About the National POLST Paradigm

The National POLST Paradigm is an approach to end-of-life planning that helps elicit, document and honor patient treatment wishes. The POLST Paradigm emphasizes:

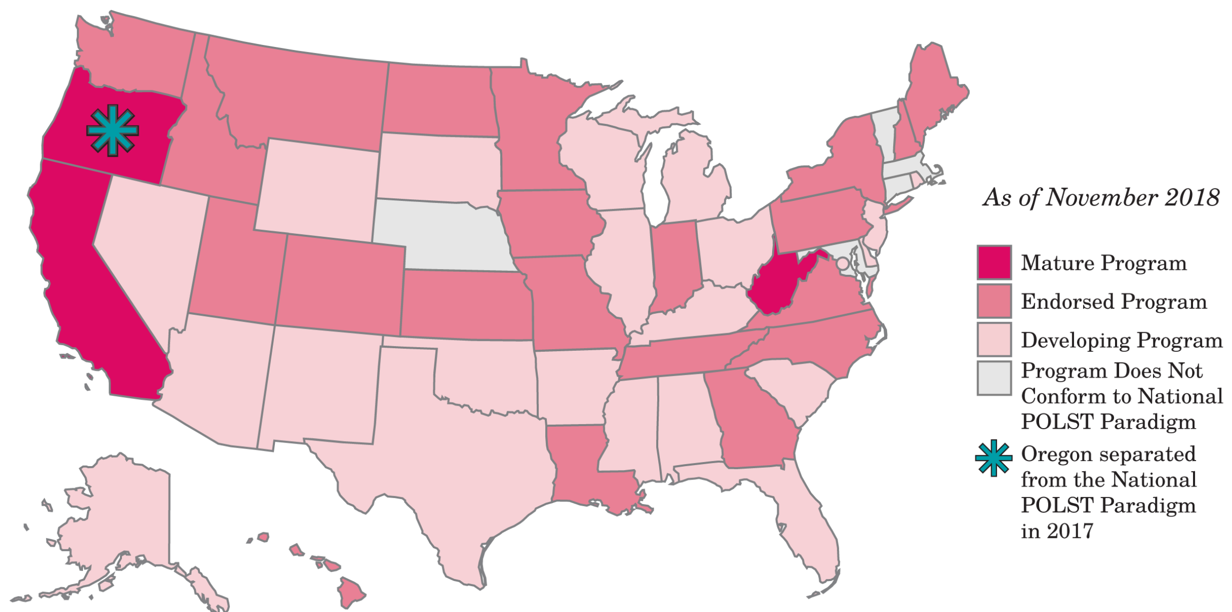
(i) advance care planning conversations between patients, health care professionals and loved ones;
(ii) shared decision-making between a patient and his/her health care professional about the treatment the patient would like to receive at the end of his/her life; and
(iii) ensuring patient wishes are honored.

The POLST form is designed to support patients transitioning between facilities—or who live outside a facility—by communicating patient treatment wishes. In the event of a medical emergency, when time is of the essence for medical decision-making, the POLST form serves as an immediately available and recognizable order set in a standardized format to aid emergency personnel. Following the POLST form orders, emergency personnel can honor the patient's treatment wishes as communicated to—and documented by—the patient's health care professional. A POLST form assures patients that health care professionals will provide only the treatments that patients themselves wish to receive, and not the treatments they wish to avoid.

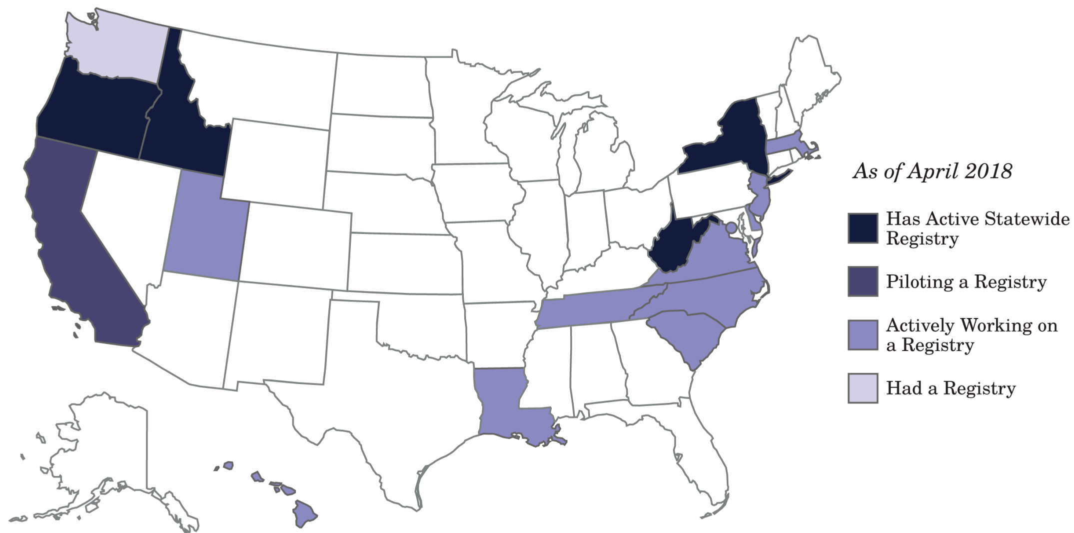
The POLST decision-making process and resulting medical orders are intended for patients who are considered to be at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. For these patients, their current health status indicates the need for standing medical orders. Another way to look at it: patients appropriate for a POLST conversation are those who are most likely to have a medical crisis (predictable based on diagnosis) but who may not want our current standard of care, which is to do everything possible in an attempt to save someone's life. For healthy patients, an advance directive is an appropriate tool for making future end-of-life treatment wishes known.

The National POLST Paradigm embodies and promotes the essential elements of a POLST Paradigm Program; individual states and regions implement POLST programs. As a result, state programs vary in name (e.g., MOLST, MOST, and POST), how their programs are implemented, and in the appearance of their forms. Programs may use the term "POLST" or a similar term but they do not represent the fundamentals of the POLST Paradigm until they have been endorsed by the National POLST Paradigm.

To learn more please visit [www.polst.org.](http://www.polst.org) This map shows POLST Program designations:



National POLST Paradigm: Registry Map (For more information, please visit www.polst.org/technology)



National POLST Paradigm: POLST Adoption by State

This map shows the general availability regarding the adoption of the POLST Paradigm within a state. For this map, POLST Program leaders were asked to use the following definitions and provide their assessment about the level of adoption of the POLST Paradigm within their state:

- **Statewide:**
  - More than 75% of Emergency Medical Service agencies have protocols that recognize and honor the state POLST form.
  - POLST is the standard preferred practice statewide for process of advance care planning for persons of any age with serious advanced illness or frailty whose health care professionals wouldn't be surprised if they died within the year
  - For each region of the state (defined by EMS, DHS or Dartmouth Atlas), POLST forms are used in 50% or more **in each**: hospital, nursing home or nursing home resident population, and hospice.
- **Working /Towards Statewide Availability**. There is greater availability/adoption of POLST than just in pilot programs or specific regional areas.
- **Pilot Programs or Limited Availability**. The POLST Paradigm is being piloted in specific areas or is only available/adopted in certain regions.