POLST®
physician orders for life-sustaining treatment paradigm®

National POLST Paradigm
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PORTLAND, Ore. – A new study, from researchers at Oregon Health & Science University and published online today in the Journal of the American Geriatrics Society, demonstrates that the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm helps patients with serious illness or frailty for whom their health care professional would not be surprised if they died within the year ensure that their treatment wishes are honored. The study indicates that patient preferences recorded on a POLST Form are significantly associated with place of death and is important news for patients choosing to use a POLST Form.

While the conclusions of this study are extremely positive, the research is based on the Oregon POLST Program, which has achieved mature status from the National POLST Paradigm Task Force (NPPTF). Mature POLST Programs are endorsed statewide POLST Programs where the POLST Paradigm is the standard preferred method of advance care planning for persons with serious illness or frailty for whom their health care professional would not be surprised if they died within the year. Mature POLST Programs are used by 50% or more of hospitals, nursing homes, and hospices in each region (as defined by established criteria such as EMS, Department of Health, or the Dartmouth Atlas) of the state. Other POLST Programs, at earlier stages of development, may not show the same results but the NPPTF believes this research shows both the promise of the POLST Paradigm and the importance of effective implementation of the entire POLST process. When the POLST Form is accompanied by education, outreach, and assessment, the NPPTF is confident that POLST Programs can show similar benefits to patients in all states.

About the National POLST Paradigm

The National POLST Paradigm is an approach to end-of-life planning that emphasizes: (i) advance care planning conversations between patients, health care professionals and loved ones; (ii) shared decision-making between a patient and his/her health care professional about the treatment the patient would or would not like to receive at the end of his/her life; and (iii) ensuring patient wishes are honored through documenting those wishes on a POLST Form. As a result of these conversations, patient wishes may be documented in a POLST form, which translates the shared decisions into actionable medical orders. The POLST form assures patients that health care

professionals will provide only the care that patients themselves wish to receive, and decreases the frequency of medical errors.

The National POLST Paradigm is an approach to end-of-life planning that emphasizes patients' wishes about the treatment they receive. The intended POLST population is those individuals with serious illness or frailty for whom their health care professional would not be surprised if they died within the year. The National POLST Paradigm Task Force (NPPTF) was convened in 2005 to develop a National POLST Paradigm and provide guidance and support to state POLST Programs. The NPPTF is comprised of one representative chosen by each state with a POLST Program that has been endorsed by the NPPTF as well as legal and emergency medical service consultants.

The National POLST Paradigm embodies and promotes the essential elements of a POLST Program; individual states and regions implement POLST Programs. As a result, state programs vary in name (e.g. MOLST, COLST, MOST, and POST), how their programs are implemented, and in the appearance of their forms. Although these state POLST Programs may be identified by the NPPTF as "Developing Programs" and/or use the term "POLST" or a similar term, they do not represent the POLST Paradigm until they have been endorsed by the NPPTF. Only state programs that have demonstrated to the NPPTF that their POLST Program and form meet NPPTF standards can be endorsed.