National POLST Paradigm
Application for Endorsed POLST Paradigm Program Status

Directions: Please complete the information requested on this form. Email the POLST Form and additional information and documents to the National POLST Paradigm Office: admin@polst.org

State:
Application Date:
State POLST Program Name:

State Contact Information

1. **Name:**
2. **Title:**
3. **Email:**
4. **Street Address:**
5. **Second Line:**
6. **City, State, Zip:**
7. **Phone:**
8. **Fax:**
    a. The state's contact information on polst.org/map needs to be updated with the information above.
    b. The state's contact information on polst.org/map is accurate.

Program Information

1. **Year POLST Coalition Started:**

2. **Year of first POLST Form Use:**

3. **Are there state laws and/or regulations that relate to POLST?**
    a. **If yes, please provide a copy of each with your application.**

4. **Please attach summary of any legislative history (such as attempts at legislation, success of legislation, major opposition groups or barriers to legislation, etc).**

5. **Please attach summary about the history of your POLST Program, including any barriers overcome or key decisions about its development and/or implementation.**

Media Information

Provide the following information and/or expectation of go-live date, if applicable:

1. **Program Website:**
2. **Program Facebook Account:**
3. **Program Twitter Account:**
4. **Program LinkedIn Account:**
5. **Other Social Media Accounts:**

Media contact

If available:

1. **Name:**
2. **Email:**
3. **Phone:**

Evaluation for Endorsed POLST Paradigm Program Status

POLST Program endorsement is based on the program's compliance with the programmatic and form elements listed below. Please indicate whether your POLST Program meets each requirement by indicating **Yes** or **No** for each item. Provide attachments requested with final submission.

POLST Program Requirements		
Yes	**No**	**Items 1-9 are Required Elements for Endorsed POLST Paradigm Programs**
		1. Program is a single statewide coalition that includes champions who are active in the program implementation and education. **Please attach a list of coalition members.**
		2. There is an entity within that is willing to accept ownership for the program (e.g., hospital association, state department of health, hospice and palliative care association, university-affiliated ethics center, etc.) and has the financial resources to implement it. **Please identify entity**:
		3. Program promotes that completion of the POLST Form is voluntary.
		4. Program promotes that the intended audience for use of POLST Forms are patients who are seriously ill ("serious advanced illness" for professionals) or frail for whom their health care professional would not be surprised if they died within the year.
		5. Program promotes that completion of the POLST Form is based on shared decision making between the patient and his/her health care professional and that the POLST Form is viewed as patient preferences documented as medical orders.
		6. The program is the preferred practice for appropriate populations (see 4 above) for the process of advance care planning and the implementation of that planning across health care settings (e.g., emergency medical services, long-term care, hospital, and hospice).
		7. There is ongoing training of health care professionals across the continuum of care about the goals of the program, the creation and use of the form, and how to conduct a POLST conversation to elicit and record patients' preferences as orders on a POLST Form. **Please provide copies of sample training materials such as PowerPoints, brochures and/or guidelines.**
		8. The program shows evidence of consideration of the NPPTF document Seven Core Elements of Sustainability for State POLST Programs, found on polst.org.
		9. There is a plan for an ongoing quality evaluation of the program and its implementation. The program has or is in the process of identifying and building a research and quality assurance component. Please see the POLST Quality and Research Toolkit (PQRsT) for suggestions. It is crucial for each program to be able to receive feedback with regard to how it is functioning.
Yes	**No**	**Items 10-12 are strongly recommended for Endorsed POLST Programs**
		10. States accept POLST Paradigm Forms completed in other states (reciprocity).
		11. The POLST Program should support the National POLST Paradigm's Digital Media Communication strategy by developing and maintaining a web presence that supports polst.org by working with the National POLST Office to use state.polst.org as their website or obtaining webpages through the National POLST Office (polst.org), to the extent possible. Any website should include educational materials for patients and families as well as health care professionals, information on how to obtain forms, and POLST Program contact information.
		12. The POLST Program should support the National POLST Paradigm's Digital Media Communication Strategy, including by providing content on a periodic basis.

POLST Form Requirements		
Yes	**No**	**Items 1-11 are required elements for Endorsed POLST Paradigm Forms**
		1. The form clearly states that it is a "medical order".
		2. Patient identifying information is on all pages of the form.
		3. The form is clearly not an advance directive nor combined with an advance directive, such as a living will, health care power of attorney or other such document, and should not require any witnesses or notarizations of patient signatures. Form shall not be combined with organ donation authorization. **Note**: A POLST Form may document the existence of these other documents but cannot be combined with them.
		4. The form requires a valid health care professional signature or electronic authentication (pursuant to state laws and regulations) and date of signature. **Note:** It is a regulatory standard that all medical orders indicate the date issued. The date will allow identification of the most current order.
		5. The form indicates with whom the order was discussed, the patient (if he/she has decision-making capacity) or the patient's surrogate (as identified by state law). Unless there is restrictive language in the state's law, the surrogate has the authority to complete an original and/or revise a POLST Form for a patient lacking decision-making capacity. **If there is a restriction in state law about surrogate authority and POLST, please provide a copy of the relevant statute or regulation.**
		6. The form provides explicit direction about resuscitation (CPR) instructions or patient preferences if the patient is pulseless and apneic.
		7. In addition to orders with regard to CPR, the form indicates the level of medical intervention for the patient (exact wording for each level may vary from state to state) comfort measures; limited additional interventions; or full interventions. Each level of intervention shall contain a description of the services to be provided and the site in which they will be provided. See 7A - 7C:
		7A. "Comfort Measures". Clearly provides option for "comfort measures" as the focus of treatment. Must provide instruction indicating that the patient is to be transferred if comfort needs cannot be met in the patient's current setting. [Goal is to include language affirming a patient's right to be transferred to receive comfort care.]
		7B. "Limited Additional Interventions". Clearly provides a separate option for "limited additional interventions." This option includes measures for comfort as well as hospital admission and treatment with IV fluids, antibiotics, and cardiac monitoring as appropriate. This option does not include intubation, advanced airway interventions, or mechanical ventilation. It may include less invasive airway support (e.g. CPAP, BiPAP) depending on patient's preferences. Should include a statement "Avoid intensive care" or "Generally avoid intensive care."
		7C. "Full Interventions." The form clearly provides an option for "full interventions". Option includes treatments such as intubation and mechanical ventilation in an intensive care unit. Patients who are already receiving long-term mechanical ventilation may indicate treatment limitations in the "Other Orders" space in the level of medical intervention section.
		8. In section with orders for level of medical intervention, form must provide space for "Additional Orders."
		9. Form clearly states that food and fluids must be offered if feasible, regardless of level of care chosen.

		10. Form clearly states that comfort measures are always provided, regardless of level of treatment chosen. **Note:** Preference is for "level of treatment" rather than "level of care" to avoid confusion. Care should always be provided whereas treatment may be withheld based on patient's preferences.
		11. The form does NOT contain any of the following language: • "Do not transfer the patient" • "Do not call 911" • Any language that could be interpreted as restricting or negating a patient's right to access comfort care. • Language defining or qualifying "futility".
Yes	**No**	**Items 12-22 are form elements strongly recommended by the NPPTF for Endorsed POLST Paradigm Forms. While Endorsed POLST Forms need not have all these items, they must comply with most of these items.**
		12. The form is uniquely identifiable (e.g., unique color) and standardized within the state.
		13. The form indicates on the front page (ideally all pages) the name of the state.
		14. Language should be positive and easily understood. (For example, the comfort measures description might read "Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route…" and should avoid negative language suggesting that care and/or comfort of the patient are being denied, "Do not intubate or transport…")
		15. The original form need not be present at the time of emergency. Form should explicitly state that faxed, copied or electronic versions of the form are legal and valid.
		16. The form should NOT contain the following language: Form is rescinded during surgeries, invasive procedures and/or hospital stays. **Note:** POLST is primarily for out-of-hospital and transition-of-care settings such as the Emergency Department. POLST orders are used to guide hospital admission orders and should be reviewed (and revised as necessary) upon discharge.
		17. All medical orders should be on the first page of the form.
		18. The form should have the following language included on them: "HIPAA permits disclosure to health care professionals as necessary for treatment."
		19. As allowed by statute and regulations, POLST Forms should require the patient's (or the patient's surrogate): (a) signature; (b) attestation; or (c) witnessed verbal consent. Requiring one of these items provides evidence that the patient or his/her surrogate have reviewed the form, agree with the orders on the form, and that the orders accurately convey their preferences. To increase accountability, it is especially important that programs being established without a governing state statute or regulation develop a process for POLST Form completion that documents review and approval of the form by the patient or the patient's surrogate has occurred.
		20. The form should provide information on how to obtain additional forms.
		21. The form should provide directions and have specific sections for: (a) completing the form; (b) using the form; (c) updating the form; (d) revoking or voiding the form; and (e) submission to the Registry (if applicable). Directions on revocation or voiding the form should be kept separate for easy navigation.
		22. There should be a section next to the date of the health care professional's signature for the time of completion. The time of the completion of the form should be entered in addition to the date to comply with good practice and regulations in most health care settings.

I. POLST Paradigm Form Use Please respond based on current use.

(1) In creating the POLST Form, did the program review the endorsement requirements?

a. Yes
b. No - explain why not

(2) POLST Forms are used in the following settings:

a. Long Term Care Facilities
b. Hospice Facilities
c. Nursing Homes
d. Hospitals

(3) POLST Forms are used:

☐ a. Statewide
☐ b. Regionally – please provide summary of regions and plans for statewide implementation.
☐ c. Pilot Programs- please provide a brief summary of the pilot programs and plans for statewide implementation.

(4) POLST Form distribution/use:

a. # of Forms distributed per year:
b. Use of Forms by those 18 years old or younger:
c. Are POLST Forms distributed from a central location?
    i. If no, how are POLST Forms distributed?

(5) POLST Form revisions:

a. How often is the POLST Form reviewed and revised?
b. Who/what group revises the POLST Form?
c. How are updated POLST Forms distributed?

II. POLST Policies Provide sample copies of policies relating to POLST use in health care settings (hospitals, EMS, nursing homes, etc). If no policies exist, please explain why not.

III. POLST Program Management

(1) Describe how the POLST Program is managed:

(2) Describe any quality assurance measures the POLST Program implements:

(3) Describe how the POLST Program incorporates the Seven Core Elements for Sustainability:

IV. POLST Education

(1) Describe training and educational materials available for health care professionals:

(2) Describe training and educational materials available for patients and the public:

V. POLST Registry

(1) Does the program have a Registry for POLST Forms?

a. If yes, please provide details about funding and timelines.
b. If no, does the program have plans for creating a Registry?

VI. Additional Information

(1) Provide any information you think would be helpful for the National POLST Paradigm Task Force in reviewing this application.

For Office Use Only:

NPO Review: _____
Date DSAC Approval: _____
Date Consultation Committee Approval: _____
Date NPPTF Approval: _____