Caring Conversations®
...continued

CENTER FOR PRACTICAL BIOETHICS
GUIDANCE AT THE CROSSROADS OF DECISION

KANSAS-MISSOURI

TPOPP

Transportable Physician Orders for Patient Preferences
A Participating Program of National POLST

Caring Conversations®...*continued*

This small booklet is titled *Caring Conversations...Continued* for a particular reason. You may be familiar with the Caring Conversations® workbook that has helped many people over the last two decades think about how to make their healthcare wishes known. The Caring Conversations® workbook guides you, your family and friends through the process of Advance Care Planning.

Even if you have thought about your healthcare wishes, talked to your family and friends and completed a Durable Power of Attorney for Healthcare Decisions, circumstances change. There are specific decisions that may become critically important if you live with an advanced chronic illness or have been told that you have a limited life expectancy.

Your Caring Conversation needs to be continued with both your medical providers and your loved ones to ensure that you fully understand your medical condition and receive the treatment you desire. The continuation of the conversation becomes more important as your health status declines or if you visit the hospital more frequently, live in a long-term care facility or you are transported by emergency medical services between care facilities.

You will find two forms in this booklet. One is a Durable Power of Attorney for Healthcare Decisions (in case you don't have one) and a bright pink form that is titled "Kansas-Missouri Transportable Physician Order for Patient Preferences (TPOPP)."

The pink TPOPP form helps you, your loved ones and your doctor continue the conversation about your healthcare wishes if you become frail or believe you have a limited amount of time to live. This "caring conversation continued" may, if you want it to, result in a medical order signed by your physician that will travel with you between healthcare settings so that no matter where you are taken care of, your wishes will be known and respected.

Please continue to read through the entire booklet and you will find basic information about Transportable Physician Orders for Patient Preferences (TPOPP) and answers to the following:

- What is TPOPP?
- What is a TPOPP Talk?
- What is a TPOPP Form?
- How do I keep track of my TPOPP Form?
- What should I do if I want to start a TPOPP Talk?

What is TPOPP?

TPOPP stands for "Transportable Physician Orders for Patient Preferences" and starts with a talk among you, your family members or loved ones if possible and your healthcare team.

Completing the TPOPP Form is your choice; it is voluntary.

If you want to complete a TPOPP form, the talk you have with your healthcare team members about CPR, treatment goals and medically administered nutrition is written on a TPOPP form which is a bright pink piece of paper and signed by you (or your recognized decision maker if you are not able) and also signed by a physician.

What is a TPOPP Talk?

TPOPP talks are about the type of care you desire in the case of an acute health decline or if you are frail or if there is a possibility that you have less than a year to live.

A TPOPP talk can be with a member of your healthcare team such as a physician, nurse, social worker or chaplain. You or a family member might begin the conversation or one of your healthcare team might begin the conversation.

The TPOPP talk is an opportunity to consider information about your current medical condition and what it means to you as you think about your treatment options.

The healthcare team brings information about your medical condition to the TPOPP talk. You and your family members bring your values, beliefs and what's important to you to the TPOPP talk.

If you are becoming frail or if you learn that your prognosis has changed, the kind of treatment you desire may change from when you were younger or healthier.

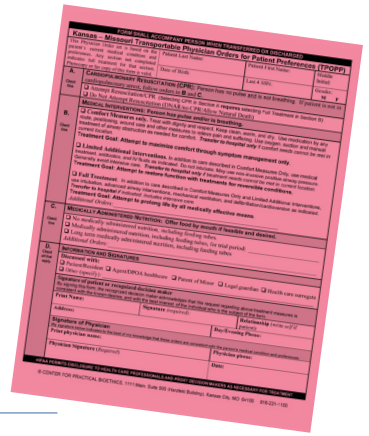
What is a TPOPP Form?

The TPOPP form is a bright pink piece of paper that helps doctors, nurses, and emergency medical workers honor your wishes for care. An example TPOPP form is included in this booklet to help you learn about TPOPP.

On the front of the TPOPP form there are spaces for your information such as your name, date of birth, etc. It's important to complete all the information so members of your healthcare team know that this TPOPP form is uniquely about you.

The TPOPP forms has areas for information about your wishes for:

- Cardiopulmonary Resuscitation (CPR);
- The level of medical intervention you want given your current health status;
- If you would want to have nutrition medically administered to you if you could not take food by mouth.


Kansas – Misdirect Transportable Physician Orders for Patient Preferences (TPOPP)

The form requires that you sign it or, if you are not able, a recognized decision maker may sign for you. This signature acknowledges that there was a conversation with the members of your healthcare team including a physician and that the treatment options are what you desire.

The TPOPP form requires the signature of a licensed physician to become a medical order. By signing the form the physician acknowledges that there was a conversation that included you (or a recognized decision maker if you are not able) about the treatment options that have been checked. The physician signature also acknowledges that the orders on the form are the treatment you desire.

On the back of the TPOPP form is a place for healthcare providers who were part of the discussion with you and your family members to enter their information.

There is also a place on the back of the form to provide information about any advance directives you may have in place or if you have signed a Durable Power of Attorney for Healthcare document.

How do I keep track of my TPOPP form?

The TPOPP form stays with you and goes with you as you go to your home, hospital, long-term care and any other care setting.

At home, keep the TPOPP form in a place where it can be seen (like on the refrigerator, by your phone or next to your bed).

If you are in a health care setting like a hospital or nursing home, the TPOPP form is kept in your chart. The original form will go with you if you go from one setting to another.

What should I do if I want to have a TPOPP Talk?

If you think a TPOPP form is right for you or your loved one, talk to your doctor, nurse or social worker. Show them this Caring Conversations Continued booklet. Your doctor, nurse practitioner, physician assistant, nurse, and social worker are the best sources for information about TPOPP and if it will be helpful to you.

– The toughest conversations... are sometimes the most important –

For more information about TPOPP go to www.practicalbioethics.org, call the Center for Practical Bioethics at 816-221-1100 or send an e-mail to TPOPP@practicalbioethics.org.

Healthcare Providers: TPOPP forms can be ordered on the Internet at www.practicalbioethics.org. Click on the TPOPP icon on the Home Page to access TPOPP information and resources.

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 both Caring Conversations® and 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 bioethic@PracticalBioethics.org.

CENTER FOR PRACTICAL BIOETHICS

GUIDANCE AT THE CROSSROADS OF DECISION

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Kansas – Missouri Transportable Physician Orders for Patient Preferences (TPOPP/POLST)

This Medical Order set is based on the patient's current medical condition and preferences. Any section not completed indicates default treatment for that section. The original form need not be present at the time of emergency. A copied, faxed or electronic version of this form is valid.

Last Name:	First Name, MI:	
Date of Birth:	Last 4 SSN or Patient ID#:	

A. CHECK ONE

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing. If patient is not in cardiopulmonary arrest, follow orders in B and C.

☐ **Attempt Resuscitation/CPR**
(Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation**
(DNAR/no CPR/Allow Natural Death)

B. CHECK ONE

INITIAL TREATMENT ORDERS: Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss treatments with patient and/or representative regularly to ensure patients care goals are met.

☐ **Full Treatments (required if CPR chosen in Section A).** **GOAL: Attempt to sustain life by all medically effective means.** Provide appropriate medical treatments as indicated in an attempt to prolong life, including intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion, including intensive care.

☐ **Selective Treatments.** **GOAL: Attempt to restore functions while avoiding intensive care and resuscitation efforts (i.e., 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.

☐ **Comfort-focused Treatments.** **GOAL: Attempt to maximize comfort through symptom management only; allow natural death.** Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or selective treatments unless consistent with comfort goal. Transfer to hospital if comfort cannot be achieved in current setting.

C. CHECK ONE

MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if desired by patient, is safe and tolerated.

☐ Provide feeding through new or existing surgically-placed tubes
☐ Trial period for medically assisted nutrition but no surgically-placed tubes
☐ No medically assisted means of nutrition desired
☐ Not discussed or no decision made

D.

ADDITIONAL ORDERS OR INSTRUCTIONS FOR SECTIONS B AND C: Includes e.g., time trials, blood products, and other orders. [EMS Protocols may limit emergency responder ability to act on orders in this section.]

E. CHECK ALL THAT APPLY

INFORMATION AND SIGNATURES (E-Signed documents are valid)

Discussed with:

☐ Patient ☐ Agent/DPOA Health Care ☐ Parent of minor ☐ Legal guardian
☐ Patient Representative ☐ Other *(specify)*: _____

Signature of patient or recognized decision maker (all fields required): By signing this form, the patient/recognized decision maker voluntarily acknowledges that this treatment order is consistent with the known desires and/or best interest of the patient.

Print name: EDUCATIONAL PURPOSES ONLY	Signature: FOR EDUCATIONAL PURPOSES ONLY	The most recently completed valid TPOPP/POLST form supersedes all previously completed TPOPP/POLST forms.
Address:	Relationship:	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. (verbal orders are acceptable with follow up signature)

Print name of authorized provider and/or Physician: FOR EDUCATIONAL PURPOSEsS ONLY	Phone:
Signature of authorized provider: FOR EDUCTIONAL PURPOSES ONLY	Date:

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

Kansas-Missouri TPOPP
practicalbioethics.org

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Patient Last Name:	First Name, MI:	DOB:	Last 4 SSN/Patient ID#:

ADVANCE CARE DIRECTIVES & EMERGENCY CONTACTS

Review of Advance Directives (Check all that apply)

☐ Healthcare Directive (Living Will) ☐ Other Instructions or Documents
☐ Advance Directives Unavailable ☐ No Advance Directives Exist
☐ Appointment of Durable Power of Attorney for Health Care (Name):_____ (Phone):_____

Patient's Emergency Contact (if other than person signing form) and Provider(s)

Full Name:_____ Phone (voice __ text __): _____

Primary Care Provider Name: _____ Phone: _____
Hospice Care Agency (If Applicable) Name: _____ Phone: _____

Health Care Providers and Others Assisting with Form Preparation Process (Check all that apply)

☐ Social Worker ☐ Nurse ☐ Clergy ☐ Palliative Care Provider
☐ Health Care Agent ☐ Parent of Minor ☐ Family Member ☐ "Person of Care and Concern"
☐ Patient Advocate ☐ Legal Guardian ☐ Other: _____

Instructions for Completing TPOPP/POLST

- Completing a TPOPP/POLST form is always voluntary. TPOPP/POLST is a useful tool for the understanding of and implementation of physicians' orders that are reflective of the current medical condition and preferences of a patient. The orders are to be respected by all receiving providers in compliance with institutional policy. On admission to the hospital setting, a physician who will issue appropriate orders for that inpatient setting will assess the patient.
- TPOPP/POLST is a physician order set and as such does not replace Advance Directives but should serve to clarify them.
- TPOPP/POLST must be completed by a health care provider based on patient preferences and medical indications. Upon completion it must be signed by a physician, APRN, or PA in compliance with state law, regulation, and scope of practice; and by patient *(or representative)* to be valid.
- Photocopies and Faxes of signed TPOPP/POLST forms are valid. Use of original form is strongly encouraged. A copy shall be retained in patient's medical record and accompany the patient to all settings.

Using TPOPP/POLST

(Any incomplete section of TPOPP/POLST implies full treatment for that section).

- **SECTION A:**
  - If found pulseless and not breathing, no defibrillator *(including automated external defibrillators)* or chest compressions should be used on a person if "Do Not Attempt Resuscitation" is selected.
- **SECTION B:**
  - When comfort cannot be achieved in the current setting, the person, including someone with "Comfort-focused Treatments" should be transferred to a setting able to provide comfort *(e.g., treatment of a hip fracture)*.
  - Non-invasive positive airway pressure includes continuous positive airway pressure *(CPAP)*, bi-level positive airway pressure *(BiPAP)*, and bag valve mask *(BVM)* assisted respirations.

Reviewing TPOPP/POLST

- TPOPP/POLST form should be reviewed when:
  - The person is transferred from one care setting or care level to another, or
  - There is a substantial change in the person's health status, or
  - The person's treatment preferences change, or
  - The care provider changes.

Modifying and Voiding TPOPP/POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a TPOPP/POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating.
- A legally recognized decision-maker may request to modify the orders, in collaboration with the physician/APRN/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

For information, clinical guidance resources or to obtain more forms, contact: TPOPP@practicalbioethics.org

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

Kansas-Missouri TPOPP
practicalbioethics.org

Durable Power of Attorney for Healthcare Decisions

■ ***Take a copy of this with you whenever you go to the hospital or on a trip*** ■

It is important to choose someone to make healthcare decisions for you when you cannot make or communicate decisions for yourself. Tell the person you choose what healthcare treatments you want. The person you choose will be your agent. He or she will have the right to make decisions for your healthcare. If you DO NOT choose someone to make decisions for you, write NONE on the line for the agent's name.

I, _____, SS#_____ (optional, last 4 digits), appoint the person named in this document to be my agent to make my healthcare decisions.

This document is a Durable Power of Attorney for Healthcare Decisions. My agent's power shall not end if I become incapacitated or if there is uncertainty that I am dead. This document revokes any prior Durable Power of Attorney for Healthcare Decisions. My agent may not appoint anyone else to make decisions for me. My agent and caregivers are protected from any claims based on following this Durable Power of Attorney for Healthcare. My agent shall not be responsible for any costs associated with my care. I give my agent full power to make all decisions for me about my healthcare, including the power to direct the withholding or withdrawal of life-prolonging treatment, including artificially supplied nutrition and hydration/tube feeding. My agent is authorized to

- Consent, refuse, or withdraw consent to any care, procedure, treatment, or service to diagnose, treat, or maintain a physical or mental condition, including artificial nutrition and hydration;
- Permit, refuse, or withdraw permission to participate in federally regulated research related to my condition or disorder
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other healthcare organization; and, employ or discharge healthcare personnel (any person who is authorized or permitted by the laws of the state to provide healthcare services) as he or she shall deem necessary for my physical, mental, or emotional well -being;
- Request, receive, review, and authorize sending any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; and execute any releases that may be required to obtain such information;
- Move me into or out of any State or institution;
- Take legal action, if needed;
- Make decisions about autopsy, tissue and organ donation, and the disposition of my body in conformity with state law; and
- Become my guardian if one is needed.

In exercising this power, I expect my agent to be guided by my directions as we discussed them prior to this appointment and/or to be guided by my Healthcare Directive *(see reverse side)*.

If you DO NOT want the person (agent) you name to be able to do one or other of the above things, draw a line through the statement and put your initials at the end of the line.

Agent's name _____ Phone _____ Email_____

Address_____

*If you do **not** want to name an alternate, write "none."*

Alternate Agent's name _____ Phone _____ Email_____

Address_____

Execution and Effective Date of Appointment

My agent's authority is effective immediately for the limited purpose of having full access to my medical records and to confer with my healthcare providers and me about my condition. My agent's authority to make all healthcare and related decisions for me is effective when and only when I cannot make my own healthcare decisions.

SIGN HERE for the *Durable Power of Attorney* and/or *Healthcare Directive* forms. Many states require notarization. It is recommended for the residents of all states. Please ask two persons to witness your signature who are not related to you or financially connected to your estate.

Signature _____ Date_____

Witness_____ Date _____ Witness_____ Date_____

Notarization:

On this _____ day of_____ , in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of_____ , State of _____, on the date written above.

Notary Public_____

Commission Expires_____

Healthcare Treatment Directive

■ *If you only want to name a Durable Power of Attorney for Healthcare Decisions, draw a large X through this page.* ■

I, _____ , SS# _____ want everyone who cares for me to know what healthcare I want.
(optional, last 4 digits)

I always expect to be given care and treatment for pain or discomfort even if such care may affect how I sleep, eat, or breathe.

I would consent to, and want my agent to consider my participation in federally regulated research related to my disorder or condition.

I want my doctor to try treatments/interventions on a time-limited basis when the goal is to restore my health or help me experience a life in a way consistent with my values and wishes. I want such treatments/interventions withdrawn when they cannot achieve this goal or become too burdensome to me.

I want my dying to be as natural as possible. Therefore, I direct that no treatment (including food or water by tube) be given just to keep my body functioning when I have

- a condition that will cause me to die soon, or
- a condition so bad (including substantial brain damage or brain disease) that I have no reasonable hope of achieving a quality of life that is acceptable to me.

An acceptable quality of life to me is one that includes the following capacities and values. (Describe here the things that are most important to you when you are making decisions to choose or refuse life-sustaining treatments.)

_____

_____

_____

_____.

Examples:
- recognize family or friends
- make decisions
- communicate
- feed myself
- take care of myself
- be responsive to my environment

If you do not agree with one or other of the above statements, draw a line through the statement and put your initials at the end of the line.

In facing the end of my life, I expect my agent (if I have one) and my caregivers to honor my wishes, values, and directives.

For further clarification, please refer to my *Caring Conversations* Workbook, which is located at _____.

Be sure to sign the reverse side of this page even if you do not wish to appoint a Durable Power of Attorney for Healthcare Decisions

Talk about this form and your ideas about your healthcare with the person you have chosen to make decisions for you, your doctors, family, friends, and clergy. Give each of them a completed copy.

You may cancel or change this form at any time. You should review it often. Each time you review it, put your initials and the date here. _____

This document is provided as a service by the Center for Practical Bioethics.
For more information, call the Center for Practical Bioethics at 816-221-1100
Email – *center@practicalbioethics.org* • Website – *www.practicalbioethics.org*