

Appropriate POLST Form Use Policy

National POLST is an approach to end-of-life planning that emphasizes eliciting, documenting and honoring patients' preferences about the medical treatments they want to receive during a medical crisis or as they decline in health. Fundamentally, POLST is not a form: it is a *process*.

The POLST form is a portable medical order designed to support patients transitioning between health care facilities or living in the community by communicating patient treatment preferences. 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. This aids emergency personnel in implementing patient treatment preferences as communicated to—and documented by—the patient's health care professional. This information and the documentation occurs after a conversation involving shared decision-making.

National POLST supports reimbursement for quality advance care planning conversations. However, the fundamental tenets described below must always be upheld; we do not support incentives, financial or otherwise, for *completing* POLST forms—as POLST form completion should **always** be voluntary. Incentives that require or encourage non-voluntary POLST completion are contrary to—and inconsistent with—the intent of POLST.

The appropriate use of POLST forms supports the integrity of POLST. Below are eight fundamental tenets all health care professionals should follow to ensure appropriate POLST form use:

1. **POLST form completion should *always* be voluntary.** Just as patients may choose to refuse treatment or decide to not have an advance directive, patients may refuse to have a POLST form completed on their behalf. It is inappropriate to require patients to have a POLST form because it may be forcing them into either making decisions that they may not be ready to make or participating in advance care planning, which they may not want to do.

A facility, organization, or other entity may have a policy to *offer* a POLST form to all appropriate patients but should never have a *requirement* of completion.

2. **Completion of a POLST form without patient or surrogate¹ knowledge is contrary to the purpose and intent of POLST and violates patient self-determination, informed consent and principles of person and family-centered care.** Patients have a right to participate in medical decision-making regarding their treatment plan.

If a patient lacks medical decisional making capacity, a patient's surrogate needs to make decisions for the patient in the context of the current diagnosis, health status and prognosis and may complete the POLST form on the patient's behalf. Regardless of whether the surrogate is completing an original form or a revision, treatment choices should reflect what the patient would want, according to the patient's known values and preferences—not the surrogate's preferences—or best interest and in consideration of the patient's current diagnosis, health status and prognosis.

¹ The term "surrogate" refers to anyone authorized to make health decisions on behalf of a patient lacking decisional capacity. Depending on the state, this person may be known as a "proxy," "durable power of attorney for healthcare," "health care agent," or "medical power of attorney".

3. **Conversation is the cornerstone of POLST: the POLST form is only as good as the conversation(s) preceding it.** The POLST form is a step in a process that includes—and in fact, depends upon—a conversation. The form is designed to document treatment decisions made after shared decision-making conversations between a patient and his/her health care professional. The conversation should include the patient’s goals of care considering their current diagnosis, prognosis, and treatment options (including risks and benefits of each). The result of the conversation may be the completion of a POLST form—or it may be a first step in the care planning process.

POLST emphasizes the need for a patient-professional conversation in two ways:

- a. National POLST encourages all states to require patient or surrogate signature, attestation, or acknowledged verbal approval for POLST form orders to be valid.
 - b. Most state POLST forms include attestation statements so that, by signing a POLST form, the health care professional is acknowledging the orders contained on that POLST form are consistent with patient treatment preferences. Patient preferences cannot be known unless at least one conversation has occurred.
4. **Skilled advance care planning facilitation is essential for completion of a POLST form.** This includes:
 - a. understanding how to elicit patients’ goals of care considering their current medical condition;
 - b. aligning the patients’ treatment preferences with their expressed goals;
 - c. accurately documenting patient treatment preferences as medical orders on a POLST form; and
 - d. understanding—and being able to explain to patients and families—POLST forms and advance directives, including their differences and benefits.
 5. **POLST forms should be used within the intended population.**² 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. This is regardless of patient age or what facility, organization, or other entity a patient is in. For example, most 65-year-olds are too healthy to have POLST orders and not all residents in a nursing home may be appropriate for a POLST form. Generally, patients who do not meet these criteria are not appropriate to have a POLST form.

The intended population are the individuals with whom health care professionals can initiate specific and detailed conversations about the patient’s goals of care, current diagnosis, prognosis, treatment options, and the likely effect those treatments will have on that patient (e.g., what will most likely happen if CPR is attempted). For example, the POLST form provides medical orders for what happens tonight if a medical crisis occurs given the patient’s current medical condition. If conversations with this level of specificity cannot happen, or if the patient is not appropriate for a POLST form based on his/her clinical status and prognosis, then a POLST form should not be offered to, or completed for, that patient (and an advance directive should be offered instead).

6. **Health care professionals should complete the POLST form.** Since POLST forms are medical orders completed by health care professionals to communicate treatment decisions to other health care professionals, it is **never** appropriate to provide a POLST form to a patient, surrogate, or family member to complete.

² For more guidance on the appropriate population, see: <http://polst.org/guidance-appropriate-patients-pdf>

Additionally, since POLST forms use medical terms not all patients understand, it is important that health care professionals share treatment options utilizing language and tools (e.g., videos or visuals) to help patients and families understand. It is the task of the health care professional to translate the individual's goals of care, priorities, and wishes into medical orders using the language of medical professionals.

Physicians, advanced practice registered nurses, and physician assistants should be permitted to participate in POLST process and be able to sign POLST forms. Other professionals, including registered nurses, social workers and chaplains, may have roles in the process, such as helping patients identify goals of care.

7. **A POLST form is not a “one-and-done” document.** National POLST recognizes that things change over time, including a patient's goals of care, prognosis, health status, treatment options, and preferences for treatments. It is well known that some patients change their mind about treatment options over the trajectory of their illness or want their surrogate to be able to consider their values when their condition or prognosis changes. The POLST form is intended to be dynamic, reflecting a patient's current preferences about the medical treatments he/she wants to receive. This dynamic process is achieved through ongoing conversations when a POLST form review is completed: upon changes in patient's goals of care, medical condition, level of care, or location.
8. **Completing only Section A (Cardiopulmonary Resuscitation options) can be a disservice to patients.** The POLST form is intended to provide emergency personnel more than just code status information:
 - Section A (Cardiopulmonary Resuscitation options) allows a patient either to confirm they actually *do* want CPR attempted or that they want to refuse attempted resuscitation.
 - Section B (Medical Interventions or Treatments) provides direction about treatment preferences to emergency personnel and other health care professionals in situations other than full cardiac and respiratory arrest.

Limited information about patient treatment preferences is provided if a patient has a DNR order or only Section A on a POLST form completed. A DNR (do-not-resuscitate) order (also known as a do-not-attempt resuscitation [DNAR] order, or an order to allow natural death) **only** indicates that a health care professional has issued an order based on the patient's wish to forgo resuscitation in the event of a cardiac or respiratory arrest. If a patient is responsive, has a pulse, or is breathing, the question in this circumstance is no longer whether the patient wants to be resuscitated, but rather what level of treatment and what other medical interventions the patient wants—or does not want—in that medical crisis. Neither a DNR order nor a POLST form with only Section A completed provides that time-sensitive, critical information.

Understanding the importance of Section B on a POLST form is very important—it is the heart of POLST. The literature indicates not all people who complete a DNR order want the same level of treatment; half of patients with only Section A of a POLST form completed or only a DNR order may receive treatment they didn't want.³ If a patient wants to have a POLST form, both Sections A and B should be completed in order to fully document and protect patients' treatment wishes.

³ A majority of individuals with DNR orders requested some other form of life-extending treatment. Hickman, S. E., Tolle, S. W., Brummel-Smith, K. and Carley, M. M. (2004), Use of the Physician Orders for Life-Sustaining Treatment

