Long-Term Care (LTC) Implementation Overview

• Identify Champions: Clinical and Administrative partners
  o May be an Administrator, Director of Nursing, Medical Director or Social Service Director
  o Role is to shepherd TPOPP through the policy approval process, help organize LTC facility for education/training and administrative implementation.
  o LTC champion(s) submit initial Data Survey to alert TPOPP leadership of interest in exploring implementation.

• Introduction and Approval
  o Introduce TPOPP to appropriate LTC policy and governing committees.
  o Obtain approval for implementation at the facility or system level.

  ▪ TPOPP Integration into LTC Facility Policy/Procedures
    o LTC facility policy must recognize TPOPP as an out of hospital order set for code status and level of intervention orders to be honored at the point of care.
      ▪ Policy can be included in the LTC facility’s resuscitation status policy.
    o The LTC facility should implement appropriate policy and procedures specific to TPOPP.
    o Crosswalk TPOPP with policies on advance directives, end-of-life, resuscitation status, handling of OHDNR orders.
    o Crosswalk TPOPP with medical facility bylaws as appropriate to include notation regarding TPOPP where necessary.

  ▪ Implementation: Procedures
    o Identify valid/complete TPOPP forms
      ▪ At admission;
      ▪ At Care Plan conferences.
    o How form is stored and verified as part of the record.
      ▪ System insures that residents who have a TPOPP form can be identified.
      ▪ System must handle the storage of a TPOPP form so that it is readily accessible so that the original form goes with the resident when discharged or transferred to other care setting (hospital home, hospice inpatient, rehabilitation).
      ▪ System must address how to reconcile and store multiple forms.
      ▪ System must address hot to identify a resident who had TPOPP form at discharge/transfer and who does not have a TPOPP form when returning to the facility.
    o How TPOPP orders are placed on the POS.
• **Implementation: The TPOPP Conversation**
  o Identify residents who can benefit from a TPOPP discussion.
    ▪ Anyone with a limitation in code status;
    ▪ Anyone where provider would not be surprised by death within 1 year;
    ▪ Anyone who is in a “high risk for readmission based on diagnosis.”
  o Identify persons in the organization who would have the TPOPP conversation with residents/families and who might update the form.
    ▪ Medical director
    ▪ Attending physician
    ▪ Nurse Practitioner
    ▪ Physician Assistant
    ▪ MDS nurse
    ▪ Attending physicians
    ▪ Nursing coordinators
    ▪ Nursing team leaders
  o The TPOPP conversation is not a “one and done” event but may require several distinct conversations and include several care team members.
  o Physician must be an integral part of the conversation team and verify with resident/representative (signature on TPOPP form) prior to signing TPOPP form thereby creating a medical order.
  o How and where will healthcare team members access blank TPOPP forms to use during TPOPP conversations?

• **Implementation: Community**
  o Identify community stakeholders
    ▪ Residents
    ▪ Families and recognized decision makers
    ▪ Supporting organizations such as hospice, home health care or other referral sources

• **Implementation: Data Collection**
  o Identify patients in their system who have TPOPP forms.
  o Commit to respond to survey requests at set intervals to gather data to be aggregated via REDCap for research and quality control purposes.

• **Implementation: Education**
  o Facility identifies and engages the providers who need to be trained:
    ▪ Those who will receive or discharge patients
      • Nursing staff
      • Social service staff
    ▪ Those who will be responsible for maintaining the chart
      • Medical records
      • Nursing staff
  o Hospitals commit to semi-annual or annual education.