Kansas-Missouri TPOPP

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

CENTER FOR PRACTICAL BIOETHICS
GUIDANCE AT THE CROSSROADS OF DECISION

Fast Facts: TPOPP/POLST for Long-Term Care (LTC)

What is TPOPP/POLST?
Transportable Physician Orders for Patient Preferences (TPOPP/POLST) is an initiative designed to improve the quality of care people receive at the end of life by translating patient/resident goals and preferences into medical orders for treatment, and by building community infrastructure to ensure that those goals and preferences are reviewed and honored as appropriate as patient illness changes over time.

What is the TPOPP/POLST form?
The TPOPP/POLST form is a distinct paper that can communicate patient preferences regarding life-sustaining medical treatment. When signed by a patient (or a recognized decision maker) and a physician licensed in Kansas or Missouri, it becomes a medical order. Providers at all sites of care should follow the medical orders.

Who could have a TPOPP/POLST form?
Persons living with advanced or serious illness or are interested in further defining their care wishes.

Where did TPOPP/POLST begin?
TPOPP/POLST is based on a paradigm that originated in Oregon in the early 1990s: Physician Orders for Life Sustaining Treatment (POLST). Today POLST paradigm programs are in over 40 states at varying levels of saturation. A Kansas City Metropolitan TPOPP/POLST task force representing many hospital and health care providers created TPOPP/POLST. Since 2009 a team has been working toward TPOPP/POLST implementation. In 2012 the Kansas-Missouri TPOPP/POLST Coalition was formed to coordinate efforts for TPOPP/POLST across the two states.

Who should complete the form with the resident?
The TPOPP/POLST form provides a framework to engage in a rich and sensitive conversations about values, goals and preferences for care during serious illness and at end of life. A physician, nurse practitioner or other health care provider should facilitate such a conversation with the resident/family. Other members of the healthcare team may help explain the TPOPP/POLST form and support residents in making decisions. These team members should have training on serious illness conversations before assisting with completion of the form. The physician is responsible for reviewing the preferences and orders with resident (or recognized decision maker) before signing the TPOPP/POLST form.

Is TPOPP/POLST voluntary?
TPOPP/POLST is a voluntary form. Facilities cannot require that a resident complete a TPOPP/POLST form. TPOPP/POLST forms should not be included in the admission packet and should not be filled out as a checklist or admission requirement. Completion of a TPOPP/POLST form is one possible outcome of good serious illness conversations.

What is the role of the physician? The physician must engage in understanding and appropriately communicating medical information regarding the person's condition and prognosis. TPOPP/POLST is a physician order. By signing the TPOPP/POLST form, the physician verifies that the orders on the form are consistent with the resident's medical conditions and preferences.

When are TPOPP/POLST orders valid?
The TPOPP/POLST form is valid when signed and dated by (1) the person or, if the person lacks decision making capacity, the resident's recognized decision maker; and (2) the physician.

What happens to the TPOPP/POLST form when the resident is transferred or discharged?
When a facility resident is transferred or discharged the original TPOPP/POLST form is sent with the resident. A copy of the form should remain in the chart. The medical orders are recognized and followed by emergency medical providers if the resident is transferred.

Is there a MDS Section S requirement?
While MDS Section S requires facilities to report whether a resident has a POLST (TPOPP/POLST) form, it does not require facilities to use TPOPP/POLST nor does it require an individual resident to have a TPOPP/POLST form. Section S is used for data collection (not survey) purposes, thus accurate information is critical. It a resident does not have a TPOPP/POLST form, Section S should be completed to indicate so.

Does TPOPP/POLST support resident-centered care?
TPOPP/POLST aims to uphold and respect the resident's preferences for medical care during serious illness and at the end of life. TPOPP/POLST enhances the communication of these preferences at points of transitions.

Is TPOPP/POLST education helpful?
At the heart of the TPOPP/POLST program is education for all staff members, residents and family. Ongoing education will be important in program implementation.

Where can I get more information?
Visit the website of the Center for Practical Bioethics at www.practicalbioethics.org, send an e-mail to TPOPP@practicalbioethics.org or call the TPOPP Managing Director at 816-979-1366.