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POLST
physician orders for life-sustaining treatment paradigm

September 27, 2013

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Maryland Department of Health and Mental Hygiene
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300 West Preston Street, Suite 302
Baltimore, MD 21201

Dear Ms. Nay and Mr. Ballard:

Thank you for the work that you and your Maryland colleagues have done to develop your state POLST Paradigm Program: Maryland 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 (NPPTF) was created in 2004 to establish quality standards for POLST programs. The NPPTF endorses states that have proved their programs meet those standards. While the NPPTF avoids frequent revisions of these 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 NPPTF has decided to distinguish POLST Paradigm Programs from those programs that may use "POLST" or a similar term (POST, MOLST, etc) but which are being implemented in a manner open to certain criticisms. These states, which are significantly down the road in implementing their programs state-wide in such a manner that they are not currently on the pathway to becoming endorsed by the NPPTF, will be clearly identified on the National POLST Paradigm Program map on our website (www.polst.org) as a state with a program not conforming to POLST requirements by being shaded grey. This distinction and the explanation of non-conformance with POLST Paradigm standards are increasingly important as the POLST Paradigm is misunderstood by those who are criticizing it. It is necessary for the NPPTF to take this action and distinguish such programs as 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 NPPTF.

Unfortunately, the NPPTF has identified Maryland as a state that needs to be labeled as not adhering to the POLST standards created by the NPPTF because of the mandate that MOLST forms be given to all patients, with three limited exceptions. It is a fundamental tenet of the POLST Paradigm Program that completion of MOLST forms always be voluntary; while it may be mandatory to offer a MOLST form, the completion must remain voluntary. The POLST Paradigm relies on public trust and mandating form completion runs counter to the sense of patient autonomy and choice, thus undermining trust.

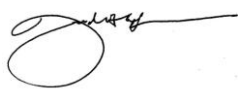
Further, the new Maryland MOLST form does not comply with the NPPTF endorsement requirements. he POLST Paradigm standards require a single section clearly defining level of care options beyond CPR (comfort measures only, limited additional interventions, and full treatment) since data has shown that 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 and Section B of the attached Oregon POLST Form as an example. Instead, the Maryland MOLST Form has multiple sections that require interpretation in order to determine what level of the care the patient may have wanted. While the NPPTF notes that elements of the "limited additional intervention" option have been spread among multiple sections of the Maryland MOLST Form, the lack of the obvious option is problematic. There are other elements of the form not meeting the endorsement requirements, but this omission is the reason Massachusetts is being called out as non-conforming.

We appreciate the fact that every state faces challenges in working through its unique political situation but the success of the National POLST Paradigm Program is contingent on all POLST Paradigm Programs being unified in their programmatic approach, education of health care providers, and elements of their form. It is only when program quality is uniform that we can achieve credibility, consistency, and reciprocity among all states-- which will ensure that patients will have their wishes honored, wherever they are in the United States at the time of a medical crisis. Between the mandatory requirement for MOLST completion and the MOLST Form, as currently drafted, lacking the clearly identifiable levels of care, the Maryland MOLST creates too much confusion to be honored beyond Maryland and is likely less effective in assuring that patient wishes are honored.

We regret having to make this decision. The NPPTF's goal is to encourage and assist all states to achieve endorsement. If you would like to discuss this letter, or the NPPTF's decision, please contact Amy Vandenbroucke at (503) 494-9550 or vandenbr@ohsu.edu. If you would like, she will also work with the Developing State Assistance Committee to schedule a time for your coalition to meet with them to discuss this letter further.

This change will go into effect on October 31, 2013. If you have any questions or would like additional clarification or assistance, please feel free to contact Amy.

Sincerely,



Judy Citko, JD
Chair,
National POLST Paradigm Task Force

Amy Vandenbroucke, JD
Executive Directive,
National POLST Paradigm Task Force

Attachments: MOLST Form
NPPTF Request for Endorsement Program Status Form
Oregon POLST Form

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial	Date of Birth	☐ Male ☐ Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician or nurse practitioner must accurately and legibly complete the form and then sign and date it. The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

_____ Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. **The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary.** If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

1

CPR (RESUSCITATION) STATUS: EMS providers must follow the *Maryland Medical Protocols for EMS Providers*.

_____ **Attempt CPR:** If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.

[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

_____ **Option A-1, Intubate:** Comprehensive efforts may include intubation and artificial ventilation.

_____ **Option A-2, Do Not Intubate (DNI):** Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

_____ **No CPR, Option B, Palliative and Supportive Care:** Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

PHYSICIAN'S OR NURSE PRACTITIONER'S SIGNATURE (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

Patient's Last Name, First, Middle Initial	Date of Birth	Page 2 of 2 ☐ Male ☐ Female

Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.

2 ARTIFICIAL VENTILATION

2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.

2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial.
Time limit_____

2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated.
Time limit_____

2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).

3 BLOOD TRANSFUSION

3a. _____ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated.

3b. _____ Do not give any blood products.

4 HOSPITAL TRANSFER

4a. _____ Transfer to hospital for any situation requiring hospital-level care.

4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.

4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.

5 MEDICAL WORKUP

5a. _____ May perform any medical tests indicated to diagnose and/or treat a medical condition.

5b. _____ Only perform limited medical tests necessary for symptomatic treatment or comfort.

5c. _____ Do not perform any medical tests for diagnosis or treatment.

6 ANTIBIOTICS

6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.

6b. _____ May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.

6c. _____ May use oral antibiotics only when indicated for symptom relief or comfort.

6d. _____ Do not treat with antibiotics.

7 ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION

7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.

7b. _____ May give artificially administered fluids and nutrition, if medically indicated, as a trial.
Time limit_____

7c. _____ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition.
Time limit_____

7d. _____ Do not provide artificially administered fluids or nutrition.

8 DIALYSIS

8a. _____ May give chronic dialysis for end-stage kidney disease if medically indicated.

8b. _____ May give dialysis for a limited period.
Time limit_____

8c. _____ Do not provide acute or chronic dialysis.

9 OTHER ORDERS _____

_____

_____

_____

_____

PHYSICIAN'S OR NURSE PRACTITIONER'S SIGNATURE (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

INSTRUCTIONS

Completing the Form: The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. Use Section 9 to document any other orders related to life-sustaining treatments. The order form is not valid until a physician or nurse practitioner signs and dates it. Each page that contains orders must be signed and dated. A copy or the original of every completed MOLST form must be given to a competent patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

Selecting CPR (Resuscitation) Status: EMS Option A-1 – Intubate, Option A-2 – Do Not Intubate, and Option B include a set of medical interventions. You cannot alter the set of interventions associated with any of these options and cannot override or alter the interventions with orders in Section 9.

No-CPR Option A: Comprehensive Efforts to Prevent Cardiac and/or Respiratory Arrest / DNR if Arrest – No CPR. This choice may be made either with or without intubation as a treatment option. Prior to arrest, all interventions allowed under *The Maryland Medical Protocols for EMS Providers.* Depending on the choice, intubation may or may not be utilized to try to prevent arrest. Otherwise, CPAP or BiPAP will be the only devices used for ventilatory assistance. In all cases, comfort measures will also be provided. No CPR if arrest occurs.

No-CPR Option B: Supportive Care Prior to Cardiac and/or Respiratory Arrest. DNR if Arrest Occurs – No CPR. Prior to arrest, interventions may include opening the airway by non-invasive means, providing passive oxygen, controlling external bleeding, positioning and other comfort measures, splinting, pain medications by orders obtained from a physician (e.g., by phone or electronically), and transport as appropriate. No CPR if arrest occurs.

The DNR A-1, DNR A-2 (DNI) and DNR B options will be authorized by this original order form, a copy or a fax of this form, or a bracelet or necklace with the DNR emblem. EMS providers or medical personnel who see these orders are to provide care in accordance with these orders and the applicable *Maryland Medical Protocols for EMS Providers*. Unless a subsequent order relating to resuscitation has been issued or unless the health care provider reasonably believes a DNR order has been revoked, every health care provider, facility, and program shall provide, withhold, or withdraw treatment according to these orders in case of a patient's impending cardiac or respiratory arrest.

Location of Form: The original or a copy of this form shall accompany patients when transferred or discharged from a facility or program. Health care facilities and programs shall maintain this order form (or a copy of it) with other active medical orders or in a section designated for MOLST and related documents in the patient's active medical record. At the patient's home, this form should be kept in a safe and readily available place and retrieved for responding EMS and health care providers before their arrival. The original, a copy, and a faxed MOLST form are all valid orders. There is no expiration date for the MOLST or EMS DNR orders in Maryland.

Reviewing the Form: These medical orders are based on this individual's current medical condition and wishes. Patients, their authorized decision makers and attending physicians or nurse practitioners shall review and update, if appropriate, the MOLST orders **annually and whenever the patient is transferred between health care facilities or programs, is discharged, has a substantial change in health status, loses capacity to make health care decisions, or changes his or her wishes.**

Updating the Form: The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician or nurse practitioner shall void the old form and complete, sign, and date a new MOLST form.

Voiding the Form: To void this medical order form, the physician or nurse practitioner shall draw a diagonal line through the sheet, write "VOID" in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician or nurse practitioner to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record.

Revoking the Form's DNR Order: In an emergency situation involving EMS providers, the DNR order in Section 1 may be revoked at any time by a competent patient's request for resuscitation made directly to responding EMS providers.

Bracelets and Necklaces: If desired, complete the paper form at the bottom of this page, cut out the bracelet portion below, and place it in a protective cover to wear around the wrist or neck or pinned to clothing. If a metal bracelet or necklace is desired, contact Medic Alert at 1-800-432-5378. Medic Alert requires a copy of this order along with an application to process the request.

How to Obtain This Form: Call 410-706-4367 or go to marylandmolst.org

Use of an EMS DNR bracelet is OPTIONAL and at the discretion of the patient or authorized decision maker. Print legibly, have physician or NP sign, cut off strip, fold, and insert in bracelet or necklace.	☐ DNR A-1 Intubate ☐ DNR A-2 Do Not Intubate ☐ DNR B Pt. Name _____ DOB _____ Phys./NP Name _____ Date _____ Phys./NP Signature _____ Phone _____

POLST
physician orders for life-sustaining treatment paradigm®

Request for Endorsement Program Status

Endorsed Program Request for:	***Insert State Name Here***

Name:
Title:
Phone:
Fax:
E-mail:

Mail Address:

Check whether the contact information for your state on www.polst.org needs to be updated and notify the national POLST Paradigm office if it does.

Date Completed:
Program Name:
Area of Use:
Program Website:

Date Updated:

The National POLST Paradigm Task Force (NPPTF) strongly encourages POLST Paradigm Programs to develop on a statewide basis. While it recognizes barriers to statewide implementation may exist within individual states and will accept the application of a regional program within a state or within bordering states, the expectation is that an Endorsed Regional POLST Paradigm program will work toward statewide implementation.

Program Status Requested:

☐ Endorsed Regional POLST Paradigm Program
☐ Endorsed Statewide POLST Paradigm Program

Evaluation for Endorsed Programs

Yes	No	Please indicate whether your state or regional program meets each program requirement below (Y/N) and provide evidence of the same.
		1. Has an effective statewide or regional coalition(s). If there are two or more regional coalitions within a state, confirm they are working on a coordinated strategy towards statewide implementation.
		2. Has identified champions who are active in the program implementation and education. Please attach a list of coalition members.
		3. There is an entity within the region or state 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 resources to implement it. **Please identify entity**:_____
		4. The POLST Paradigm Program is the preferred practice for appropriate populations (see 6B) 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). The completion of a POLST Paradigm form should be based on the patient's preferences that are translated into medical orders. The POLST Paradigm system should ensure that the patient receives the treatment that is ordered.
		5. 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 Paradigm conversation to elicit and record patients' preferences

		as orders on a POLST Paradigm form. **Please provide copies of sample training materials such as PowerPoint documents, brochures and/or guidelines.**
		6. Program promotes the concepts listed in 6A-B below. 6A. Completion of the form and the decisions recorded on it should be voluntary and based on shared medical decision-making.
		6B. The intended audience for use of POLST Paradigm forms is patients for whom the health care professional's response to the surprise question- "Would I be surprised if this patient died in the next 12 months?"- is "No, I would not be surprised." These include: (1) seriously ill patients with life-limiting progressive advanced illness; and (2) patients with advanced frailty.
		7. The program shows evidence of consideration of the NPPTF document, "Seven Core Elements of Sustainability for State POLST Paradigm Programs" found on www.polst.org.
		8. 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**	**The following POLST Paradigm Program element is strongly recommended by the NPPTF for Endorsed Programs. Please indicate (Y/N) if your program meets the following program element.**
		9. States accept POLST Paradigm forms completed in other states (reciprocity).
Form Information		
Yes	**No**	**Endorsed Program POLST Paradigm Forms are required to include the following elements. Please indicate whether your state or regional program meets each form requirement below (Y/N).**
		1. The form clearly states that it is a "medical order".
		2. Patient identifying information (e.g., name) is on all pages of the form.
		3. The form is not an advance directive and shall not be combined with an advance directive such as a living will or health care power of attorney document. Since the form is a medical order, there shall not be a requirement that it needs to be witnessed or notarized.
		4. The form requires a valid health care professional signature (physician, nurse practitioner, or physician assistant, depending upon state laws and regulations about who may sign the form) and date of signature. 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 or revised POLST Paradigm form for a patient lacking decision-making capacity.
		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 as tolerated.
		10. Form clearly states that comfort measures are always provided, regardless of level of care chosen.
		11. The form does NOT contain any of the following language: A. "Do not transfer the patient" B. "Avoid calling 911" or "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**	**The NPPTF <u>strongly recommends</u> the following POLST Paradigm Form elements to be in the POLST Paradigm Form. Endorsed Programs must show evidence of complying with the majority of these elements. Please indicate whether your state or regional program meets the following recommendations below (Y/N).**
		12. The form is uniquely identifiable (e.g., unique color) and standardized within a state/region. The form indicates on the front page (ideally all pages) the name of the state or region.
		13. 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…"]
		14. 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.
		15. The form also includes directions on other types of intervention that the patient may or may not want. For example, medically administered nutrition, etc.
		16. The form should NOT contain of the following language: Form is rescinded during surgeries, invasive procedures and/or hospital stays.

		[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.]
		17. Additions to forms are not prohibited, but language added to the POLST Paradigm form that undermines the goals of the POLST Paradigm Program or the intent of the form may render the program ineligible for endorsement.
		18. All medical orders should be on the first page of the form.
		19. As allowed by statute and regulations, POLST forms should require the patient's (or the patient's surrogate): (a) signature; (b) attestation (if electronic); 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 Paradigm form completion that documents review and approval of the form by the patient or the patient's surrogate has occurred.
		20. Forms should have the following language included on them: "HIPAA permits disclosure to health care professionals as necessary for treatment."
		21. The forms should provide information on how to obtain additional forms.
		22. The forms 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.
		23. 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.

Program Information

EXTENT OF USE OF POLST PARADIGM FORMS:

Start year:

Used in the following health care settings:

Range of use:

Use by those under 18yrs:

Are you distributing forms: YES ☐ NO ☐ **If yes, how many forms distributed per year:**

HISTORY:

BARRIERS OVERCOME:

RELEVANT STATE LAW AND REGULATIONS:

Describe how your program meets the seven core requirements for sustainability of a POLST Paradigm program (see attachment of the seven core requirements).

POLST PARADIGM IN THE HEALTH CARE SETTING:

Do you have a sample of policies regarding the use of your POLST Paradigm form in health care settings (hospitals, nursing homes, EMS, etc.): YES ☐ NO ☐ (If yes, please attach sample policies)

Do you have a Registry for POLST Paradigm Forms: YES ☐ NO ☐

If no, do you have plans for starting Registry for POLST Paradigm Forms: YES ☐ NO ☐
If yes, please elaborate on the plans (funding, timeline, etc):

POLST PARADIGM PROGRAM MANAGEMENT (please describe):

Describe program management:

Who distributes forms:

Describe how oversight of the program exercised to ensure quality:

POLST PARADIGM TRAINING (please describe):

Training for health care professionals:

Training for the public and patients:

POLST PARADIGM PROGRAM EVALUATION (please describe):

CQI projects and research:

FORM REVIEW (please provide copy of POLST Paradigm Form and describe):

How often, by whom, and under what circumstances is your POLST Paradigm form reviewed?

ADDITIONAL INFORMATION:

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.
For more information on Oregon POLST visit: www.orpolst.org

Patient Last Name:	Patient First Name	Middle Int.

Date of Birth: (mm/dd/yyyy)	Gender:	Last 4 SSN:
_____ _____ _____	☐ **M** ☐ **F**	☐☐☐☐

Address: (street / city / state / zip)

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

Check One

☐ **Attempt Resuscitation/CPR**
☐ **Do Not Attempt Resuscitation/DNR**

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B — MEDICAL INTERVENTIONS: *If patient has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** (**A**llow **N**atural **D**eath). Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments.* ***Transfer*** *if comfort needs cannot be met in current location.*
Treatment Plan: Maximize comfort through symptom management.

☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: Full treatment including life support measures in the intensive care unit.

Additional Orders: _____

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

Check One

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

Additional Orders: _____
_____
_____

D — DOCUMENTATION OF DISCUSSION:

☐ Patient (Patient has capacity)
☐ Parent of minor
☐ Court-Appointed Guardian
☐ Health Care Representative or legally recognized surrogate
☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)
☐ Other _____

Signature of Patient or Surrogate

Signature: ***recommended***	Name (print):	Relationship (write "self" if patient):

This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box ☐

E — SIGNATURE OF PHYSICIAN / NP/ PA

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's **current** medical condition and preferences.

Print Signing Physician / NP / PA Name: ***required***	Signer Phone Number:	Signer License Number: *(optional)*

Physician / NP / PA Signature: ***required***	Date: ***required***	Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Information for patient named on this form PATIENT'S NAME: _____

The POLST form is **always voluntary** and is usually for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Oregon Advance Directive is recommended for all capable adults, regardless of their health status. An Advance Directive allows you to document in detail your future health care instructions and/or name a Health Care Representative to speak for you if you are unable to speak for yourself.

Contact Information

Surrogate (optional):	Relationship:	Phone Number:	Address:

Health Care Professional Information

Preparer Name:	Preparer Title:	Phone Number:	Date Prepared:
PA's Supervising Physician:		Phone Number:	
Primary Care Professional:			

Directions for Health Care Professionals

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- Should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form; refer to *Guidance for Health Care Professionals* at www.orpolst.org.

Sending to Oregon POLST Registry (Required unless "Opt Out" box is checked)

For the Oregon POLST Registry the following must be completed:

- Patient's full name
- Date of birth
- Section A
- MD / DO / NP / PA signature
- Date signed

Send a copy of <u>both</u> sides of this POLST form to the Oregon POLST Registry.

<u>FAX or eFAX</u>:
503- 418-2161
or
<u>Mail</u>:
Oregon POLST Registry
CDW-EM
3181 SW Sam Jackson Park Rd.
Portland, OR 97239

Date Submitted _____ /_____ /_____

MAY PUT REGISTRY ID STICKER HERE:

<u>Registry Phone</u>: 503-418-4083
*Please allow up to 10 days from receipt for processing into the Registry. Mailed confirmation packets may take four weeks for delivery.

Reviewing POLST

This POLST should be reviewed periodically and if:

- 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, or
- The patient's primary care professional changes.

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry as above (required).
- If included in an electronic medical record, follow voiding procedures of facility/community.

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