National POLST Form Guide

Introduction

Note: National POLST started using “POLST” as a term, defining it simply as a “portable medical order” in 2018; most states continue to use an acronym.¹

POLST exists to provide seriously ill or frail patients a tool to communicate their treatment preferences as they transition across care settings or travel throughout the United States. While not solely for emergencies, the POLST form is valuable in communicating to EMS whether the patient wants CPR or not and whether they want to be transported to the hospital or remain in place and made comfortable. Therefore, the POLST form itself must be immediately recognizable to all EMS providers and healthcare professionals—and be able to be honored by all—in order to reach its full value to patients.

Advance care planning is delegated to the states, meaning that each state creates its own rules about POLST forms: the name and color of the form, what language may be required, who can use and sign the form, and whether an out-of-state version of the form is valid. Although implemented at the state level, POLST is not really a state program: it is a national movement that should support patients wanting to use POLST who travel among states, even if just across a border for treatment.

National POLST exists because the founders of POLST realized consistency among POLST forms was needed to make the document portable—and they created standards around form elements to help. The vision of National POLST is for states to establish national standards, resulting in greater consistency of process, improved patient care and greater patient control and direction over medical treatment.

When this project started in December 2017, there were 47 existing POLST forms to review.² Essentially, they were 47 variations of the same concept using 16 names and five different colors. There is no compelling reason for this variation. Form variation undermines National POLST’s vision because they unnecessarily limit the value of POLST and create unnecessary administrative burdens and worries on the very patients POLST intends to help. Patients traveling or living on state borders have an administrative burden of managing and keeping two or more versions of the POLST form current. Additionally, these patients are unable to travel with the peace of mind knowing, if they had an emergency, their POLST form would be recognized and honored in another state. Finally, variation is a barrier to nationally educating about the concept, intent and value of POLST and to conducting any significant and meaningful national research or quality assurance activities.

National POLST has a duty to patients and health care professionals to make POLST easier and better: both of these duties can be accomplished with the creation and establishment of a National POLST Form. The National POLST form was created because a single form will make it easier, among other things:

- For providers to recognize a POLST form and how to correctly interpret and follow POLST form orders, thereby enabling them to honor patient treatment preferences;
- To conduct research and quality assurance activities, creating shared data for generalizable knowledge and ability to improve POLST; and
- To more broadly educate patients and providers about POLST so the process and form are understood and appropriately implemented consistently everywhere.

From its start, POLST has been a voluntary, collaborative group process. This project adheres to that fundamental principle and represents a major step towards national consensus on the POLST form. It is the product of almost two years of interviews, consensus building, feedback, compromise and iterative versions of the form and patient guides. As

¹ National POLST. (n.d.) Logo. www.polst.org/logo. Different programs use different terms; for a full list of names, or to learn what POLST is called in your state, see https://polst.org/program-names
² Alabama, Alaska and DC did not have POLST forms; DC introduced their form in 2018.
more states adopt the National POLST Form, the acceptance, understanding and use of POLST can become standard of care for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.³

Some critical principles reflected in the National POLST Form are:

- **Inclusion.** Like all projects, the development of the National POLST Form was driven by consensus with broad input from a variety of stakeholders. Inclusion of, and buy-in from, POLST Program leaders was critical to this project’s success. This form supports all policies created by POLST Programs participating in the governance of National POLST.⁴

- **Respect.** Every POLST Program—active or not in National POLST—was invited to participate in this project. Significant time was spent reviewing each POLST Program’s current and previous POLST forms and interviewing POLST Program leaders to learn what changes they would want to see, current and previous barriers to POLST forms, language preferences or challenges, and areas of consensus or disagreement relative to their forms. All participants were given significant time to review and comment on several iterations of the National POLST Form.

- **Transparency.** This Guide is a critical part of this project, documenting the rationale included and excluded elements on the National POLST Form and identifying the areas needing additional research.

- **Simplicity.** The National POLST Form represents a universal desire to keep this medical order simple and intuitive to use, focusing on medical order elements and excluding elements that were process-based.

This Guide is organized into five sections: purpose, form elements, excluded form elements, research opportunities, and project information (participants and key activities). It is not all encompassing as it is almost impossible to detail every decision point. If more information is desired, please email admin@polst.org.

Finally, this is an iterative process and that the form will, over time, be updated to reflect new research and best practices. The first form focuses on supporting the things that are working and where we had the most agreement to establish a baseline on which National POLST can grow while identifying the areas needing further research and discussion.

**A caveat:** The National POLST form must be adopted at the state level⁵ before it can be completed by a provider in that state. Not all POLST Programs are able to adopt the national POLST form; there are states with legislative or regulatory barriers that make adopting the national form impossible at this time. For those with challenges, hopefully this Guide provides rationale to align their current form with the national one as much as possible.

**Thank You to The Gordon and Betty Moore Foundation**

Thank you for providing the resources for National POLST to review and evaluate all state POLST forms (current and past), interview state leaders about their POLST form and its development in their state, work with external national partners and leaders, and review research related to the POLST form to determine best practices. National POLST appreciates the support for developing a National POLST Form, creating this guide, and developing related patient education.

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³ [https://polst.org/guidance-appropriate-patients-pdf](https://polst.org/guidance-appropriate-patients-pdf)
⁴ Programs participating in POLST governance are identified as “active” on the national map: [www.polst.org/map](http://www.polst.org/map). POLST policies can be found at [www.polst.org/policies](http://www.polst.org/policies).
⁵ Each state has its own adoption process.
# Table of Contents

**INTRODUCTION** ................................................................................................................................................................................. 1

**THANK YOU TO THE GORDON AND BETTY MOORE FOUNDATION** ............................................................................................... 2

**THE POLST FORM** .............................................................................................................................................................................. 5

- **OVERVIEW** .................................................................................................................................................................................. 5
- **PURPOSE** ..................................................................................................................................................................................... 5
- **POLST FORM STANDARDS** ............................................................................................................................................................ 5
- **FORM RECIPROCITY IS INSUFFICIENT** ............................................................................................................................................. 6
- **POTENTIAL VALUE OF A SINGLE NATIONAL POLST FORM** ....................................................................................................... 6
  - Improved Patient Care .................................................................................................................................................................. 7
  - Increased Shared Data to Keep Improving POLST Quality ...................................................................................................... 8
  - Uniform, Consistent Patient and Provider Education ............................................................................................................... 8
  - Stronger National Form—and Program ....................................................................................................................................... 9
- **A NOTE ABOUT STATE LEGISLATION AND REGULATION** ......................................................................................................... 9

**FORM ELEMENTS** ........................................................................................................................................................................... 10

- **FORM COLOR** ............................................................................................................................................................................... 10
- **TOP OF FORM** .............................................................................................................................................................................. 10
  - Header Language & Medical Record Number Box ..................................................................................................................... 10
  - Form Name ............................................................................................................................................................................... 10
  - Critical Reminders about the POLST Process and Intended Population ................................................................................ 12
- **PATIENT INFORMATION** ............................................................................................................................................................... 13
  - POLST is always voluntary ......................................................................................................................................................... 13
  - POLST forms are medical orders, not advance directives .................................................................................................... 13
  - Patient Demographic Information ............................................................................................................................................. 13
- **SECTION A: CARDIOPULMONARY RESUSCITATION (CPR) ORDERS** .......................................................................................... 14
  - Section Terminology .................................................................................................................................................................. 15
  - Choosing CPR Means Choosing Full Treatments in Section B ............................................................................................. 15
- **SECTION B: INITIAL TREATMENT ORDERS** ................................................................................................................................... 16
  - Trial Periods .............................................................................................................................................................................. 16
  - Language Decisions ................................................................................................................................................................ 16
  - Order of Options .................................................................................................................................................................... 17
  - Goal Statements ....................................................................................................................................................................... 17
  - Section B Treatment Lists ........................................................................................................................................................ 17
- **SECTION C: ADDITIONAL ORDERS OR INSTRUCTIONS** .............................................................................................................. 18
- **SECTION D: MEDICALLY ASSISTED NUTRITION** ...................................................................................................................... 18
- **PATIENT OR PATIENT REPRESENTATIVE SIGNATURE** ............................................................................................................... 19
- **Provider Signature** .................................................................................................................................................................. 20
- **FOOTER** ..................................................................................................................................................................................... 21
- **SIDE 2: OPTIONAL INFORMATION** ........................................................................................................................................... 21
  - Contact Information ................................................................................................................................................................. 22
  - Form Completion Information .................................................................................................................................................. 23
  - Form Information and Instructions ......................................................................................................................................... 23
  - Voiding a POLST Form ............................................................................................................................................................... 24
  - Reconciling State Needs ............................................................................................................................................................. 25
- **OVERARCHING FORM DESIGN ELEMENTS** ............................................................................................................................... 25
  - High Health Literacy Level ........................................................................................................................................................ 25
  - Form Section Details ................................................................................................................................................................. 26
  - Other design details .................................................................................................................................................................... 26

**FORM ELEMENTS CONSIDERED BUT NOT INCLUDED** ............................................................................................................... 26

- **CODE STATUS CHECKBOX** .......................................................................................................................................................... 26
- **DIAGNOSTIC PREFERENCES SECTION** ........................................................................................................................................... 27
The POLST Form

Overview
The POLST form is a portable medical order communicating patient treatment preferences. It is part of advance care planning but differs from advance directives. While the conversation leading to a POLST form is the most important part of the POLST process, the form is the most tangible piece, serving many functions:

- **For patients, families and caregivers:** it is a medical order communicating treatment preferences to providers when they lack the capacity or ability to speak for themselves.
- **For healthcare providers (providers):** it is a medical order communicating a patient’s treatment preferences. It provides guidance to:
  - hospitals for creating in-hospital resuscitation status and other treatment order sets;
  - facilities for transfer care upon discharge; and
  - other providers so they can align other treatments not covered by the POLST form they may offer or provide to the patient’s goals of care.
- **For emergency medical service personnel (EMS):** unlike advance directives, it provides immediately actionable orders regarding resuscitation and transporting the patient to the hospital in an easy-to-understand format with a more useable timeframe.

For the POLST form to be successful, it must be:

- Intuitive to accurately complete after a quality shared decision-making conversation between a provider and the patient or his/her surrogate;
- Easily recognized and understood by providers throughout the US, including EMS; and
- Periodically reviewed to ensure it is still an appropriate document for the patient’s health status and accurately reflects patient treatment goals and preferences.

Purpose
The POLST form is a medical order 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. It is instructive during an emergency, providing critical orders when conversation (even with a surrogate) is impossible. It supports patients across the care continuum and in many facilities. POLST supports patient self-determination in medical decision making regarding their treatment plan, informed consent and the principles of person-centered care.

As a medical order it is not—and cannot be—a one size fits all document. For simplicity and ease of use, the POLST form intentionally addresses a limited number of treatment options, prioritizing those that are emergent or that are highly beneficial to patients toward the end of life, to help the majority of patients within the intended population. The POLST form may not be appropriate or helpful for some patients within the intended population if their medical condition or treatment preferences are too complex.

While the form can provide prompts for an advance care planning or a POLST conversation, it is not a substitute for training advance care planning or having a quality shared-decision making conversation. The POLST form is only as good as the conversation preceding its completion and cannot solve process problems.

POLST Form Standards
Ever since the first iteration of the POLST form was created over 20 years ago in Oregon, national leaders have debated what elements define a POLST form: what must be included, what should be excluded, and how to best present form

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6 For more information about how POLST forms differ from advance directives or how it fits into advance care planning, visit [https://polst.org/polst-advance-care-planning](https://polst.org/polst-advance-care-planning) and [https://polst.org/about/polst-and-advance-directives](https://polst.org/about/polst-and-advance-directives)

7 See [www.polst.org/form](http://www.polst.org/form) for review chart samples facilities can use to help with reviews

8 [https://polst.org/guidance-appropriate-patients-pdf](https://polst.org/guidance-appropriate-patients-pdf)
elements while keeping the medical orders on one page and not exceeding two total. The National POLST Paradigm Task Force (Task Force) was created in 2004, in part, to identify “minimum features that could still qualify as a POLST form.”

The Task Force established a process for endorsing POLST programs conforming to national standards, including form standards. Initially created by the founding Task Force members, POLST form standards were periodically reviewed and updated based on the experience of the members within their states. Task Force project emails and committee notes about form requirements were reviewed and no formal document was found providing rationale about why certain elements were required, were not acceptable, or were in a grey area.

Unfortunately, standards are not enough to eliminate problematic variation among POLST forms. Susan Hickman and Rebecca Critser reviewed forms from all endorsed programs; the Task Force endorsed these programs after having confirmed their POLST forms complied with national standards. They found that while the form requirements helped create substantive similarities among state forms, there was still significant variation leading to issues with reciprocity, or accepting another state’s form.

Form Reciprocity is Insufficient
Since POLST is a medical order that may be used in an emergency, it needs to be immediately recognizable to first responders and emergency room personnel. Reciprocity does not solve this problem and is a poor workaround to achieving true POLST portability. Every state variation of POLST unnecessarily limits the value of POLST and creates unnecessary administrative burdens and worries on the very patients POLST intends to help.

As of December 2017, there were 47 existing POLST forms varying in language, name and color. It is entirely possible a provider in Louisiana, using the goldenrod colored LaPOST form, would not immediately recognize or know they could use the pink TPOPP form from Missouri or the green POLST form in New Jersey. Failure to recognize or honor a POLST form can result in providing unwanted treatment to a patient. Beyond recognition, there are many reasons described in the next section about why a single form is more beneficial than reciprocity.

To support patients, POLST should subtract anything that creates a barrier to portability and simplicity: rather than adding new laws or regulations that add complexity, fail to address the root cause of portability, and that may give the deficient current situation some credibility, resources should be focused on subtracting variation and simplifying to a single form.

Potential Value of a Single National POLST Form
POLST forms are currently like driver’s licenses, each state has its own version. Unlike driver’s license, however, POLST forms are not readily recognizable across state lines and there are questions about out-of-state form legality. The National POLST form is making POLST more like a passport: easily recognizable and honored in every state. The idea of a single form is about subtracting barriers and creating simplicity. It also creates possibility for improving POLST.

The vision of National POLST is for states to adopt national standards, resulting in greater consistency of process, improved patient care and greater patient control and direction over medical treatment. The goal is that a patient with a POLST form from one state to be able to travel anywhere in the US and have that form recognized and honored, especially during a medical emergency. Hickman and Critser’s research showed having standards was not adequate enough to support National POLST’s goal.

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9 National POLST Founders Story, available at: https://polst.org/founders-story-pdf
10 There was little to no research or quality assurance information available for many of those early years.
11 In 2019, National POLST instituted a 3-year review of all endorsed programs to ensure on-going compliance with national programmatic and form standards.
Form variation undermines the vision. Variations unnecessarily limit the value of POLST and create unnecessary administrative burdens and worries on the very patients POLST intends to help. Patients traveling or living on state borders have an administrative burden of managing and keeping two or more versions of the POLST form current. Additionally, these patients are unable to travel with the peace of mind knowing, if they had an emergency, their POLST form would be recognized and honored in another state. There are many complications in having multiple variations of POLST forms:

<table>
<thead>
<tr>
<th>Complication with Multiple POLST Forms</th>
<th>How a National POLST Form Solves the Complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients living on state boarders or traveling need to track 2+ POLST forms (and caregivers need to help)</td>
<td>A single form eliminates need for more than 1 form and improves providers ability to understand, complete and honor POLST forms, thus supporting patients</td>
</tr>
<tr>
<td>Providers need to be familiar with 47 versions of POLST forms, know which they can honor, and advise patients and caregivers about what forms they need</td>
<td>More comprehensive and specific education and training possible with single form</td>
</tr>
<tr>
<td>Each Program spend money to create and set up own POLST education</td>
<td>Also improves consistency of message and terminology, helping improve adoption</td>
</tr>
<tr>
<td>Provider training must be done at state level to address specifics about state form</td>
<td>Easier to create and undertake broader quality assurance activities and research, creating more shareable and generalizable data that can inform POLST form improvements</td>
</tr>
<tr>
<td>Each program needs to create and set up own Quality Assurance programs</td>
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<tr>
<td>Data collection is specific to state forms, more challenging to do research</td>
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</tbody>
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Figure 1. How a National POLST Form Can Solve Known Issues

National POLST has a duty to patients and health care professionals to make POLST easier and better: both of these duties can be accomplished with the creation and adoption of a National POLST Form. A single POLST form helps eliminate unnecessary complications that are contrary to the vision of National POLST and strengthens POLST in many critical ways:

- Improved patient care;
- Increased ability to improve the quality of POLST; and
- Stronger education about the value of POLST and how to use it appropriately.

**Improved Patient Care**

Patient care can be improved by increasing the likelihood a POLST form can be identified and honored by EMS. In order for POLST forms to be effective, especially during emergencies, providers must be able to immediately recognize and understand the POLST form. In August 2019, there were 48 different POLST forms. This means that, during an emergency, EMS personnel are being asked to:

1. Identify a document as a POLST form. This is not insignificant as there are 16 different acronyms, 5 different colors, and 48 different formats.  
2. Know if that version of the POLST is valid in their state.  
3. Honor the form. If the language differs from what they’ve been trained on, or if there is concern the form is not valid in that state, this can be a challenge that results in the patient not getting the treatment they wanted.

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13 Some forms vary significantly from the national standards. Ability to identify and honor can be a challenge, for example, in Maryland whose law says all POLST forms can be honored but whose form (MD MOLST) is significantly different from the majority of other POLST forms.

14 States with legislation have different requirements about reciprocity. For more information, see Issue 12 in the Legislative Guide: https://polst.org/legislative-guide-pdf
Providing patients unwanted treatment is not patient-centered care and, legally, it is battery. A single form eliminates any confusion, allowing providers (including EMS) to recognize, understand and honor patient treatment preferences throughout the US.

A single version also eliminates the burden on patients and their caregivers to make sure they have the right POLST form when traveling. Currently providers must not only understand POLST within their state but be able to advise their patients who are traveling or who live on a state border about how to get two or more versions of their POLST form to ensure it will be honored wherever they are during an emergency. Patients and caregivers must also then keep track of two or more POLST forms when traveling (even if it is just over a state border to see their provider): this can be an incredible burden.

A single version makes all of this easier. Rather than providers having to recognize 48 different POLST forms and know which are able to be honored in a state, providers can become more familiar and comfortable with one. Rather than patients having to worry about getting—and keeping track of—multiple versions of a POLST form when they travel, they can have one.

Finally, since EMS providers follow protocols in responding to emergencies, a single form makes protocols to honor patient treatment preferences easier. Training and improving protocols using a national form would help EMS recognize and honor POLST medical orders faster: the need to figure out what to do with an out-of-state order is eliminated.

**Increased Shared Data to Keep Improving POLST Quality**

Any creation and subsequent revision of a POLST form should be informed by robust data. A national form creates an opportunity to nationally conduct research and quality assurance activities, creating shared data for generalizable knowledge that can identify and answer outstanding questions, and evaluate rationale for all POLST form elements.

A single form increases the potential to undertake national evaluation of the form and process by expanding the scope of potential research and increasing the amount of shared data and generalizable knowledge that can impact POLST nationally. Current research and quality assurance data are limited because it generally focuses on a single state form and a limited geographic area. Although the knowledge may be generalizable to other states, the data set may be too specific to be of value. A larger data set has a better chance of meaningfully improving POLST. Quality assurance activities can be more easily created, and results pooled. This data could inform improvements to the POLST form and process, strengthening POLST overall.

**Uniform, Consistent Patient and Provider Education**

For POLST to be successful, patients and providers must understand the process and form. Variations of forms, form elements and form terminology obstruct national education efforts. Ideally, education should start with the concept of POLST. Unfortunately, it starts with this:

![Figure 2. PowerPoint Presentation showing different acronyms for POLST](https://polst.org/form-guide-pdf)
Every point of variation is an unnecessary opportunity for confusion and misunderstanding. Increased consistency in terminology and a single POLST form will help improve POLST education. Simplifying with one form easily allows for consistent education and messaging that will likely help more people understand POLST and likely increase the use of it appropriately and nationally.15

Provider education and training can be easier. Currently, POLST education is specific to that state’s POLST program. If the provider moves, they need new training about POLST (which may be called something else) in their new state. A single form means provider education can be uniform and consistent across the US, resulting in providers being more knowledgeable and comfortable with completing and honoring POLST forms.

**Stronger National Form—and Program**

POLST was created to be portable throughout the US, not just within a state. A patient should be able to get a form in one state and be able to travel anywhere in the US and have it honored. When forms and education are limited to a state, the impact and value of POLST is similarly limited. No state can successfully implement POLST on its own: state leaders must consider patients wanting to use POLST coming into their state or leaving their state to make the program successful.

Adopting a single national POLST form would dramatically increase the ability to influence national policy. The lack of form uniformity and consistency thwarts National POLST’s ability to engage in national policy supporting POLST. Variation gives the perception that POLST is not national in scope, which is a non-starter for creating national policy. The creation of the Plenary Assembly, the governance group of POLST Program leaders,16 has helped but is not enough.

**A Note About State Legislation and Regulation**

From interviews, POLST Program leaders agreed that, regardless of their own state’s ability to adopt—or interest in adopting—the national form, having a national form would help National POLST, was a worthy endeavor, and that pooling collective wisdom is important.

Not all states will be able to use the National POLST Form; some states have legislative or regulatory barriers making the adoption of the national form impossible. However, these barriers should not deter a national form from being introduced or programs who can adopt it from doing so. Instead, the introduction of a national form—built on consensus among POLST Program leaders (even those with barriers)—is an opportunity to publicly assert and reinforce the value and intent of National POLST as an organization. National POLST exist because leaders, from the start, identified the need to create national standards for POLST forms and programs in order for POLST was to be successful. The experiment of having individual state forms was successful in seeing what different leaders wanted in the form but, ultimately, has led to complications that harm and prevent POLST from being a stronger tool that helps patients across the US and conflicts with National POLST’s vision and mission.

This project does not intend to shame any POLST Program but, instead, provide credible resources built by consensus that POLST Program leaders can use to update their forms and perhaps change their legislation or regulation. These resources reinforce that POLST is truly a national, not state, program.

There will be a period of transition as POLST Programs start adopting the National POLST Form and figuring out how to manage statutes and regulations that are barriers to this form in some states. This is unavoidable and, in the end, likely good for the national movement and advance care planning overall (could POLST can be a model for advance directives?).

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15 Despite having 48 forms, POLST is not yet available nationally. Many programs, developing and endorsed alike, are still at the pilot stage. For information about how available POLST is within a state, see https://polst.org/use-map-pdf.

16 https://polst.org/leadership/
Form Elements
This section reviews each part of the form and providing inclusion and design rationale.

Form Color
The National POLST Form does not require being printed on a specific color and states may use whatever color required by their law for the national form. Participants were clear that for states not currently using pink, requiring pink (the color most states use and basis for national branding), would be a deal breaker. Some participants shared stories emphasizing the hazards of requiring a color (or a change of color) for a POLST form:

Several years ago, one of my patients was transferred to a skilled nursing facility. Upon arrival the staff flipped through the chart looking for the bright yellow DNR form. When they did not see the yellow form, they erroneously assumed the patient was full code. Later that week the patient suffered from a cardiac arrest and attempts were made at resuscitation which was against her preferences. The staff at the hospital had copied the chart using white paper only.

As you know there are numerous errors which occurred in this scenario all of which were/are opportunities for additional education:
- The SNF staff’s assessment of a DNR status only included looking for a yellow form instead of having a discussion with patient/family
- The hospital staff did not send the original yellow form to the SNF
- There was not a person to person report given by staff at hospital to staff at SNF.

While the endorsement form standards have always required programs use a bright color for their forms, thinking this made the form easier for EMS to locate on a fridge covered in pictures or other documents, none of the EMS participants suggested having a white form was a concern.

Top of Form

Header Language & Medical Record Number Box
The header language, “HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT,” has been a POLST form requirement since HIPAA became law; its purpose is to alleviate concerns about the legality of sharing POLST forms/orders with other providers.

All state forms have language similar to the second line on the National POLST Form, “SEND FORM WITH PATIENT WHENEVER TRANSFERRED TO DISCHARGED,” although some include “original” before “form.” “Original” was excluded since forms are increasingly being completed electronically and, therefore, no “original” version exists. Regardless of whether an electronic or paper POLST is completed, the patient should receive a copy of the form signed by the provider.

Since many participants indicated a medical record number (MRN) box would be helpful but was not necessary, it was added as optional to the top right of the form. Though the MRN varies by facility, it may potentially help match the patient to the form. Since MRNs generally appear in the upper right corner, it was similarly added here for consistency.

Form Name
This form is named the “National POLST Form: A Portable Medical Order”. Participants engaged in two discussions about the name: should the name stay “POLST” and, if yes, how should POLST be defined.
From 2017-2019, POLST leaders discussed renaming POLST because what the acronym stood for, *physician orders for life-sustaining treatment*, no longer supported the POLST concept in a few ways, including:

- many thought the term “life-sustaining treatment” was value-laden language;
- National POLST promotes a team approach to the POLST process\(^{17}\) so the term “physician” ignores the other providers appropriately involved in the POLST process; and
- providers other than physicians can sign a POLST form in most states.\(^{18}\)

This information is available at [https://polst.org/logo](https://polst.org/logo).

While names used by some POLST Programs addressed these concerns, such as MOST (Medical Orders for Scope of Treatment), national leaders kept “POLST” for a couple of reasons. First, many people know “POLST”, even if they don’t know the acronym, and 20+ years of building brand equity in the term “POLST” shouldn’t be disregarded. Second, the term “POLST” is used in many documents, such as the IOM’s Dying in America report\(^{19}\) referring to the National POLST Paradigm (now National POLST) and trying to educate on a new term could be challenging and confusing.

National POLST now uses “POLST” as a term, not an acronym, because there was a lack of agreement about re-defining the acronym. In 2018, National POLST stopped defining “POLST” as “physician orders for life-sustaining treatment,” instead referring to POLST as “portable medical orders.” If there is more space, National POLST describes a POLST form as “a portable medical order designed to document and implement a clinical process across care settings for a patient with serious life-limiting medical conditions, which may include advance frailty, and who voluntarily participates in the process and which includes shared, informed decision making, reflecting the individual’s goals of care and values.”

This evolution of using POLST as a term rather than an acronym is not a new branding concept.\(^{20}\) Using the term “POLST” allows us to continue building brand equity around a familiar term, standardize the term, and keep the focus on the POLST concept. It eliminates needing to continue using a lengthy set of terms that isn’t commonly used or known and the constant need to explain what POLST means and how it inaccurately reflects the organization or movement today.

### Adoption vs. Adaptation of Form

While the National POLST Form is *the* form National POLST encourages all states to adopt (it is not a model), states unable to do so *until legislation or regulation changes* are still encouraged to modify their form to adopt as much of the National POLST Form as possible. Any substantive change to the form or edits that threaten reciprocity will require states to change the title of the form to include their state name and to include “(adapted from the National POLST Form)”; final decisions about whether a form is adopted versus adapted are made by National POLST.

Further, since many states have already put significant time into their own branding and name recognition, states may opt to use their name in the title of the form.

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\(^{17}\) [https://polst.org/appropriate-use-pdf](https://polst.org/appropriate-use-pdf) - see #6

\(^{18}\) [https://polst.org/state-signature-requirements-pdf](https://polst.org/state-signature-requirements-pdf)


\(^{20}\) Other examples include KFC, AMDA, WW, GE, AARP, etc. These brands are recognized by their letters.
If State: Then may title their POLST Form (in order of preference):

| adopts National POLST Form as is | National POLST Form: A Portable Medical Order  
|                                   | **STATE ACRONYM** (consistent with the National POLST Form)  
|                                   | **STATE** POLST Form: A Portable Medical Order  
| adapts National POLST Form | **STATE NAME** (adapted from the National POLST Form)  
|                                 | West Virginia POST Form: A Portable Medical Order (adapted from the National POLST Form)  

Figure 3. POLST Form Title Options

**POLST Forms are not just for Emergencies**

POLST forms are not just emergency order sets: they provide useful guidance about care and treatment preferences as patients decline, helping providers offer and provide aligned treatments not covered by the order set.

Some state leaders and EMS suggested including “emergency” in the title of the POLST form (e.g., Portable Emergency Medical Orders) to both emphasize one of the form’s primary purposes and provide quicker recognition of the form, especially if EMS were presented with a white copy.

The vast majority rejected including the term “emergency” in the title of the form. State POLST leaders voted against including the term at the May 2019 Plenary Assembly meeting (annual governance meeting of state POLST leaders) due to concerns that including “emergency” in the form title could harm POLST by:

- causing people to think the form is only valid during an emergency or that the orders only apply to EMS;
- shifting the POLST conversation focus from a whole treatment plan to only what treatments are provided in an emergency; and
- decreasing use of POLST forms. Some leaders felt providers and patients shied away from completing anything saying “emergency” with regards to end-of-life planning unless death is imminent.

In short, having “emergency” in the title implies limits to the true, broader scope of the POLST form so it wasn’t included.

**Critical Reminders about the POLST Process and Intended Population**

Health care providers should complete this form only after a conversation with their patient or the patient’s representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

The first box under the form title provides critical reminders about the POLST process and intended population. The language was included to educate or remind anyone looking at the form that:

1. The form should be completed by a provider and not a patient. National POLST’s Appropriate POLST Form Use Policy supports this position: it is not okay for POLST forms to be provided in nursing home admission packets or to patients to complete prior to appointments and this reminder was added to help address this issue.
2. Completing a POLST form requires a conversation between the provider and patient or patient’s surrogate. (The signature section provides more detail about the conversation.)

21 https://polst.org/guidance-appropriate-patients-pdf
3. The POLST form is not a checklist. One draft had language bolded at the top “This is not a checklist—completion of this form requires conversation with the patient/patient representative” but was not included in the final version because providers found it condescending.

4. POLST is not for everyone. Our disability consultant felt it was critical to describe the intended population at top of the form for clarify. To further emphasize this point the form links to additional guidance created to help providers determine if their patient is appropriate for POLST.22

Patient Information

POLST is always voluntary
It is a fundamental tenet of POLST that having one is always voluntary; National POLST has policies23 and quality indicators24 emphasizing this point. POLST Programs and National POLST increasingly have been educating on this point, working with facilities that have been requiring POLST forms as a condition of admission, and correcting surveyors who think it is required. The language “having a POLST form is always voluntary” was added to support these efforts.

POLST forms are medical orders, not advance directives
The large font and box saying “POLST is a medical order, not an advance directive” was added to address an ongoing source of confusion among providers and patients. Rather than providing a longer instruction section or information about the form, this box hit the salient point and provides a link to additional information about the two documents, as well as patient guides for preparing for a POLST conversation, interpreting a POLST form, and videos.

The relationship of the two documents is additionally emphasized on page 2 of the form where there is an optional section encouraging the provider to ask for, and ideally review, a patient’s advance directive to ensure there is no conflict with the POLST form. Or, if there is one, to alert the patient it needs to be addressed in order to avoid potential confusion:

<table>
<thead>
<tr>
<th>Reviewed patient’s advance directive to confirm no conflict with POLST orders:</th>
<th>Yes; date of the document reviewed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A POLST form does not replace an advance directive or living will)</td>
<td>□ Conflict exists, notified patient (if patient lacks capacity, noted in chart)</td>
</tr>
<tr>
<td></td>
<td>□ Advance directive not available</td>
</tr>
<tr>
<td></td>
<td>□ No advance directive exists</td>
</tr>
</tbody>
</table>

Unfortunately, some state legislation inappropriately conflates POLST forms and advance directives. These statutes provide that, in the event of a conflict, the more recent of the two documents should be followed.25 This form section was added, in part, to help providers in those states ensure that the POLST form can be followed without a problem.

Patient Demographic Information
The patient demographic box on this form reflects the consensus recommendation from the attendees of the 2018 National POLST Paradigm Technology Consensus Conference.26 They agreed about the minimum demographic elements that should be required on the form to ensure matching of patients to POLST forms.

Most state forms ask for the same information: patient name (first and last, usually middle), date of birth and gender. Participants universally agreed that a full legal name and date of birth were the most critical elements and having a

22 https://polst.org/guidance-appropriate-patients-pdf
23 https://polst.org/appropriate-use-pdf - see #1 and 2
25 https://polst.org/legislative-guide-pdf (see page 8).
26 A list of attendees at the Technology Conference can be found at the end of the Technology Guide available at https://polst.org/tech-guide
middle name or initial and suffixes is very helpful. They also agreed that ethnicity had absolutely no place on a POLST form: although it may be valuable to ask for research purposes, the potential value to research was far outweighed by the negative perceptions about how this information could be used.

Most participants felt gender was unnecessary but potentially helpful and, if included, the options needed to go beyond the binary male or female. The National POLST Technology Committee advised using a generic “X” to help gender non-binary and transgendered patients feel included and seen, as opposed to a blank space to write in patient gender preference. They were concerned a blank space created an opportunity for a variety of answers that may not work within electronic health care systems. It was also recognized that there is a research and education opportunity here to discuss how this section is completed for it to have value (see Research Opportunities).

With respect to other demographic information, state forms varied in asking for the last four social security numbers (SSNs), addresses, nicknames, hair color and eye color. Participants generally agreed that:

- Addresses are problematic because patients move around, different health care systems and facilities use different address (e.g., legal address, where the patient actually lives, where the patient receives mail—all of which may be different). The national form left addresses off, instead only asking to fill in where the form was completed. This was added in case there were questions about state law and form validity.
- Since SSNs could help match the form to the patient, it should be included as optional. It should not be a required element due to privacy concerns or because it may discourage an undocumented individual from using the form.
- While hair and eye color could be helpful for EMS to physically match a patient to the form these physical traits could be easily changed through hair dyes and contacts. Since no EMS participant felt strongly this should be included, it was left out of this section.

Section A: Cardiopulmonary Resuscitation (CPR) Orders

<table>
<thead>
<tr>
<th>Pick 1</th>
<th>YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)</td>
</tr>
</tbody>
</table>

Since the first POLST form, national EMS advisors have recommended CPR orders be at the top or bottom of the form and almost all states have it as Section A. While most state forms have this section labeled “Cardiopulmonary Resuscitation” the national form, to reinforce this is a medical order, the national form added “orders” to the end to the title.

Likewise, the national form included “follow these orders” preceding a phrase commonly found on state forms, “if patient has no pulse and is not breathing”. The American Heart Association says CPR is “performed when the heart stops beating,” meaning that the patient does not have a pulse. Ideally, providers are explaining that the patient has died and CPR is a process by which they may be brought back to life. The language “and is not breathing” was added to help reinforce the concept that the patient has died to patients looking at this form. Additionally, although some participants suggested removing this language since providers and EMS would know when to follow Section A versus Section B, the language was included because the majority of participants felt it would be helpful for emergency providers, especially when Do Not Attempt Resuscitation was selected in Section A with Full Treatments selected in Section B. No participant saw harm in keeping this language on the form.

The national form included language typically in the instruction section on the back of state POLST forms, “including mechanical ventilation, defibrillation and cardioversion,” for clarity about what choosing “Yes CPR” meant and to remind providers what they may need to discuss with their patient.
One draft added “deactivate internal defibrillators” to the NO CPR option. This was not included in the final form because participants felt choosing DNR didn’t automatically mean patients would also want their internal defibrillator turned off. Providers agreed that there is a significant difference between a patient receiving a quick automatic shock internally to reverse a deadly heart rhythm versus receiving full external CPR, intubation and ventilation. While some suggested modifying the language to “discuss deactivation of internal defibrillator” most wanted it deleted entirely. Instructions commonly found on state forms, “no defibrillator (including automatic external defibrillators) or chest compressions should be used if “No CPR” is chosen,” was added to the Instruction section on page 2 under Using a POLST form.

Section Terminology
The term “CPR” was used both with the “yes” and “no” to clarify to the patient they are making a binary decision about CPR; some participants felt having CPR and DNR as the options was potentially confusing or at least not as clear as it could be. The term “attempt” was included in both the yes and no options to manage patient expectations.

Choosing CPR Means Choosing Full Treatments in Section B
The national form clearly states, in Sections A and B, that choosing “Yes CPR” requires choosing “Full Treatments.” This is based Task Force discussions since 2016 and interviews with state leaders as part of this project. Almost all state POLST leaders agreed allowing “Yes CPR” orders with anything other than Full Treatment is clinically inappropriate.

POLST leaders have always agreed that choosing Yes CPR in Section A and Comfort-Focused Treatments in Section B is medically incompatible but there has been ongoing debate about the validity of a CPR and Selective/Limited Treatments order set. The confusion may be about what is possible in-hospital versus out-of-hospital: POLST forms are out-of-hospital medical orders and what may be possible within a hospital is not in the field. CPR survival rates of individuals within the intended POLST population differ between out-of-hospital and in-hospital (where patients may be immediately treated) incidents. What can be done inpatient isn’t necessarily bound by the same kinds of protocols EMS are held to; for someone who is in full arrest outside the hospital, standard procedure includes intubation. EMS participants were clear: in the field, no one is going to initiate CPR on a patient and not intubate.

It was important that the National POLST Form not offer patients treatments that cannot be provided as it would betray their trust and harm the concept of POLST. Resuscitation cannot be a la carte for a POLST-appropriate patient. Once the resuscitation process has started, providers must be able to provide everything that goes along with it, including being admitted to the ICU and intubated. Some participants argued it should be the patient’s choice; for example, choosing CPR but refusing intubation. However, choosing CPR without intubation could cause EMS moral distress because the order is essentially saying EMS must start CPR on a patient and, potentially, bringing them back from the dead but then let them die again because they refused intubation. EMS participants said protocols would not allow for this option.

The debate over this order set emphasizes the importance of the conversation leading up to the completion of the form and providers explaining what choosing CPR means for the patient: chest compressions (with the high likelihood of multiple rib fractures and requiring prolonged ventilator support if the CPR is successful), intubation, defibrillations, IV medications, all of which is only provided under the Full Treatments option.

Most states already requiring this order set clearly state in Section A that choosing CPR requires choosing Full Treatments; to avoid an error, the national form goes further by reiterating in Section B that Full Treatments must be chosen if “Yes CPR” is chosen in Section A. For additional clarity, the “No CPR” in Section A states a patient may choose any option in Section B, as each is medically compatible.

27 Some registries, like the Oregon POLST Registry, will not accept a form with these orders (CPR- comfort).

28 CPR without intubation only occurs with a witnessed arrest and a shockable rhythm; this is extremely unlikely to occur outside a hospital. Otherwise, in almost all cases, for CPR to be effective requires airway management with good oxygenation (provided via intubation).
Section B: Initial Treatment Orders

**B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.**

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient’s care goals. Consider a time-trial of interventions based on goals and specific outcomes.

<table>
<thead>
<tr>
<th>Pick 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Treatments (required if choose CPR in Section A).</strong> Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.</td>
</tr>
<tr>
<td><strong>Selective Treatments.</strong> Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts [ventilator, defibrillation and cardioversion]. May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.</td>
</tr>
<tr>
<td><strong>Comfort-focused Treatments.</strong> Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.</td>
</tr>
</tbody>
</table>

The box under the section header reminds everyone that these orders are not fixed but flexible and, as the patient’s condition change, the expectation is that the provider will periodically reassess and discuss the goal of care and treatment plan with the patient to ensure that the treatments are meeting the patient’s care goals. It was important to many providers that the form not be too prescriptive about what treatments must be provided to a patient but, instead, give providers a sense of what the patient wants for treatments.

**Trial Periods**

Draft forms provided many iterations of trial periods, but more research needs to be done (see the Research Opportunities below for more information about Trial Periods). In the interim, the statement in the box under the heading includes “consider a time-trial of interventions based on goals and specific outcomes” as a reminder that a time-trial was possible and that any such trial should be linked to the patient’s goals of care.

**Language Decisions**

As in Section A, in order to reinforce that this document is a medical order, the national form added “orders” and “follow these orders” to this section header. Both “interventions” (a term used in many state forms) and “treatments” were evaluated as a title for this section. Although participants were almost equally divided, “treatment” was chosen as the more approachable and descriptive term for this section. Additionally, “treatment” was intentionally included for each option, emphasizing these were three different treatment options and only one should be picked.

The “pick 1” on the left of this box was added to reinforce this concept. In early versions of POLST forms had Full or Selective Treatments and Comfort-Focused Treatments chosen because patients wanted to make sure they received comfort measures. On page 2 under “Using a POLST form” there are instructions that, “for all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.” While similar language is found in state form or state forms have language within the options like “in addition to care described [above, below]” to reinforce that comfort measures are always provided, most participants felt this obvious. They agreed while unnecessary to have on the front of the form, it was helpful to keep the concept under instructions.

The term “Full Treatment” is used by almost all states. State forms were divided about using “Selective” or something like “Limited Additional” for the second option. The term “Selective” was chosen because using “limited” could be viewed as a negative and lead to fewer treatments being provided, or that some choices are not allowed rather than chosen. “Select” implied that the patient could pick and choose what they want, which isn’t appropriate. Participants thought “Selective” was a good descriptor of the goal statement and treatment options listed.
“Comfort-focused Treatments” was chosen for the final option as several states use this term. Some states use “Comfort Measures Only”; the term “only” was not used because it was seen as limiting and concerns raised about the term leading to less treatment.

Order of Options
The national form lists Full Treatments to align with the majority of current state POLST forms. Of the 47 state POLST forms, 3 didn’t have a Section B and 26 either had full treatment first or they were revising their form to have it first. Several states had used this order of treatment options to alleviate concerns from right to life groups that this document implicitly biases patient towards less treatment (e.g., the “do not treat bias”) or because they were concerned that, by starting with comfort first, patients may feel they need to “negotiate” for more aggressive treatments. Of the 18 states having comfort orders first, most had put comfort first to emphasize that patients wouldn’t be abandoned if they didn’t want full treatment but were flexible in changing the order to list Full Treatments first.

Goal Statements
Each option has a goal statement to clarify the intent of the patient’s choice and the objective for each option. The goal statement provides information to assist providers in aligning other treatment choices to the patient’s overall goal of care.

The challenge with the goal for Full Treatments was what word to use after “attempt to.” Participants agreed on “sustain” after discussion though “preserve” would have been acceptable. They agreed “prolong” conveyed bias against life and not appropriate. Additionally, participants debated whether to include “effective” in the goal statement. Some providers felt that no medical intervention was going to be appropriate for many patients who are appropriate for a POLST. Ultimately, “effective” was included to manage patient expectations and be clear that not everything would be done; treatments provided needed to be reasonable and medically appropriate.

The goal language for selective treatments varied and most included language like “avoid burdensome treatments.” This is subjective language, and a challenge is that a POLST form is used when the patient cannot speak for him/herself so it falls to the provider—who may not know the patient—to determine what the patient would consider “burdensome.” This is not clinically helpful or patient-focused to include in a goal statement. Further, Washington recently learned this language was being perceived negatively and recommended avoiding the term as it was considered value-laden; the national form chose to be more descriptive with the goal statement, clarifying that someone choosing Selective Treatments wanted to avoid the ICU and resuscitation efforts (reinforcing that CPR only goes with Full Treatments).

The language under comfort-focused matches most state POLST forms including goal statements.

Section B Treatment Lists
Many state forms have a longer list of specific treatments under their Full Treatment option. For simplicity, and since this option reflects the standard of care, the national form simply states: “provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.” The “as indicated” was added to manage patient expectations that any treatments provided will be medically appropriate: with respect to patient autonomy, patients have a right to refuse treatments, not the right to demand inappropriate ones.

There was a lot of variation among states in what was listed under Selective Treatment; the language on the national form was based on multiple iterations and feedback from draft forms provided. The treatment list under Comfort-Focused reflects language found in most state forms.

After CPR preferences, the second more important piece of information to EMS is transfer preferences. In an effort to keep this form as clean and uncluttered as possible, transfer information was not included under Full Treatments. Given that this option reflects standard of care many providers felt it was obvious and unnecessary to explicitly state. For the other two options, transfer is clarified. A defining characteristic of Comfort-Focused Treatments is the patient’s desire not to be transferred and that is reflected on this form.
Section C: Additional Orders or Instructions

<table>
<thead>
<tr>
<th>C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).</th>
</tr>
</thead>
<tbody>
<tr>
<td>[EMS protocols may limit emergency responder ability to act on orders in this section.]</td>
</tr>
</tbody>
</table>

Forms have always been required to include a place for additional orders. State forms have taken two approaches: some included a line(s) within Section B while others, like the national form, have a separate section. The title of this section intentionally used “orders” and clarifying language that whatever is written in this section is *in addition* to what is chosen above. The purpose for this section is to put context around anything ordered in Section B and any other specific treatment preferences. Some states phrased this section as something like “Optional Orders,” meaning that this *section* was optional. Participants were concerned providers would think *following* the orders was optional, so the term wasn’t used.

When asked if the header for this section should provide a lengthy list of examples about what could be included here, a short list or nothing, a majority of participants preferred a short list of two. Blood products were included as a reminder to providers for when there may be religious exemptions and dialysis was the most common order mentioned in interviews about what people put in “additional orders” (regardless of where that section was on the form).

The full list of what state leaders said they included in education regarding this section included: dialysis, blood products, limited time interventions, assisted nutrition or hydration, total parenteral nutrition (TPN), cardiac or breathing support, antiarrhythmic drugs, medications, antibiotic treatments, hyperalimentation, electrolyte or acid/base corrective measures, hospice evaluation, chemotherapy or radiation preferences, and diagnostic testing preferences (labs, imaging or X-ray or diagnostic testing restrictions. All would still be appropriate to include.

“EMS protocols may limit emergency responder ability to act on orders in this section” was added based on EMS participants recommending the form temper expectations from patients and providers. Many providers thought EMS always looked at and followed this section, which is not the case. EMS look for two things: CPR choice and transfer orders. It is possible EMS wouldn’t even look at Section C and, even if they did, protocols may limit what they can do with the orders contained therein.

Section D: Medically Assisted Nutrition

<table>
<thead>
<tr>
<th>D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pick 1</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

This section had the most variation among state forms including what options were offered, providing both nutrition and hydration or just nutrition options, giving the ability for limited trials, or listing it as “optional” on the back of their form. During this project Oregon POLST leadership announced they were removing the section entirely from the Oregon POLST form.²⁹ At their 2019 May meeting Plenary Assembly members debated what to do with this section and voted unanimously to keep it as part of the national standards for POLST forms, to include it on the National POLST Form and to respond publicly to Oregon. National POLST’s response was published in August 2019.³⁰ The group also agreed additional research was needed regarding this question (see Research Opportunities).

On the National POLST Form, this section was titled “medically assisted nutrition” instead of “artificial nutrition” because it was more descriptive and accurate. Since “offer food by mouth if desired by patient” is found on most state forms and supports patient autonomy, this language is on the form as well. The phrases “if medically feasible” and “always” were intentionally left off because participants felt it was important to focus on the patient and whether they are wanting to eat, not whether it is possible to force someone to eat (language on this form shouldn’t suggest that is okay to force feed). As one commenter shared: “obviously if someone is voluntarily stopping eating and drinking, it is a distinct unkindness to walk in the room with a delicious-smelling meal and ‘offer’ the food, or come in (as nurses did to a patient of mine in a nursing home some years ago) saying ‘wouldn’t you like a sip of this nice, ice-cold lemonade?’ It made her dying process last 6 weeks instead of 2 weeks.”

With respect to the section content, many draft options were presented to participants. The takeaways include:

- Complex medical decisions like PEG tubes or TPN should not be options on the form. Not all patients are physiologically eligible for one and they may need a J-tube or some other creative modality and it is important providers have the opportunity to offer and provide the appropriate option given the patient’s current medical condition. Instead, participants agreed that capturing high-level decisions about the patient’s desire for a surgical (long term) vs. non-surgical (short term) option was more helpful. Rather than using “long term” or “short term” options or trials, the form uses surgical language as a reminder for providers to explain the types of feeding tubes to patients.

- To respect patient autonomy, it was important to provide a “no artificial means of nutrition” option. Some state laws require additional conditions which must be met before this can be an option; that would be addressed within state education (and is part of the reason the form includes the state where form completed under demographics).

- Including the language “hand feed if safe” as a general instruction for this section was redundant and, for some, unacceptably micromanaging.

Including an option that the topic was discussed but no decision was made was added to let another provider know that the patient had discussed the topic but didn’t want to make a decision. This option includes “provide standard of care” to reinforce the idea that no decision is a decision and that the standard of care will be provided. [There is language under the “Using a POLST Form” instructions that standard of care will be provided when any section is not completed.]

Some state forms included trial period language but varied on their approach: some linked to time frames while other goals of care. Most said the trial period didn’t mean much clinically or that once a line was in, the trial period was moot. In the absence of compelling research about the approach, trial periods were left off. (See Research Opportunities)

Patient or Patient Representative Signature

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient’s representative, the treatments are consistent with the patient’s known wishes and in their best interest.

(required)

If other than patient, print full name: Authority:

The most recently completed valid POLST form supersedes all previously completed POLST forms.

To emphasize the patient-focused intent of the form, the patient signature section is first. This placement and asking only for the date of the signature for the provider reinforces that the provider should sign last.
Since states vary and no consensus exists on the terminology to use on a nationally facing form to describe both legally authorized individuals and other surrogates speaking on behalf of the patient, the form uses “patient representative.”

In 2014, the Task Force decided POLST forms should require the patient’s, or the patient’s representative’s, signature, attestation or witnessed verbal consent because “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.” Almost all state forms require patient or the patient representative’s signature and the national form reflects both the Task Force’s decision and the majority of state forms.

The language just above the signature box is simple and highlights the key aspects of the POLST form: (again) that it is voluntary and there was a conversation where treatment options and goals of care were discussed. If the patient representative is signing the form, the last sentence underscores the decisions made were in line with what the patient would have wanted (substituted judgment); several providers have indicated problems with patient representatives not appreciating the concept of substituted judgment and appreciated this language being added as an educational tool.

It was intentional that nothing in this section implies the patient understands or agrees with the orders listed on this form. As described below, the National POLST Form was intentionally written at a high health literacy level and asking the patient to sign saying they understand or agree to the orders conflicted with that concept. The patient should understand what has been ordered from the conversation and, to help, a patient guide written at a lower health literacy level was created to help ensure the patient understands the orders on their form.

The statement “eSigned documents are valid” reinforces that signatures electronically captured and printed on the form are valid, though validity of forms electronically signed vary by state law.

As a reminder that the patient or patient representative’s signature is required, “required” was placed by the X. Space for a date was not included to avoid confusion about when the form became valid (the provider date controls). Space is provided for the patient representative’s name and list under what authority they are signing the document (this varies by state law and, in some states, facility policy).

Although possibly intuitive, some leaders felt it was helpful to explicitly articulate that the most recently completed valid POLST supersedes all previously completed forms.

**Provider Signature**

<table>
<thead>
<tr>
<th>F. SIGNATURE: Health Care Provider (eSigned documents are valid)</th>
<th>Verbal orders are acceptable with follow up signature.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have discussed this order with the patient or his/her representative. The orders reflect the patient’s known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]</td>
<td>Verbal orders are acceptable with follow up signature.</td>
</tr>
<tr>
<td>X (required)</td>
<td></td>
</tr>
<tr>
<td>Date (mm/dd/yyyy): Required</td>
<td>/ /</td>
</tr>
<tr>
<td>Phone #:</td>
<td>( )</td>
</tr>
<tr>
<td>Printed Full Name:</td>
<td>License/Cert. #:</td>
</tr>
<tr>
<td>Supervising physician signature:</td>
<td>License #:</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

31 For example, the term “surrogate” can mean either a legally authorized individual or any substitute decision-maker, regardless of legal authority. Additionally, just because a term is used in statute doesn’t mean that term is used correctly by providers within the state. For more information on this topic see our Legislative Guide: [https://polst.org/legislative-guide-pdf](https://polst.org/legislative-guide-pdf)

32 [https://polst.org/endorsement-application-pdf](https://polst.org/endorsement-application-pdf) - see form requirements #19


34 [https://polst.org/tech-guide-pdf](https://polst.org/tech-guide-pdf) (see section on electronic signatures)

35 A majority of states have statutes listing who speaks for a patient when they cannot speak for themselves but there are a few states that don’t have such a statute, or their statute only covers limited situations. In those states, facility policy may identify the order in which patient representatives should be considered to provide input about a patient’s treatment plan.
Since POLST is a medical order it must be signed by a provider to be valid. Like the previous patient signature section, the statement “eSigned documents are valid” reinforces that signatures electronically captured and printed on the form are valid, though validity of forms electronically signed vary by state law. This section header addresses a common question that verbal orders are acceptable with follow up signature; facilities using verbal orders should have processes for them.

What the provider is agreeing to, in signing this order, is that they have discussed the order with the patient or his/her representative and that the orders reflect the patient’s best known preferences, to the extent the provider knows them. Some states use attestation language; the majority felt keeping the language simple helped emphasize that a conversation should have occurred and that the orders must reflect the patient’s preferences. Including language that the provider agreed the orders on the form were “medically appropriate” was not included in the final version because participants agreed providers shouldn’t ever create or sign medically inappropriate orders.

A couple of states have had issues with non-licensed providers signing POLST forms. Although this is an issue with those providers not knowing their scope of practice, because it impacts the validity of the form and who can sign varies by state, the form includes the statement: “Note: only licensed providers authorized by law to sign POLST forms in state where completed may sign this order” as a reminder about signature authority.

Since 2016 National POLST has supported physician assistants (PAs) signing POLST forms (see here and also #6 Appropriate POLST Form Use Policy). While most states allow PAs to sign POLST forms independently, a few require a supervising physician signature. In order to achieve a truly national form, there had to be a space for such a signature. For states where PAs can sign without a supervising physician signature, programs may pre-populate the “state where completed” box with their state information and pre-check the “n/a” box by supervising physician signature to eliminate any questions.

“Required” is included after both the “X” and “date” as a reminder about requirements for a valid form. Finally, although most states don’t ask for the license or certification number, a few states indicated it would be a deal breaker if excluded, so space was provided for this optional information.

Footer
The year is listed for version control. The footer language, “a copied, faxed, or electronic version of this form is a legal and valid medical order. This form does not expire,” is found on most POLST forms. Since the expiration only applies to the medical orders on page 1, the footer statement on page 2 replaces the expiration language with contact information.

If the patient has a valid POLST form, regardless of how it is presented, it should be honored. An original form should not be required because there are times where there is only a copy or fax available or, increasingly with electronically completed POLST forms, no “original” even exists.

Side 2: Optional Information
Side 2 of the form has optional field designed to support the patient and provider. The top asks for the patient’s full name to help match side 1 and 2 if they are separated.
Contact Information

Participants agreed this contact information about be helpful and, particularly the emergency contact and hospice information, belonged on the back of the form. One form draft had included a check box with contact information about who to reach in an emergency, but participants thought providers completing the form would be confused and concerned it would wrongly discourage someone from calling 911 in an emergency.

Most state forms provide space for emergency contact information, but state leaders shared there was often confusion with people thinking this was where they could legally appoint someone to be their surrogate/proxy/representative (it is not; that must be done in an advance directive). To help educate about this, two explicit statements were added.

Space for the patient’s primary care provider name and number is included in case they are not the provider signing the POLST form. Some providers thought this was potentially helpful information to have readily available.

Hospice was only mentioned on one state form mentioned hospice. Florida’s form included the following section:

Hospice participants appreciated this section, feeling it would increase awareness of about the hospice benefit and remind providers to refer. This level of detail was excluded from the national form because most participants expressed concern that this language—particularly as it relates to palliative care—could cause problems if it were unavailable in the area where the patient lived. Participants agreed that the National POLST Form could be improved by having something about hospice on the form, agreeing it could be valuable as a reminder to providers to consider a hospice referral since patients within the intended population may also be appropriate for hospice care. Since it was not a treatment decision, it was put on the back of the form in this section.

36 Also called different things in different states.
Form Completion Information

<table>
<thead>
<tr>
<th>Form Completion Information (Optional but helpful)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewed patient’s advance directive to confirm</td>
</tr>
<tr>
<td>no conflict with POLST orders:</td>
</tr>
<tr>
<td>(A POLST form does not replace an advance</td>
</tr>
<tr>
<td>directive or living will)</td>
</tr>
<tr>
<td>Yes; date of the document reviewed:</td>
</tr>
<tr>
<td>Conflict exists, notified patient (if patient</td>
</tr>
<tr>
<td>lacks capacity, noted in chart)</td>
</tr>
<tr>
<td>Advance directive not available</td>
</tr>
<tr>
<td>No advance directive exists</td>
</tr>
<tr>
<td>Check everyone who participated in discussion:</td>
</tr>
<tr>
<td>Patient with decision-making capacity</td>
</tr>
<tr>
<td>Court Appointed Guardian</td>
</tr>
<tr>
<td>Parent of Minor</td>
</tr>
<tr>
<td>Legal Surrogate / Health Care Agent</td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td>Professional Assisting Health Care Provider w/</td>
</tr>
<tr>
<td>Form Completion (if applicable):</td>
</tr>
<tr>
<td>Full Name:</td>
</tr>
<tr>
<td>Date (mm/dd/yyyy):</td>
</tr>
<tr>
<td>Phone #:</td>
</tr>
<tr>
<td>This individual is the patient’s:</td>
</tr>
<tr>
<td>Social Worker</td>
</tr>
<tr>
<td>Nurse</td>
</tr>
<tr>
<td>Clergy</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

This optional section captures information about the form completion process. The top portion about advance directives is discussed earlier in this guide. The row about who participated in the conversation is frequently found on the front side of state forms to reinforce that a conversation should have occurred prior to completion of a POLST form. It was added to page 2 on this form because of space limitations on page 1 and since it isn’t necessary for a valid medical order.

National POLST encourages a team approach for the POLST process. Space for the name, date, phone number and relationship of the professional to the patient was included to identify professionals other than the provider involved in the completion of the specific POLST form.

Form Information and Instructions

- **Completing a POLST form:**
  - Provider should document basis for this form in the patient’s medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See [www.polst.org/state-signature-requirements.pdf](http://www.polst.org/state-signature-requirements.pdf) for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify/match patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.

- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient’s preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if “No CPR” is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.

- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  1. is transferred from one care setting or level to another;
  2. has a substantial change in health status;
  3. changes primary provider; or
  4. changes his/her treatment preferences or goals of care.

- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.

- **Voiding a POLST form:**
  - If a patient or patient representative (for patients lacking capacity) wants to void the form: destroy paper form and contact patient’s health care provider to void orders in patient’s medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - For health care providers: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).

- **Additional Forms:** Can be obtained by going to [www.polst.org/form](http://www.polst.org/form)

- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.
This section’s language and format reflects most state forms. Though many state forms combine instructions for modifying and voiding a form into one section, the National POLST Form separates them. A number of state leaders mentioned problems with patients (or even providers) modifying POLST forms rather than completing new ones (choices scratched out and new choices checked). Modified forms are invalid since edits create questions about form credibility and validity. Therefore, the national form has an explicit “Modifying a POLST form” instruction that makes it clear this form cannot be modified.

The information and instructions under “Completing a POLST form” provide a quick list of critical reminders: the conversation should be documented in the patient’s medical record, state law determines who the patient representative, state law determines which providers can sign POLST, patients should be given a copy of the POLST, the last four digits of the SSN for patient demographic information is optional and if a translation is used to facilitate the conversation, it should be attached to the signed English form.

Under “Using a POLST form” the last bullet was on page 1 in most drafts but participants agreed the language described the standard of care and could be moved the back of the form, in the interest of removing clutter from the medical orders. While some POLST forms clarified that the “most aggressive” or “highest level” of care should be provided if no decision was made for a section on the POLST form, these instructions encourage the provision of the standard of care, as the “most aggressive” treatment may not be standard in all situations and the term could be perceived as value-ladden.

The “Reviewing a POLST form” instructions reiterates that forms don’t expire and provides guidance about when the form should be reviewed, as discussed earlier. Intentionally excluded from this list is a review requirement for every time the patient sees a provider, which would be onerous, inefficient and perhaps harmful.37

**Voiding a POLST Form**

Although every state form allows the patient to void the form, this wasn’t a topic that had been discussed by the Task Force.38 Patients have a right to participate in medical decision-making, including completing advance care planning documents to share their wishes and treatment preferences. With advance directives, patients should have the ability to create, modify and void them. As a medical order, POLST is different because a provider is signing, under his/her license and within his/her scope of practice, that the order is appropriate. While patients can void a POLST, they should not have the ability to create or modify them.

At the 2018 Conference there was robust discussion about patients and surrogate ability to void a POLST form.39 National POLST had always advocated that patients must be able to void their own form, as their decisions and preferences changed over time. However, many participants felt that only providers should be able to void forms due to the controls this would enforce such as:

- Providing an opportunity for the provider to learn why the patient (or appropriate surrogate) wants to void their POLST form;
- Confirming the patient has the right level of decision-making capacity to void the form or is not being coerced or influenced inappropriately; and
- Ensuring the accuracy of the patient’s medical record related to the most recent POLST form, as well as any registry.

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37 As one commenter wrote: One would no more revisit a POLST “every time the patient sees his/her provider” than one would do a social resources screen, spirometry or a rectal exam at every visit.
38 There were no documents on this topic in any of the National POLST archives going back to 2004. Since leaders from six states and advisors had been meeting prior to the creation of the Task Force it is possible this discussion took place earlier, prior to when formal minutes were kept.
39 [www.polst.org/tech-guide](http://www.polst.org/tech-guide)
Although agreeing with the above, state POLST leaders claimed removing patient authority to void the form was a non-starter. Just as a patient can choose not to fill a prescription or rip up the script, they should be able to void a POLST form immediately if they want. They shouldn’t have to pay for an appointment with their provider to get the form voided.

Since it is critical that the POLST be voided everywhere if the patient decides to void it, both the form and patient guide include a reminder to patients to let their provider know they want their POLST form voided; providers can then update the patient’s chart and registry. Providers should also follow up with patients to learn the rationale.

**Reconciling State Needs**

<table>
<thead>
<tr>
<th>State Specific Info</th>
<th>For Barcodes / ID Sticker</th>
</tr>
</thead>
</table>

Most participants agreed the national form should exclude state-specific information. However, a small box for state information was added on page 2 to accommodate a few state POLST leaders who felt that as long as there was a small section where they could add state specific information, they might be able to adopt the form earlier than if they had to wait for legislative change. It is unknown what impact this may have on the form transferring among states.

Most participants felt space for a barcode was not necessary but some were adamant it was needed.

**Overarching Form Design Elements**

**High Health Literacy Level**

The POLST form is a medical order communicating treatment orders from one provider to another. According to one participant: “This is essential. [The POLST form] is a medical order and needs to be understood as a medical order.”

Although patients are given the original or a copy of the form, the form was intentionally drafted at a high health literacy level for several reasons. First, there is a problem with patients completing POLST forms, for a variety of reasons, which violates the appropriate use of a POLST form. Since this problem may be exacerbated by writing the form at a lower literacy level, this form was drafted at a high literacy level, hopefully forcing patients to ask providers questions about the form and forcing providers to become involved (beyond just signing the form) to explain terminology. Second, higher health literacy terminology makes treatment preferences clear to providers. Confusion can occur in translating medical procedures and treatments into a lower literacy level, making what the patient actually wanted unclear and harder to honor. There are limited instances, described above, where form language intentionally was chosen to be more approachable to patients so as not to completely alienate them.

Although patients should be aware of what the POLST form means after having the POLST conversation with their provider, this project included the creation a patient guide that “translates” the form to help patients understand the form and explain it to their representative or loved ones.

Participants strongly disliked one draft of the form that started with lower healthy literacy FAQs taking up most of page 1. The intent had been to emphasize the patient-centeredness of the form and provide information to the patient first about what the POLST form was, as well as serve as a reminder to providers. Participants felt trying to reach both the provider...

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40 [https://polst.org/appropriate-use-pdf](https://polst.org/appropriate-use-pdf) - see #6
41 A quality, shared-decision making conversation about the patient’s diagnosis, prognosis, treatment options and goals of care that may lead to decisions that can be captured on a POLST form.
and patient audiences in a single document made it cluttered and confusing and that trying to simultaneously achieve other goals degrades the form’s performance with regards to its primary objective. They agreed the POLST form should remain directed at providers and separate guidance should be created for patients.

Form Section Details
This form uses the “A, B, etc.” that most states use to identify different sections of the form. Participants felt having these identifiers form education easier.

For clarity, in each medical order section on the form, on the left side are instructions to “pick 1.”

The medical orders have horizontal options (Section A), vertical options (Section B) and both (Section C). One draft included only vertical options and participants felt this optically made the form look like a checklist, which something everyone wanted to avoid.

Other design details
Participants liked the visual “X” image added indicating where to sign.

Standard font was used throughout for easier readability. Space for written information or signatures was optimized as much as possible. A form consultant was hired to help improve form design, but those versions were universally hated.

Although National POLST uses the term “professional” in all of its materials the term “provider” was used in the form because it (1) helped make the form consistent with many state laws and (2) saved space (every little bit helps).

The form and patient guides use the term “patient”, rather than person, to emphasize this form is a medical order (based on a provider-patient relationship) and that the intended population are individuals who are within the care continuum frequently as patients. In National POLST education materials, the distinction between “patient” and “resident” is made but there was not space to do so on this form.

Form Elements Considered But Not Included
It is impossible to provide an exhaustive list of what was excluded on the final version of the National POLST Form but below are items that were discussed (either as part of this project or in the past).

Code Status Checkbox
POLST leaders have been in an on-going discussion about whether POLST forms can be code status documents, meaning a form is completed only to document whether the patient (usually resident in a nursing home) wants CPR or not. Two draft forms provided different approaches to potentially solving this problem.43 One included the box on the right in Section A (CPR); the thought was if we can’t stop facilities from using POLST as a code status document, is there something that can be added to the form to communicate to others that the form was only for code status?

Some participants though this was valuable in letting other providers know the rest of the form had not been discussed. Most, however, found it problematic because it was impossible to reconcile the strong emphasis National POLST places on the voluntary nature of this form with the fact that most facilities using POLST as a code status document require form

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43 The other draft approached the POLST form by combining the treatments of Sections A, B and C under goal statements; this is a form that many participants liked but felt was too radical a change and required significant research and piloting to even consider adopting—see Form Layout under Research Opportunities.
completion, regardless of the patient’s preferences. Concerns were also raised about how use of the box would be implemented, what processes would be required, and what education supporting its use would be required.

At the May 2019 Plenary Assembly state POLST leaders agreed POLST should not serve as a code status document.

**Diagnostic Preferences Section**

<table>
<thead>
<tr>
<th>D. DIAGNOSTIC PREFERENCES (e.g., labs, imaging or x-ray)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ May perform any medical test indicated to diagnose and/or treat a medical condition.</td>
</tr>
<tr>
<td>□ Only perform limited tests necessary for symptomatic treatment or comfort.</td>
</tr>
<tr>
<td>□ Do not perform any medical tests for diagnosis or treatment.</td>
</tr>
</tbody>
</table>

An early draft form included a diagnostic preferences section, recommended by an emergency department physician. This was not included because most participants felt this information fell under the purview of Section B. There was concern about the potential contradictory message between Section B and this section and agreement that decisions about ordering diagnostic tests should be aligned with the patient’s goals of care identified in Section B.

**Expiration Date**

Although some state laws include expirations for POLST forms, POLST forms should not expire. Instead, the orders should be reviewed periodically, as stated under the instructions on page 2 of the form. In addition to being an administrative burden to complete a new POLST when the current one still accurately reflects the patient’s preferences, expiration dates are also an unnecessary burden on the patient because they require the patient to:

- Keep track of the expiration of the form (although providers can help with this);
- Schedule an appointment prior to that date;
- Travel to the appointment; and
- Pay for the appointment.

Some of these can be a hardship for patients or their families and shouldn’t be a barrier to having a POLST.

**Goals of Care Section**

National POLST has many documents emphasizing the importance of discussing a patient’s goals of care when completing a POLST form including the National POLST Fundamental Policy Principles and the Appropriate POLST Form Use Policy. While a few state POLST forms include this section, it was excluded from the National POLST Form for several reasons.

First, medical orders don’t contain process information. POLST is a medical order that needs to communicate treatment preferences to other providers. It is inappropriate to use a medical order to also document process or conversation leading to those orders; the appropriate place to document goals of care that may lead to the completion of a POLST form or the sections of the POLST form is in the patient’s medical record (there is a reminder to do this under the “Completing a POLST form” instruction).

Second, the value of the section is unclear. The state POLST leaders who had forms with such sections shared that it was rarely used or, if it was used, the information wasn’t always clinically useful. POLST leaders from states who’d previously had this section but removed it from their form said its removal was not protested by users in their states. Finally, how

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44 Kentucky, Mississippi and Oklahoma require their state POLST forms be reviewed annually. New York has a 90 day requirement.
45 Form review templates for charts were created for this project: https://polst.org/form-review-document-pdf
46 https://polst.org/policy-principles-pdf - see Principles 1-4
47 https://polst.org/appropriate-use-pdf - see #3
48 There is research in New Jersey on this topic; the researchers involved were very helpful during this project in providing preliminary data (how patients were completing this section). This section of the form and guide could be updated on their data in the future.
the section was completed varied greatly. Participants suggested if there was strong education about how to use this section and what information belonged in it, there may be value.

Most participants agreed the standardized goal statements tied to treatments in Section B was more clinically valuable than having a goals of care section. Given the lack of data supporting the clinical value of this section, the experiences of the states who have (or have had) this section on their form, and the limited space available on the POLST form, this section was not included. National POLST will continue to emphasize the need to have a conversation that includes goals of care prior to completing a POLST form in its education and policies.

Hydration
EMS participants were clear they were interested in two things: whether the patient wanted CPR and transfer orders. As discussed in Section C (Additional Orders), EMS generally do not look at the rest of the form but are following their protocols. They shared the provision of fluids was the default and determined by the patient’s medical condition, not what was on their POLST form. Therefore, having a section about hydration on the POLST form could cause confusion or set inappropriate expectations about what treatments would be provided.

Other providers shared that the role of hydration at the end of life has changed and they wanted more latitude to provide medically appropriate care rather than having a decision made in advance. Also, if a patient felt strongly about hydration, that could be stated in Section C (Additional Orders). Since Section C already provides a caveat that “protocols may limit emergency responder ability to act on orders in this section,” offering this write-in as an option—rather than including hydration as an option in Section D—helps appropriately manage patient expectations.

Organ or Body Donation
Previously, some states had expressed an interest in using the POLST form to capture additional about a patient’s end of life decisions, such as organ or body donation preferences. Since POLST is about how people want to live and be cared for with their serious illness or frailty, the Task Force felt including post-death information like organ or body donation would unacceptably shift the focus of POLST. Participants agreed and felt it may also expose POLST to attacks about pushing patients towards less aggressive levels of care.

Patient’s First Form Check Box
An early draft included space to check a box if this was the patient’s first POLST form. Some participants saw value for data analysis purposes, determining if a patient was already in a database, and for providers to know whether they need to review previous versions and/or how comprehensive their background description of POLST should be. Most felt it would be confusing or unreliable.

Summary of Medical Condition
Similarly to the goals of care section, a few state POLST forms included—or had previously included—a summary of medical condition section. Again, most removed this section because the information not clinically helpful, there was provider confusion about how much information to provide, and patients were concerned about privacy (being told to put their POLST form in a visible place put also putting their diagnosis on the document was uncomfortable to some).

EMS participants liked having that information about a patient, especially if the patient had a cognitive impairment, but most providers said a patient’s diagnosis doesn’t share anything about prognosis or goals of care, so it has limited value. Those providers were concerned that untrained providers would think the POLST form was valid only if the medical issue related to the diagnosis listed on the form. And, finally, many participants noted that the diagnosis doesn’t matter: if the

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49 https://polst.org/DWD-pdf
50 Providers weren’t sure if they had to list everything. At least one state tried to address this concern by labeling the section “Primary Diagnosis.”
patient is appropriate for a POLST, and a provider signs the form, they are the orders. If a summary of medical condition(s) was included, it may unacceptably open the orders up for second guessing.

As with goals of care, the summary of a medical condition is about the process and justification for the form and more appropriate for the patient’s medical record. Since most providers also felt it didn’t have clinical value and there were patient privacy concerns, this section was not included.

Witness Signatures
Witness signatures have never been acceptable on POLST forms for two reasons:
1. Requiring witness signatures creates confusion between POLST (medical orders) and advance directives (legal documents).
2. Obtaining witness signatures can be a barrier to completing a POLST form, particularly in rural communities.

POLST forms already go one step beyond medical orders in requiring patient signatures, to help confirm the patient is aware of the POLST form and participated in a conversation. Witness signatures go too far away from medical orders towards legal documents.

Research Opportunities
All aspects of the POLST form could benefit from research but this section specifically calls out areas that were raised during this project.

Does the Form Need a Separate Antibiotic Section?
The Task Force was divided about how to interpret a 2010 research article about the antibiotic section found on some POLST forms. Although the article, authored by several national POLST leaders, advised “further research is needed to determine the value of standing orders regarding antibiotic use and factors that may influence decisions regarding the use of medications to treat infections near the end of life”, the Task Force discouraged states to include antibiotics on their forms. As of 2018, only five programs include antibiotics on their forms. Several other programs had previously included antibiotics but had removed them; from interviews, several of those state leaders indicated they had done so either following Oregon’s lead or because of a recommendation from the National POLST Office. Interestingly Indiana, a program led by Susan Hickman who was the lead author for the 2010 article, still includes antibiotics on their form.

When Task Force members briefly revisited the topic via email in 2016, there was still concern about why additional conversation about antibiotics during POLST form completion and documentation on a separate section hadn’t happened and why the Task Force continued to “identify a separate antibiotic section as problematic enough to warrant a recommendation against its inclusion.” One national leader commented that, since the article was published in 2010, there has been in “increased interest in antibiotics given increasing threats raised by antimicrobial resistance and a push for antibiotic stewardship programs so there may be a shift underfoot in terms of the practice environment that may alter perceptions of the importance of this section. These changes also raise questions about the applicability of our findings from a decade ago.”

52 Task Force records are unclear why this decision was made. Perhaps noteworthy/informative: the National POLST Paradigm Task Force office was housed in the same place as the Oregon POLST Program, which removed the antibiotics section from its form after this article.
53 Delaware, New Jersey, Rhode Island, Utah, and Washington.
55 Email among select Task Force Members, November 4, 2016.
56 Email among select Task Force Members, November 4, 2016.
In this form, antibiotics is specifically listed under Selective Treatments, but more research should be completed to follow up on the 2010 findings and determine its value as a separate section.

Artificial Nutrition Section
When the Plenary Assembly voted in May 2019 to keep the artificial nutrition section on the national form, they also agreed that significant changes, such as removing a section long held to be a standard part of a POLST form, should only be based on robust data and to do otherwise could impact the credibility of National POLST. The group also agreed that it was a question worth investigating and researching in the future.

As discussed earlier, under Section D, the vote to keep this section on the form was because compelling data or rationale for removal was not presented.

An additional question raised was whether feeding tube preferences could/should be combined with Section B and/or can the form be rephrased or restructured to have the goal statement clearly direct providers about what artificial nutrition the patient would want to receive.

Should all POLST Forms Only Be DNR Orders?
Not an insignificant number of providers suggested that POLST forms should only be used for individuals who do not want CPR. Those providers suggested that patients wanting CPR will receive the standard of care so there is no need for a POLST form to say they want CPR and Full Treatments. National POLST has educated that POLST forms are not just for patients wanting DNR, but a way for patients to confirm they actually want CPR attempted, especially for patients appropriate for POLST where there may be a question given how traumatic the process can be for frail individuals. The Plenary Assembly confirmed this in passing the Intended Population policy in 2018.

A research question of interest is whether there is value in having “Yes CPR” as an option on a POLST form or should it solely be focused on serving patients who want No CPR (thereby eliminating Section A).

What is the Best Terminology for the Cardiopulmonary Resuscitation Section?
The National POLST Form uses “Do Not Attempt Resuscitation (DNAR)” in order to keep consistent language between the two options in Section A, hopefully eliminating confusion. Some leaders suggested that “Allow Natural Death” be used instead, arguing that it more clearly described, in low literacy terms, what “NO CPR” actually meant. Additionally they said it is critically important that patients, loved ones and surrogates recognize that DNR does not mean Do Not Intubate (DNI) or Do Not Treat (DNT), and most certainly does not categorically mean “Just stand by and let me die,” as the general public may believe.

Form Layout
Many different options for the POLST form were presented during this project, resulting in many strong opinions from participants about what the POLST form should look like (now and in the future). State leaders were clear a significantly different form would be difficult/impossible to adopt, undo their education efforts to date, and cost more to create new education going forward (even conducting new education sessions with national materials). Newly developing state leaders pointed out that they were just getting providers on board with POLST and a radical change would be a significant challenge to implementation. Finally, others pointed out that the national form being so dramatically different from state forms—including endorsed states which followed national standards—would be confusing and ultimately harm patients. Participants were clear: any radical change would lose momentum for the POLST movement.

57 https://polst.org/appropriate-use-pdf - see #8
58 https://polst.org/guidance-appropriate-patients-pdf
Otherwise, participants agreed National POLST should continue to support research for and consider other form layouts for future revisions. A few providers felt National POLST should try to develop and evaluate a form that combined sections A, B and C (as one draft did), emphasizing goals of treatment to patients and providing clearer clinical direction to providers. Many wanted to see a simpler version of the form and felt it was possible, but not as a first national form and not without additional research and pilot testing.

The purpose of this project was to create a national POLST form, based on best practices and consensus, that a majority (or all!) states could adopt. Therefore, it was necessary to keep a similar format for this initial version.

Purpose of Selective Treatments in Section B
For years, POLST leaders have been guessing what patients are trying to communicate in choosing Selective Treatments, what providers think they are communicating, and what is actually being provide. This middle option in Section B had the most variation among state POLST forms. For example, some programs educate or say “do not intubate” in this section while others allow it. Consistency about the intent of this section and what treatment options would be appropriate is necessary for this part of the form to be successful.

Value of Having a Trial Period
Limited research exists about whether offering a trial period is a helpful tool on a POLST form. Participants were provided several options to review on various form drafts and the consensus was that research should be completed to determine: (a) if there is value to offering them and (b) what would be the most clinically valuable way to present the option(s).

For one draft that provided a two-week time frame for when surgical options for tube feeding would need to be considered, many providers shared something like the following:

The trial period of more or less than two weeks is great! This is the right timeline given that most physicians are looking to tracheostomy after two weeks if a patient cannot be extubated. I also like that it prompts the clinician with a designated timeline instead of leaving it open-ended. I find the write-in trial period definition is often rarely used.

I have always leaned on this two-week marker and the long-term vent/artificial nutrition support in my practice when asking patients how much they’re willing to endure for a chance at a recovery, and for how long. Having this so clearly on the form is a great value-add. And, given that this is health care speak, it is another way to communicate to patients and clinicians alike that the POLST is a medical order set.

There were equally many providers who disliked that approach, feeling was too specific about treatments, that having a specific time frame identified inhibited their ability to practice medicine, and that it set up expectations with patients and families that may not be appropriate given the patient’s current medical condition.

There was agreement the POLST form should have something about time trials and that research and pilot project should be undertaken.

Value of Gender on Form
Gender has value on the form because it can help match a patient to the form but also because it helps EMS in the field physically match a patient to a form. It is unclear how gender is or should be documented. Should it match the patient’s birth certificate? This may connect a patient to their form online but not in the field. Should it match the patient’s preference? That may help connect a patient to their form in the field, but not online. It is unclear how National POLST should encourage this section be completed (or it is should be removed) and how critical it is—really—for patient matching.
Participant List

This collaborative process focused on finding consensus among the various stakeholders. Below are the individuals, groups and organizations who participated. The goal was to include all state POLST Programs (all were invited to participate) and partner organizations and to have diversity of professional, geographic and expertise. Not all who were invited were able or willing to participate but we are thankful for the time and effort those below provided to this project.

Disclaimer: The final documents for this project were prepared by Amy Vandenbroucke, JD in her position as the Executive Director of National POLST. The opinions and content do not reflect the view of anyone listed below, although their input was considered in creation of the final product.

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<tr>
<th>State</th>
<th>Program</th>
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<td>Rhode Island</td>
<td>Maureen Glynn</td>
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Project Timeline & Activities
To provide a sense of the collaboration and effort for this project, select project activities are listed below. The grant from The Gordon and Betty Moore Foundation, which supported this work, started December 2017 and ended August 2019.

• 2018
  o January – April:
    ▪ All current POLST forms were printed, reviewed, and analyzed in detail.
    ▪ All historical documents related to state POLST forms were reviewed (e.g., previous drafts, summaries about edits and rationales, etc).
    ▪ National POLST Paradigm archives were searched for all questions and discussions related to POLST forms.
    ▪ Project consultants identified.
  o February – November:
    ▪ Workgroup focused on updating the POLST intended population created. Final guidance approved in November; this language was critical from our disability consultant’s perspective and is at the top of the national POLST form.
  o April-August:
    ▪ Individual interviews with each POLST program who wanted to participate. Reviewed form evolution in that state (if applicable) and elements on current form. Discussed form development process, form elements debated over time/during last review, wish list of changes, philosophy of a national form, etc.
  o August:
    ▪ Identified workgroup to focus on resolving question about whether it is okay for a POLST form to be used as a code status document (completion of Section A only) – this group met periodically over the year with the PA making a final decision in May 2019.
  o September- November:
    ▪ Two iterations of potential national forms with questionnaire sent to consultants for comment
    ▪ Individual meetings with project consultants
  o December:
    ▪ Collaborated with Cambia Health Solutions to identify a consumer panel

• 2019
  o January – March:
    ▪ Draft national form with questionnaire sent to participating states, project consultants, partner organizations, and other interested parties for review and comment.
    ▪ Interviews with consultants about form, participation on state coalition calls about the form.
  o March-April:
    ▪ Form drafting professional contracted
    ▪ Second draft national form and patient guides created
    ▪ Survey created and sent to all participating state programs
    ▪ In-person meeting with consumer panel to review patient guides
  o April-May:
    ▪ Second draft national form with questionnaire sent to participating states, project consultants, partner organizations, and other interested parties for review and comment
    ▪ Interviews with consultants about form, participation on state coalition calls about the form
  o May:
    ▪ Plenary Assembly (state governance group) convened. Discussions about the national form were a substantial part of the agenda, including discussions about:
      ▪ National POLST form elements,
• Whether POLST forms are only for emergencies (and if that should be reflected in the name of the document), and
• Whether artificial nutrition should be kept on the form (discussion resulted in writing and submitted a response to Oregon’s January Letter to the Editor “It’s Time to Remove Feeding Tubes from POLST Forms”)

o July-August:
  ▪ Final national POLST form draft sent to state programs for review
  ▪ Patient document review by consumer panel completed
  ▪ Final documents and website finished