April 11, 2018

Joanne Kuntz, MD
Clinical Director of Palliative Care Services
University of Connecticut
263 Farmington Ave, L6111
Farmington, CT 06030

Suzanne Blancaflor
Via email: suzanne.blancaflor@ct.gov

Connecticut Department of Public Health
410 Capitol Avenue
PO Box 304308
Hartford, CT 06134

Dear Dr. Kuntz, Ms. Blancaflor, and to whom it may concern:

Thank you for the work that you and your Connecticut colleagues have done to develop your state POLST program, called Medical Orders for Life Sustaining Treatment (MOLST). We appreciate the effort that starting your MOLST program has involved.

As you know, the National POLST Paradigm Task Force (Task Force) was created in 2004, in part, to establish quality standards for POLST programs. The Task Force endorses states that have proved their programs meet those standards. While the Task Force avoids frequent revisions of those standards, they are periodically reviewed and updated based on experiences in Endorsed states, quality reviews, and research regarding POLST forms and programs.

Due to increasing criticisms of and attacks on the POLST Paradigm, the Task Force decided to distinguish POLST Paradigm programs from those programs that may use "POLST" or a similar term but which are being implemented in a manner open to certain criticisms or in conflict with our mission. These states are implementing their programs in such a manner that they are not currently on the pathway to becoming endorsed by the Task Force and are clearly identified on our website (www.polst.org/map) as a state with a program not conforming to POLST requirements by being shaded grey. This distinction and the explanation are increasingly important as the POLST Paradigm is misunderstood by those who are criticizing it and as we are trying to achieve our goal of reciprocity of all POLST forms among all states. It is necessary for the Task Force to take action and distinguish such programs are not following the national model because they are causing confusion about the POLST Paradigm and, as a result, harming the reputation of states who have worked hard to become endorsed POLST Paradigm programs, meeting the high-quality consensus standards developed by the Task Force. These states are also inhibiting the goal of ensuring patient POLST forms can be honored throughout the United States.

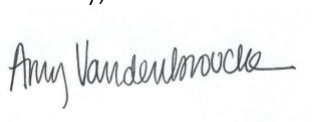
www.polst.org
208 I Street NE
Washington DC 20002
(202) 780-8352

Unfortunately, Connecticut is a state that needs to be identified as not adhering to the POLST standards created by the Task Force because its form does not comply with the endorsement requirements. The POLST Paradigm standards require a single section clearly defining level of treatment options beyond CPT, including comfort measures only, limited additional or select interventions, and full treatment. Data has shown that these three treatment options have the greatest impact on the level of life-sustaining treatments that are provided (Hickman, JAGS 2010). See Section 7 under Form Requirements for Endorsement in the attached and Section B of the attached California POLST form as an example. Instead, Connecticut's MOLST Form has multiple sections that require interpretation in order to determine what level of treatment the patient may have wanted. While the Task Force recognizes that elements of the limited additional or select interventions have been spread out within this form, the lack of the obvious option is problematic. While there are other elements of this form not meeting endorsement requirements, this omission is the primary reason Connecticut is being identified as non-conforming.

We appreciate that every state faces unique implementation challenges but the success of the National POLST Paradigm, and the POLST movement itself, is contingent on all POLST Paradigm programs being unified and consistent in their programmatic approach, education, and form elements. For the POLST Paradigm to succeed in its mission, ensuring that all patients will have their treatment wishes honored wherever they are in the United States when they have a medical crisis, we must have consistency and uniformity among POLST forms. Reciprocity provisions in many state statutes reinforce this requirement.

This change will go into effect on May 15, 2018. We regret having to make this decision. The National POLST Paradigm encourages all programs to achieve endorsement status and is happy to help provide technical assistance, mentorships, and other resources. If you would like to discuss this letter, please contact me at (202) 780-5738 or amy@polst.org. If you would like, we can also schedule a call with Connecticut leadership and the Program Assistance Committee to discuss this further.

Sincerely,



Amy Vandenbroucke, JD
Executive Director, National POLST Paradigm

This form is yours to keep with you. Bring it to all medical appointments and admissions to health care facilities.

Connecticut
Medical Orders for Life Sustaining Treatment (MOLST)
PILOT PROGRAM

PATIENT INFORMATION

Patient Last Name/First/Middle Initial		
Street	City/Town	ZIP
Date of Birth (mm/dd/yyyy)	Sex: M [ ] F [ ]	

ELIGIBLE DIAGNOSIS:
[ ] END STAGE SERIOUS, LIFE LIMITING ILLNESS: (specify)_____ OR
[ ] ADVANCED CHRONIC PROGRESSIVE FRAILTY CONDITION:

GOALS OF TREATMENT- MEDICAL INTERVENTIONS: (check one box only)
[ ] a. No limitations to medical treatment & intervention
[ ] b. Limited medical treatment or intervention
[ ] c. Comfort care; allow natural death with symptom management for comfort purposes

Section A (Check one box only)

CARDIOPULMONARY RESUSCITATION (CPR): PERSON HAS NO PULSE AND IS NOT BREATHING

[ ] Perform CPR [ ] Do Not Perform CPR

If patient is not in cardiopulmonary arrest, follow orders in section B & C.

Section B (Check one box only)

Transfer to Hospital

[ ] Transfer to hospital [ ] ICU care [ ] No ICU care	[ ] Do not transfer to hospital (unless needed for my comfort)

Intubation and Ventilation (Non CPR related)

[ ] Use invasive airway management or mechanical ventilation [ ] Use invasive airway management or mechanical ventilation, defined trial period Length of trial period: _____	[ ] No invasive airway management or mechanical ventilation

Non-Invasive Ventilation

[ ] Use non-invasive ventilation or rescue breathing for respiratory distress, such as BiPAP or CPAP [ ] Use non-invasive ventilation defined trial period Length of trial period: _____	[ ] Do not use non-invasive ventilation

HIPAA PERMITS DISCLOSURE OF MOLST TO ANY HEALTH CARE PROFESSIONAL AS NEEDED FOR PATIENT CARE

Section C (Check one box only)

Medically Administered Hydration (oral or by mouth hydration will always be offered if feasible)

[ ] Use medically administered hydration [ ] Use medically administered hydration, defined trial period Length of trial period: _____	[ ] No medically administered hydration	[ ] Undecided [ ] Did not discuss

Medically Administered Nutrition (oral or by mouth nutrition will always be offered if feasible)

[ ] Use medically administered nutrition, such as total parenteral nutrition or tube feedings [ ] Use medically administered nutrition defined trial period Length of trial period: _____	[ ] No medically administered nutrition	[ ] Undecided [ ] Did not discuss

Dialysis

[ ] Use dialysis [ ] Use dialysis, defined trial period Length of trial period: _____	[ ] No dialysis	[ ] Undecided [ ] Did not discuss

Other treatment preferences specific to the patient's medical condition, e.g. vasopressors, medications, antibiotics, etc.

Section D

For this form to be valid: The form must be a lime green original MOLST form and the provider signing must ensure the form is thoroughly completed and signed by the patient or patient's legally authorized representative, provider and witness. A form that is incomplete, improperly completed or amended, except as permitted in Section E shall be deemed invalid and of no effect.

Discussed with:

[ ] Patient

[ ] Legally Authorized Representative (specify) _____

Signature below confirms this form was signed by the patient or Legally Authorized Representative **voluntarily** and reflects his/her wishes and goals of treatment as expressed to the provider signing below. Signature by a patient representative as indicated above confirms the form reflects his/her assessment of the patient's preferences or goals of care, or if those preferences are unknown, his/her understanding of the patient's best interests.

Signature of Patient or Legally Authorized Representative:	Date:
Printed Name of Patient or Legally Authorized Representative:	
Signature of Provider: [ ] MD/DO [ ] APRN [ ] PA	
Printed Name of Provider:	Date:
Provider Phone Number:	
Signature of Witness:	
Printed Name of Witness:	Date:
Interpreter Name or ID# and/or Service	Date:

Section E

Review of this MOLST form

Date of Review	Provider Signature	Printed Name	Credentials	Reviewed With	Location of Review	Outcome of Review
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form
			[ ] MD/DO [ ] APRN [ ] PA			[ ] No Change [ ] FORM VOIDED new form completed [ ] FORM VOIDED no new form

Review of MOLST Form

This form should be reviewed upon transfer of a patient to a hospital or other health care facility, or if there is a substantial change in the patient's health status or treatment preferences. Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters on the front of the form. If no new form is completed, no limitations on treatment are documented and full treatment may be provided.

Additional Instructions For Health Care Professionals

THIS FORM IS VOLUNTARY FOR THE PATIENT

Follow orders listed in section A, B and C until there is an opportunity for the clinician to review the form with the patient or the legally authorized representative (when the patient lacks capacity).

The patient or legally authorized representative (if the patient lacks capacity) can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment .

If the patient or legally authorized representative elects short term use of a medical intervention then the trial period **MUST** be filled in on the form.

POLST
physician orders for life-sustaining treatment paradigm®

Request for Endorsement of State POLST Program

State POLST Program:	***Insert State Name Here***

Directions: Please complete the information requested on this form and submit the form and additional information and documents to the National POLST Office: polst@ohsu.edu.

Program Information

Application Date:
State POLST Program Name:

State Contact Information
Name:
Title:
Email:
Street Address:
Second Line:
City, State, Zip:
Phone:
Fax:

☐ Please update the state information page on www.polst.org with the information above.
☐ The state information page on www.polst.org is still accurate or I will provide the needed edits to the National POLST Office at polst@ohsu.edu.

Program Information
Year POLST Coalition Started:
Year of first POLST Form Use:

Are there state laws and/or regulations that relate to POLST? Yes ☐ No ☐
If yes, please provide a copy of each with your application.
Please attach a brief summary of any legislative history (such as attempts at legislation, success of legislation, major opposition groups or barriers to legislation, etc).

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

Media Information
Please provide the following information and/or expectation of go-live date, if applicable.
Program Website:
Program Facebook Account:
Program Twitter Account:
Program LinkedIn Account:
Other Social Media Accounts:

Media contact for POLST Program- please provide a contact name, if available:
Name:
Email:
Phone:

Evaluation for Endorsed Programs

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 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 dept 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 3B 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 PowerPoint documents, 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 www.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 www.polst.org for 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 www.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 (www.polst.org/state), 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 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-C).
		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: A. "Do not transfer the patient" B. "Do not call 911" C. Any language that could be interpreted as restricting or negating a patient's right to access comfort care. D. Language defining or qualifying "futility".
Yes	**No**	**Items 12-22 are form elements strongly recommended by the NPPTF for Endorsed POLST Forms. While Endorsed POLST Forms need not have all these items, they must comply with the majority 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.

Additional Information

POLST Form Use- Please respond based on current use and **provide a copy of your form**.

(1) In creating the POLST Form, did the Program review these endorsement requirements?
- ☐ Yes
- ☐ No- please explain why not

(2) POLST Forms are used in the following settings:
- ☐ Long Term Care Facilities
- ☐ Hospice Facilities
- ☐ Nursing Homes
- ☐ Hospitals

(3) POLST Forms are used:
- ☐ Statewide
- ☐ Regionally – please provide a brief summary of regions and plans for statewide implementation.
- ☐ 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? ☐ Yes ☐ No
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?

POLST Policies- **please 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.**

POLST Program Management

Describe how the POLST Program is managed:

Describe any quality assurance measures the POLST Program implements:

Describe how the Program incorporates the Seven Core Elements for Sustainability (available at www.polst.org):

POLST Education

Describe training and educational materials available for health care professionals:

Describe training and educational materials available for patients and the public:

POLST Registry

Does the Program have a Registry for POLST Forms? ☐Yes ☐No

Does the Program have plans for creating such a registry? ☐Yes ☐No

If yes, please provide details about funding and timelines.

Additional Information- please 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: _____

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact Physician / NP / PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document**.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	**FOR REGISTRY USE ONLY**
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED