when available, a statewide ePOLST system.

The NPPTF has approved the following recommendations -

Recommendations for either format:

1. POLST Forms should be displayed in a unique POLST field/tab accessible instantly within a single click from the patient header. The tab can be marked with a Yes or No box, so that the health care professional can see if a form exists before opening the tab.

2. The unique POLST filed within the inpatient and outpatient EHR contains only POLST medical orders and is independent of the advance directive information.

3. The EHR system has the ability to rapidly receive and accurately store older versions clearly demarcated as voided and display the most recent document.

4. Health care professionals should be able to access POLST Forms within the EHR system. Single sign- on should be enabled to ensure no additional username or password needs to be entered. [If the EHR system offers access to an external POLST Form database or system it should be via a secure and authenticated portal, with an interoperable data exchange standard or link.]

5. The most current POLST filed within the inpatient or outpatient EHR should be easily accessible and viewed by the patient via any integrated patient portal.

Recommendations for ePOLST systems:

1. A state specific ePOLST system and template should be developed, approved and updated in collaboration with state POLST Programs. Standards for wording and printing in ePOLST systems should align with POLST Forms designed by POLST coalitions and/or state agencies.

2. ePOLST systems must allow for a paper version to be printed to provide to patients; this paper version should be identical to current paper POLST Forms approved in the state.

3. Where statewide or regional central ePOLST completion systems are available, EHRs should integrate with them and use these systems to complete ePOLST Forms and any necessary documentation.

4. Encourage all EHR vendors and third parties developing ePOLST systems to work collaboratively towards a universal and standardized program that represents best practices for access and interoperability for all EHR users. Further, encourage expansion of system-wide thinking to include connections with registries, statewide or regional central POLST completion systems, and emergency services systems.

5. As allowed by state laws or regulations, when a statewide or regional system exists, the EHR system should allow export of POLST Forms to a regional or statewide database/system/registry for storage and authorized access of forms. Accepted interoperability standards should be used.

6. If a new POLST version is approved by a state, the ePOLST system should be able to easily update language and formatting to match updated paper POLST Forms approved in the state. Since patients are not required to update their POLST Forms whenever an update of the POLST Form language occurs, EHR systems must be able to display current POLST Forms with older formats and language in addition to the updated format and language.

7. ePOLST should use a documentation method which confirms that both the health care professional and patient/surrogate have validated the contents of the ePOLST in accordance with applicable EHR regulations and state laws.

8. Optimally, the ePOLST system should provide access to educational materials that facilitate shared informed medical decision-making and accurate completion of the form.

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