Transportable Physician Orders for Patient Preferences
A POLST Paradigm Program

A Guidebook for Health Care Providers in Kansas and Missouri
Transportable Physician Orders for Patient Preferences (TPOPP) Initiative

TPOPP is based on the belief that individuals have the right to make their own health care decisions and to participate in shared decision making. The Transportable Physician Orders for Patient Preferences (TPOPP) Initiative is designed to improve the quality of care people living with serious illness receive by translating patient/resident goals and preferences into medical orders. TPOPP is based on communication between the patient/resident or recognized decision maker (e.g., the Healthcare Agent, proxy, or other designated decision-maker) and healthcare professionals that ensures informed medical decision-making. TPOPP:

- Promotes a person’s autonomy and independence by documenting a person’s treatment preferences and having them translated into medical orders;
- Enhances the HIPAA-compliant transfer of patient records between healthcare professionals and healthcare settings throughout the continuum of care;
- Clarifies treatment intentions and minimizes confusion regarding a person’s treatment preference;
- Reduces repetitive activities in complying with the federal Patient Self-Determination Act;
- Facilitates appropriate intervention and treatment by emergency medicine and EMS personnel.

Development of the TPOPP Program

A Kansas City Regional TPOPP task force, aimed at improving care for the seriously ill in Kansas and Missouri, created the Transportable Physician Orders for Patient Preferences (TPOPP) initiative. Transportable Physician Orders for Patient Preferences (TPOPP) was adapted from called Physician Orders for Life-Sustaining Treatment (POLST Paradigm). Developed in the early 1990’s, POLST communicates medical orders describing an individual’s preferences for life-sustaining treatments. POLST was designed for use in all care settings including hospitals, long-term care facilities, and the community.
Examples of treatments addressed include:

- Cardiopulmonary resuscitation (CPR or “code status”)
- Use of IV fluids and antibiotics
- Intubation, mechanical ventilation and defibrillation
- Medically administered nutrition
- Comfort measures

A decade of research has proven that the POLST program more accurately conveys end-of-life preferences that are more likely to be followed by medical professionals. The POLST program has been a key vehicle in successful efforts to increase the effectiveness of advance care planning and decrease unwanted hospitalizations at the end of life. For more information about POLST, please visit: www.polst.org. TPOPP achieved endorsed status from the National POLST Paradigm in 2016.

➤ Special thank you to the primary care physicians, emergency room doctors, EMS staff, nurses, pulmonologists, intensivists, palliative care specialists, social workers, attorneys, consumers, long-term care facility staff, hospice workers and home care staff that created TPOPP.

Goals of the TPOPP Program

TPOPP aims to improve the communication of a person’s preferences regarding life-sustaining treatments and, thereby, generate higher quality medical care. In order to accomplish this aim, the TPOPP Program was designed to:

- Document a person’s treatment preferences regarding:
  - Cardiopulmonary resuscitation (CPR), intubation and mechanical ventilation;
  - Other life-sustaining treatments such as tube feedings, antibiotics, etc;
- Translate those treatment preferences into an actionable, portable set of physician orders;

- Communicate an individual’s care preferences across health care settings;
- Improve Emergency Medical Services (EMS) personnel’s ability to treat according to the individual’s wishes;
- Reduce repetitive documentation while complying with state laws and the federal Patient Self-Determination Act.

Core Elements of the TPOPP Program

The TPOPP Program is based on communication between the patient/resident or recognized decision maker (e.g., proxy, the Healthcare Agent or Durable Power of Attorney for Healthcare) and healthcare professionals to ensure informed medical decision-making. Medical orders derived from these conversations should be recorded on the TPOPP form. The TPOPP form is a bright pink medical order form that must be signed by a Kansas or Missouri physician or licensed eligible provider. The purpose of the form is to create a set of actionable medical orders regarding lifesustaining treatments that transfers with the patient across healthcare settings and, thus, effectively communicates to healthcare providers. The TPOPP form:

- Is recommended for individuals with advanced, chronic, progressive disease or terminal conditions or for individuals who wish to further define their treatment preferences beyond an advance directive;
- May be used to indicate a preference to receive all medically indicated treatments or to limit medical interventions including attempts at cardiopulmonary resuscitation (CPR);
- Provides explicit direction about resuscitation status (“code status”) if the patient is without a pulse and/or is not breathing (apneic);
- Includes directions about other types of intervention that the patient may or may not want (e.g., decisions about future hospitalizations, ICU care, antibiotics, medically administered nutrition, intubation and mechanical ventilation);
- Accompanies the patient as he or she is transferred home or to a new care setting (e.g. long-term care facility or hospital);
Other End of Life Documents vs the TPOPP Form

<table>
<thead>
<tr>
<th>For all adults</th>
<th>For those who are chronically ill and could be expected to die within a year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed ahead of time to address a person’s wishes in a potential future state of illness</td>
<td>Applies right now to translate patient wishes in the current state of illness into medical orders</td>
</tr>
<tr>
<td>Applies only when decision-making capacity is lost</td>
<td>Not conditional on losing decision-making capacity</td>
</tr>
<tr>
<td>Contains no actionable medical orders</td>
<td>Constitutes actionable medical orders</td>
</tr>
<tr>
<td>Often does not accompany patient</td>
<td>Accompanies patient across care settings</td>
</tr>
</tbody>
</table>

Who Should Have a Completed TPOPP Form?

Healthcare professionals should discuss patients’ end-of-life wishes with their patients who have advanced progressive chronic illness, are terminally ill or are interested in further defining their care wishes beyond a traditional advance directive. Healthcare professionals should then record patients’ decisions on a TPOPP form. Specifically, healthcare professionals should discuss TPOPP with their patients if the patient/resident:

- Wants all medically indicated treatments;
- Chooses to limit life-sustaining treatments;
- Wants to avoid all life-sustaining treatments;
- Wants to avoid cardiopulmonary resuscitation (CPR) by requesting a “Do Not Resuscitate Order” (DNR order);
- Has advanced chronic condition(s) or terminal illness;
- Resides in a long-term care facility and/or;
- Resides in the community and is eligible for long-term care.

Additionally, the TPOPP Program:

- Includes the training of health care professionals regarding the goals of the TPOPP program and the use of the TPOPP form;
- Features a plan for ongoing monitoring of the program and its implementation.

The TPOPP form and program should ensure the honoring of orders in all settings at the time of patient presentation. Although the TPOPP form should reflect the information in current advance care planning documents, it is not intended to replace them.

➤ A completed TPOPP form is one possible outcome of serious illness care planning. For physician resources on how to conduct serious illness care planning conversations, visit the Ariadne Labs website at ariadnelabs.org
Medical Orders for Life-Sustaining Treatment (MOLST) *
8-Step MOLST Protocol **

1. Prepare for discussion
   • Review what is known about patient goals and values
   • Understand the medical facts about the patient’s medical condition and prognosis
   • Review what is known about the patient’s capacity to consent
   • Retrieve and review completed advance directives and prior DNR/MOLST forms
   • Determine key family members and if the patient lacks medical decision-making capacity,
   • Identify the health care agent or surrogate
   • Find uninterrupted time for the discussion
   • Review the legal requirements under New York State Public Health Law, based on who will make the decision and where the decision is made

2. Begin with what the patient and family knows
   • Determine what the patient and family know regarding condition and prognosis
   • Determine what is known about the patient’s values and beliefs

3. Provide any new information about the patient’s medical condition and values from the medical team’s perspective
   • Provide information in small amounts, giving time for response
   • Seek a common understanding; understand areas of agreement and disagreement
   • Make recommendations based on clinical experience in light of patient’s condition /values

4. Try to reconcile differences in terms of prognosis, goals, hopes and expectations
   • Negotiate and try to reconcile differences; seek common ground; be creative
   • Use conflict resolution when necessary

5. Respond empathetically
   • Acknowledge
   • Legitimize
   • Explore (rather than prematurely reassuring)
   • Empathize
   • Reinforce commitment and non-abandonment

6. Use MOLST to guide choices and finalize patient/family wishes
   • Review the key elements with the patient and/or family
   • Apply shared, informed medical decision-making
   • Manage conflict resolution

7. Complete and sign a MOLST
   • Obtain verbal or written consent from the patient or designated decision-maker
   • Follow legal requirements under New York State Public Health Law, including Family Health Care Decisions Act (FHCDA)
   • Document conversation

8. Review and revise periodically

* Honoring patient preferences is a critical element in providing quality end-of-life care. To help physicians and other health care providers discuss and convey a patient’s wishes regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment, the New York State Department of Health has approved a physician order form (DOH-5003), Medical Orders for Life-Sustaining Treatment (MOLST), which can be used statewide by health care practitioners and facilities. MOLST is an approved Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program and incorporates New York State Public Health Law.

** Bomba, 2005; Revised 2011 to comply with Family Health Care Decisions Act, effective June 1, 2010

www.health.state.ny.us/professionals/patients/patient_rights/molst/
www.CompassionAndSupport.org
Current Medical Evidence Regarding Outcomes of CPR

Healthcare professionals need to be aware of the patient’s goals of care and share existing medical evidence with patients to facilitate their decision making. CPR was developed in the 1960s as a method of attempting to restart the heart in the event of sudden, unexpected clinical death. Originally intended as an intervention for unexpected or accidental events in healthy persons, CPR has become an expected intervention in most disease states, despite evidence that outcomes are quite poor for people in the advanced stages of illness. It is important for patients and recognized decision makers to know that CPR is not as successful as most people think. In general, CPR is not successful in persons with advanced terminal or chronic illnesses. Additionally, there may be significant complications resulting from CPR including fractured ribs, punctured lungs, brain damage, and permanent unconsciousness.

CPR works best in persons who are otherwise healthy and when it can be administered within a few minutes of the onset of cardiopulmonary arrest. Many persons appropriate for TPOPP decisions reside in long term care facilities where CPR, immediate emergency response and rapid transport to emergency care may not be available.

Nearly 90% of cardiac arrests occur outside a hospital setting and survival rates for those patients are as low as 6% to 8%. Inside the hospital, survival rates only increase to 24%.

<table>
<thead>
<tr>
<th>Research Findings on CPR Survival Rates†</th>
<th>%</th>
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<tbody>
<tr>
<td>Survival rates of CPR as portrayed on television</td>
<td>&gt;66</td>
</tr>
<tr>
<td>Actual adult rate of survival (to hospital discharge)</td>
<td>15</td>
</tr>
<tr>
<td>Frail elders*</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Long Term Care residents</td>
<td>&lt;2</td>
</tr>
<tr>
<td>Individuals with advanced Chronic Disease**</td>
<td>&lt;1</td>
</tr>
</tbody>
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*An older person with trouble performing activities of daily living because of weakness or fatigue. Frail elders are more vulnerable to acute illness due to low activity level.
**Advanced chronic illnesses such as Alzheimer’s, Parkinson’s or end-stage heart, lung or kidney
†See references. [1,3,4,5,11]
Section B: Medical Interventions

<table>
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<tr>
<th>B. CHECK ONE</th>
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</table>
| □ Full Treatment.  
In addition to treatment described in Comfort Measures Only or Selected Additional Interventions (see below), use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.  
TREATMENT GOAL: ATTEMPT TO PROLONG LIFE BY ALL MEDICALLY EFFECTIVE MEANS. |
| □ Selected Additional Interventions.  
In addition to treatment described in Comfort Measures Only (see below), use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.  
TREATMENT GOAL: ATTEMPT TO RESTORE FUNCTION WITH TREATMENTS FOR REVERSIBLE CONDITIONS. |
| □ Comfort Measures Only.  
Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location.  
TREATMENT GOAL: ATTEMPT TO MAXIMIZE COMFORT THROUGH SYMPTOM MANAGEMENT ONLY. |

Additional Orders:

Section B orders apply to emergency medical circumstances for a person who has a pulse and/or is breathing. These range from full treatment to comfort measures only. If all life-sustaining treatments are desired, the “Full Treatment” box is checked and, in medical emergencies, 9-1-1 is called. Treatment includes use of intubation, advanced airway intervention, mechanical ventilation, cardioversion, transfer to hospital and use of intensive care, as indicated. However, if the person chooses some limitation, then either the “Comfort Measures Only” box or the “Selected Additional Interventions” box should be checked. Healthcare professionals will first administer the level of emergency medical services (EMS) ordered and then contact the physician. Comfort care is always provided regardless of indicated level of EMS treatment. Other instructions may also be specified.

Full Treatment has no limitation of treatment. All medically indicated interventions needed to maintain and extend life are utilized. Use intubation, advanced airway interventions, mechanical ventilation and electrical cardioversion as indicated. Transfer to hospital and use intensive care as medically indicated. Full treatment assumes any medical interventions and comfort measures will be provided as well.

Selected Additional Interventions indicates a decision to receive simple treatments for reversible conditions in an attempt to restore function. Interventions might include oral or IV medications, IV fluids, oxygen, cardiac monitoring or other medical treatments. Intubation and mechanical ventilation are not used.

Less invasive airway interventions such as BiPAP and CPAP could be considered, if it were thought that using these treatments for a brief time could help restore normal breathing function. Transfer to a hospital will occur if it is medically indicated to do so but with the intent to avoid intensive care.

Comfort Measures Only indicates a patient’s desire to receive only those interventions that enhance comfort. Use medication by any route, positioning, wound care, and oxygen, suction and manual treatment of airway obstruction (choking) as needed for comfort. Do not transfer to a hospital unless comfort needs cannot be met in the current location. Sometimes it is necessary to transfer patients to the hospital to control their symptoms and suffering. Examples include wound care (immediate and ongoing pain relief, control of bleeding, cleaning, wound closing and dressing as needed to optimize hygiene, positioning for comfort), manual airway opening and stabilization of any fracture by splinting and/or surgery (with the goal to control pain).

➤ Note: A person may also indicate a preference for DNR or allow a natural death in section A, but then select “Full Treatment” in section B. In this case, the implication would be that the patient desires aggressive treatment up to but not including “code blue” response to a full blown

Goal Statements The “Treatment Goal” statements appearing in bold text beneath each box in section B are designed to provide more clarity regarding the ultimate treatment aims of each category. Healthcare professionals assisting with TPOPP form completion should clarify these goals with the patient and the patient’s recognized decision makers to ensure that they are consistent with the patient’s end of life preferences.

Eliciting Patient Goals and Values Pose the following question for the patient and recognized decision makers: “In light of what we know about your health condition and your preferences, when the time comes that you become more ill, which of the following choices best fits with what you’d want to have as a medical approach to your care?”
Four examples of responses include:

1. My goal would be to pursue any and all medically appropriate treatments that might keep me alive, even if it meant being on machines, like a respirator, indefinitely, and even if it meant I had to be in an ICU or another facility that has patients on respirators.

   Explore this response. Clarify what the patient or recognized decision makers mean by being kept alive. Check for congruency between this section and other sections of the form. Congruency may lead the patient to electing antibiotics and long term medically administered nutrition. Emergency transport should be expedited.

   ➤ This response corresponds most directly to the “Full Treatment” box in section B.

2. My goal would be for the doctors to treat conditions that could be reversed by using treatments that had a reasonable chance of returning me to my normal level of functioning. It would be okay for me to have painful testing or to go on artificial life support machines like a ventilator for a reasonable period of time if the doctors felt that those treatments had a good chance of making me better, but I wouldn’t want to get stuck on the machines.

   Explore this response. Clarify what the patient or recognized decision makers mean by normal level of functioning, reasonable periods of time, and “good chance”. What does “getting stuck” mean to them?

   ➤ This response corresponds most directly with the “Full Treatment” box in section B. Specify on the “Additional Orders” line that he or she desires only a time-limited trial of full treatment, accompanied by ongoing discussion with treating physicians.

3. My goal would be for the doctors to try treatments for my conditions that they thought had a reasonable chance of helping me return to my current level of functioning. However, I would not want a whole lot of painful procedures or testing or to go on artificial life support machines like a ventilator. If I became THAT sick even with treatments to get me back to where I was before, I would want, at that point, a comfort-directed approach, even if I was dying.

   Explore this response. Determine the patient or recognized decision makers understanding of reversible conditions and level of functioning. Check for congruency.

   ➤ This response corresponds most directly to the “Selected Additional Orders” line in section B.

4. My goal would be for all medical treatments to be focused solely on symptom management to maximize comfort, even if I were dying.

   Explore this response. Do all recognized decision makers/family supporting the patient understand and agree with what the patient is saying? Do the patient’s answers on the TPOPP form seem congruent with this goal or not? If not, keep talking. Congruent answers for someone answering this way would NOT include being a full code and would NOT include wanting intubation/ICU. Rather, they would only include comfort measures and, if comfort could not be maintained in the current environment, transfer to the hospital.

   ➤ This response corresponds most directly with the “Comfort Measures Only” box in section B.

Section C: Medically Administered Nutrition

Patients with progressive illnesses, including dementia, often experience a decline in eating, drinking and appetite with subsequent weight loss. In late stages of illness, this may be related to the medical condition itself or other conditions such as dysphagia, delirium, or even the natural dying process. The onset of such conditions can be a distressing time for patients, families and medical providers. Discussions about medically administered nutrition (MAN), usually by means of tube feeding, occur during these times. In discussing these choices, patients, families and medical providers should be aware of the medical evidence to date regarding the use of MAN in late stage diseases such as advanced dementia or metastatic cancer causing cachexia [2, 6-10]:

- Studies show that MAN can actually increase the risk of aspiration and its complications;
- A common cause of death for person’s with feeding tubes is aspiration pneumonia;
- Tube feeding does not appear to prolong life in patients with advanced dementia.

In section C of the TPOPP form, patients who can make their own
decisions regarding long-term MAN may check the appropriate box that fits their preferences. However, boxes in this section should be checked only after all feeding options are fully explained to the patient and his/her recognized decision maker, and after the patient, recognized decision maker and physician have thoroughly discussed the patient’s preferences and goals of end-of-life care. If medically feasible, fluids and nutrition should always be offered to the patient orally. A defined trial period of medically administered nutrition may allow the patient and recognized decision maker decision maker some time for the course of an illness to become more clear, or to allow the patient an opportunity to clarify treatment goals and assess risks and burdens.

Additional information regarding MAFN can be found at Guidelines for Long Term Feeding Tube Placement: http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center/tube_feeding_peg_s

Section D: Information and Signatures

D. INFORMATION AND SIGNATURES

<table>
<thead>
<tr>
<th>CHECK ALL THAT APPLY</th>
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<tbody>
<tr>
<td>□ Patient</td>
</tr>
<tr>
<td>□ Agent/DPOA healthcare</td>
</tr>
<tr>
<td>□ Parent of minor</td>
</tr>
<tr>
<td>□ Legal guardian</td>
</tr>
<tr>
<td>□ Health care surrogate</td>
</tr>
<tr>
<td>□ Other (specify):</td>
</tr>
</tbody>
</table>

Signature of patient or recognized decision maker (All fields required): By signing this form, the recognized decision maker acknowledges that the person has discussed above treatment measures in consultation with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print name: ____________________________
Signature: ____________________________
Relationship: ____________________________
Address: ____________________________
Phone: ____________________________

Signature of authorized healthcare provider (All fields required): My signature below indicates to the best of my knowledge that these orders are consistent with the person’s medical condition and preferences.

Print name of authorized provider and Physician: ____________________________
Signature of authorized provider: ____________________________
Phone: ____________________________
Date: ____________________________

Upon completion of the form, the medical provider must check the box indicating with whom he or she discussed the orders and have the patient or appropriate recognized decision maker sign the form. The physician or authorized licensed provider must then provide his or her name and contact information, and sign and date the form. In doing so, the provider indicates to the best of his or her knowledge that these orders are consistent with the person’s current medical condition and preferences. Additional information supporting the basis for the orders should be reflected in the medical record.

Without a provider’s signature, the orders are not valid. Clinicians who are not specifically authorized to sign this form by licensure or state law may assist in its development, but only an authorized provider may sign the form.

A provider’s verbal orders are valid as allowed by institutional or community policy. Compliance with that policy is essential. Effective date and contact information is also required for the orders to be valid. A faxed signature is valid.

The TPOPP form includes notations that the original form should accompany the person whenever transferred or discharged. Transporting a form with the patient between care settings enables receiving healthcare professionals to have current, accurate information regarding the medical orders and the patient’s preferences for treatment and increases the likelihood that these orders will be followed in the new care setting. Health systems with electronic record capability may scan the TPOPP form to ensure the orders are accessible.

Section E: Advance Directive and Durable Power of Attorney for Healthcare Decisions

E. ADVANCE DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

Healthcare Directive or other Advance Directive
Durable Power of Attorney for Healthcare Decisions document*

*Name of Agent: ____________________________
Phone: ____________________________

The TPOPP form does not replace advance care planning documents. Rather, it is a physician order set which reflects the patient’s preferences for life-sustaining treatment in the patient’s current state of health. The existence of advance care planning documents, particularly a Durable Power of Attorney for Healthcare Decisions, can be noted on the TPOPP form by checking the appropriate box in section E. If a Durable Power of Attorney for Healthcare Decisions document has been completed, the name of the Agent with contact information can be included.

Side 2: Additional Documentation

Health Care Providers Assisting with Form Preparation

| Name: ____________________________ | Title: ____________________________ | Phone: ____________________________ |
| Name: ____________________________ | Title: ____________________________ | Phone: ____________________________ |
Oftentimes a team of healthcare providers engage with patients and families about chronic illness planning. Other healthcare professionals may assist with the conversation and completion of the TPOPP form such as a nurse, social worker or chaplain. Their names, titles and contact information may be reflected on the form in the space provided.

What to Do With a Completed TPOPP Form

Transportability

TPOPP forms are designed to travel with the individual between care settings. The form should be kept in the front of the individual’s medical chart when residing in a facility. When the individual is transferred between care settings, a copy of the form should be kept in the medical chart at the old location. The original form should accompany the individual and be presented to each provider (first responder, hospital or other care setting). When the individual is at home, the TPOPP form should be kept in a conspicuous location (e.g., near refrigerator, phone, bedside) and presented to EMS personnel upon arrival. Every time there is a change in location of care, the order set should be reviewed and updated if necessary or reissued if goals change. The most recent document should take precedence.

Frequently Asked Questions (FAQs)

1. How much of the form should be completed?

The TPOPP order set is designed to be completed in its entirety. Incomplete forms reflect need for additional discussion and clarification of goals of care in order to provide guidance to clinicians and practitioners across settings.

2. Is there any reason to complete the TPOPP form if the patient chooses full cardiopulmonary resuscitation?

Yes. Reviewing the entire TPOPP form with a patient serves to educate the patient regarding additional choices for treatment and goals of care. Furthermore, inconsistencies in goals and preferences that need to be reconciled may emerge through discussion of the TPOPP form. For example, a patient may indicate a desire to never undergo intubation and mechanical ventilation under any circumstance. However, the patient may not realize that intubation and mechanical ventilation will be required as part of resuscitation for cardiopulmonary arrest.

3. Can a patient choose CPR order and also choose an order for no intubation?

No. These preferences are inconsistent and reflect a lack of understanding of CPR. Choosing CPR implies accepting the entire array of treatments in an emergency situation without limitations. Since intubation is required after successful CPR, the presumption in the case of full cardiopulmonary arrest is that the patient agrees to intubation and mechanical ventilation. All patients who prefer no intubation should also have a DNR order. However, the discussion regarding a Do Not Intubate (DNI) order is in the context of an individual who still has a pulse and/or is breathing. Thus, in this context, a patient who chooses not to be resuscitated may still consent to external defibrillation, Heimlich maneuver, clearing of the airway, etc.

4. Should all patients who choose DNR also be DNI?

No. DNR applies to patients who experience acute cardiopulmonary arrest, where no breathing or pulse can be detected, whereas DNI applies only to intubation for patients who experience impending pulmonary failure. Patients may not want CPR and have a DNR order, but may benefit from ventilator support and therefore may elect intubation. This may result in limited trial or long term intubation and mechanical ventilation. These distinctions are complex and should be thoroughly discussed.

5. What is a trial period of intubation and ventilation?

A time-limited trial of intubation and mechanical ventilation provides the patient a choice of therapy for an agreed upon time frame to determine if the underlying acute impending pulmonary failure is reversible. The patient may not wish long-term mechanical ventilation because the goal of the intervention is reversal of the condition.

The potential need for tracheotomy, preferences for alternate treatment such as BIPAP and CPAP and the provision of symptomatic treatment for dyspnea (labored breathing) should be reviewed. The patient’s preferences, as well as goals of care should be documented in the patient’s chart and clarified on the TPOPP form by checking Section B and adding text under “Additional Orders.”
6. Does a trial period of intubation raise ethical issues?
Time-limited trials are ethically and legally appropriate. There is no ethical or legal distinction between withholding and withdrawing life-sustaining treatment.

7. Can the format of the TPOPP form be changed if the patient or doctor does not like the form?
No. The TPOPP form cannot be changed. The standardized document follows the prescribed elements of the National POLST (physician orders for life sustaining treatment) paradigm and cannot be altered. The “Additional Orders” portions of the document provide flexibility for the physician. Additionally, if an individual seeks to make an explicit directive not captured in the form, an advance directive that includes that instruction should accompany the TPOPP form.

8. If a provider is unable at the time of patient presentation to get confirmation from the individual that the TPOPP form signed by the patient is accurate, how should the health care professional proceed?
Healthcare professionals should assume that the physician orders are valid and executable if the form is properly completed regardless of the patient’s mental capacity at the time of presentation. Additional confirmation may be warranted if circumstances present contrary or contradictory evidence to the provider. In those cases:

1. As much as possible, assess the patient’s decisional capacity at the time of completion of the TPOPP form. This may be evidenced by the fact that in addition to the physician’s dated signature, the patient himself or herself completed the form and dated it in a timely fashion.

2. Review patient records or transfer papers for evidence of documentation that a conversation occurred between the patient and provider at the time of the form’s completion.

3. If no verification documentation is available and questions persist, verify with the physician who completed the TPOPP form. Physician contact information can be found on the form in section E.

4. If capacity is intact at the time of patient presentation, the provider may initiate a goal-based discussion per the protocol. Patients with capacity may void the orders at any time.

9. Is a COPY of the TPOPP form acceptable? Yes.

10. Is a faxed copy of the TPOPP form acceptable? Yes.

11. Is a stamped signature on the TPOPP form acceptable?
No. Hand written signatures should be on the form. Physician signatures secured through verbal orders must comply with agency or provider policy.

12. Is an electronic version of the original signed TPOPP form acceptable?
Yes.

13. Why is the TPOPP form pink?
The color allows providers to quickly identify the form.

14. How can the TPOPP form’s pink color be maintained?
When the individual is transferred between care settings, a copy of the TPOPP form should be kept at the initial location on pink paper if possible. The original pink TPOPP form should accompany the patient and be placed in the patient’s record in the new setting.

15. Does the existence of a TPOPP form mean that the patient has made a decision to forgo CPR and has a DNR?
No. The TPOPP program is based on ensuring goal-oriented discussions that integrate patient preferences and informed medical decision making. It is NOT based on limiting medical interventions. A TPOPP form signifies that a thoughtful conversation has occurred regarding a range of treatment options resulting in a set of physician orders that reflect the patient’s preferences and current medical condition. The orders may range from limiting every intervention to receiving all medically appropriate interventions.
16. How does TPOPP differ from Advance Directives like the living will or durable power of attorney?

The TPOPP form contains actionable medical orders for seriously ill patients. These orders are based on patient directives and treatment preferences. When patients with TPOPP forms present to medical providers the orders are actionable, ensuring that those providers will incorporate the TPOPP order set information so that they can appropriately respond in accordance with patient directives. Orders should incorporate the TPOPP order set information so they can appropriately guide care provided by EMS personnel in pre-hospital settings.

17. Is the TPOPP program successful in the community and in health settings?

Yes. The TPOPP program is based on the national POLST paradigm. Growing evidence points to the success of this model. A list of these citations is available at www.polst.org.

18. Does a DNR order imply that a patient does not want treatment?

No. Do Not Resuscitate (DNR) should never mean Do Not Respond. An informed patient recognize that a DNR is limited to CPR attempts. In the presence of advanced or serious illness, CPR may provide no benefit and may actually injure the patient. Patients with a DNR may want and often need a variety of other supportive medical interventions other than resuscitation. TPOPP orders reflect those treatment preferences and goals.

References

12. Adapted with permission from the MOLST 8-Step Protocol, 2005, revised 2011, developed by Patricia A. Bomba, MD, FACP for New York State’s Medical Orders for Life-Sustaining Treatment (MOLST) Program.
Vision
Ethical discourse and action advance the health and dignity of all persons.

Mission
To raise and respond to ethical issues in health and healthcare.

Our Core Value
Respect for human dignity.

We believe that all persons have intrinsic worth.

- We promote and protect the interests of those who can and cannot speak for themselves.
- We commit to the just delivery of healthcare.

We welcome your interest in Transportable Physician Orders for Patient Preferences (TPOPP). For more information about the Center for Practical Bioethics, please contact us at 816-221-1100, visit our website www.PracticalBioethics.org, or e-mail us a TPOPP@PracticalBioethics.org.