

About POLST

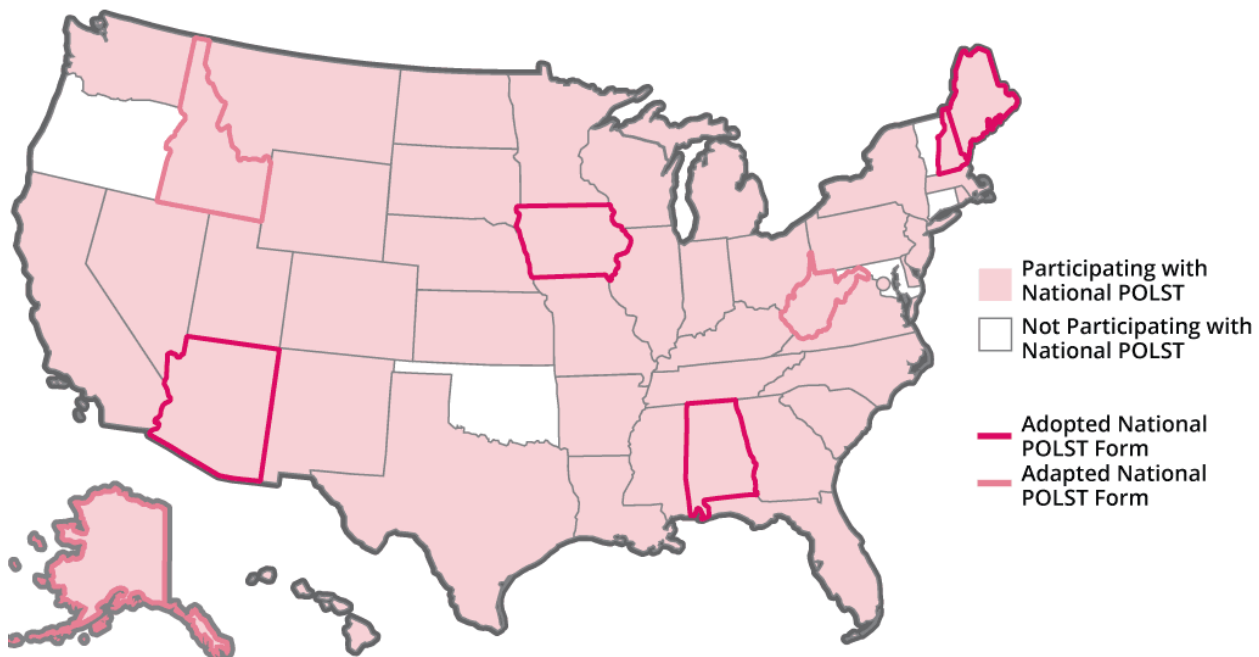
POLST is both a process and a portable medical order set for patients who are considered to be at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. It is an important component of advance care planning that emphasizes eliciting, documenting and honoring patients' preferences about the treatments they want to elect or decline during a medical emergency or as their health status changes.

This portable medical order set is designed to promote coordinated care for patients by communicating their treatment preferences as they transition across care settings or travel to other states. While not solely for emergencies, POLST is valuable in communicating to emergency personnel and other treating health care professionals whether the patient wants to elect or decline CPR, transfer to a hospital, advanced respiratory interventions, IV antibiotics, and medically assisted nutrition.

About National POLST

National POLST is the expert and preeminent leader in advancing POLST and the organization that establishes standards for POLST implementation, forms and processes. 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. To learn more please visit www.polst.org.

National POLST: Participating Programs and National POLST Form Adoption Information

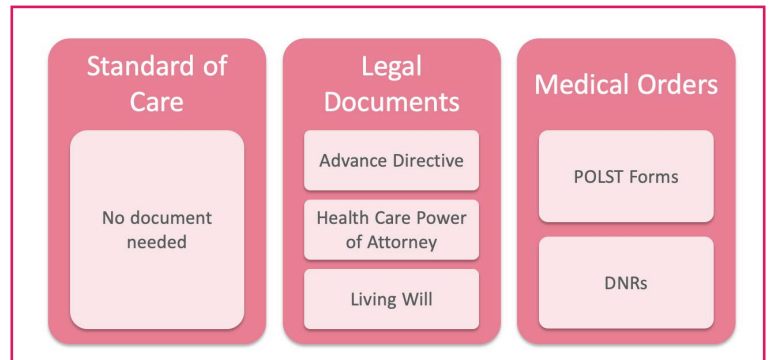


National POLST encourages all programs to consider adopting the National POLST Form, which was created through consensus and released in September 2019 (<https://polst.org/national-polst-form-pdf>). A map showing states considering adopting the form is available at: <https://polst.org/national-form-adoption-map-pdf>.

POLST Fundamentals

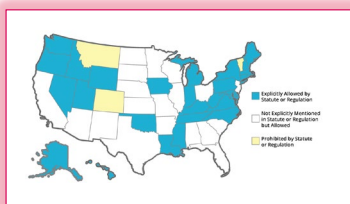
The integrity and success of POLST relies on everyone honoring the following ten fundamental tenets:

1. POLST should be used within the intended population, not health individuals.
2. POLST should *always* be voluntary.
3. Conversation is the cornerstone of POLST: the POLST order set is only as good as the conversation(s) preceding it.
4. Skilled advance care planning facilitation is essential for completing a POLST order set.
5. Health care professionals—not patients or families—must complete the POLST order set.
6. Completion of a POLST without patient or surrogate¹ knowledge is contrary to the purpose and intent of POLST and violates principles of patient self-determination, informed consent and person and family-centered care.
7. POLST is a medical order set that health care professionals should use in an emergency recognizing that standard of care must always dictate a professional’s conduct.
8. Completing only the section on Cardiopulmonary Resuscitation (Section A) preference is a disservice to patients.
9. A POLST form is not a “one-and-done” document; periodic reviews are essential.
10. POLST forms should not be accessible online without something reminding individuals that they should not be completing the form.



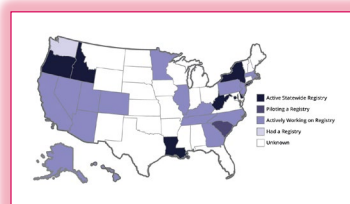
Find more detail on each of these in our Appropriate POLST Use Policy: <https://polst.org/appropriate-use-pdf>

Other Maps



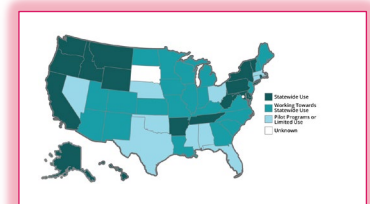
Pediatric

<https://polst.org/pediatric-map-pdf>



State Registries

<https://polst.org/registry-map-pdf>



Level of POLST Use

<https://polst.org/use-map-pdf>

Most Requested Additional Resources

- Advance Directives & POLST: <https://polst.org/compared-with-advance-directives-pdf>
- Legislative Guide: <https://polst.org/legislative-guide-pdf>
- Policies:
 - Distinguishing POLST from Medical Aid in Dying: <https://polst.org/maid-pdf>
 - Incentive and Quality Assurance Policy: <https://polst.org/incentive-policy-pdf>
- POLST Form Signature Requirements: <https://polst.org/state-signature-requirements-pdf>
- State Laws and Regulations Grid: <https://polst.org/legislative-comparison-pdf>
- Technology Guide: <https://polst.org/tech-guide>

¹ “Surrogate” refers to anyone authorized to make health decisions on behalf of a patient lacking decisional capacity. Depending on the state, this person may be known as a “proxy,” “durable power of attorney for healthcare,” “health care agent,” etc.