Kansas-Missouri

TPOPP

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

Long-Term Care (LTC) Implementation Overview

- **Identify Champions: Clinical and Administrative partners**
  - May be an Administrator, Director of Nursing, Medical Director or Social Service Director
  - Role is to shepherd TPOPP/POLST through the policy approval process, help organize LTC facility for education/training and administrative implementation.

- **Introduction and Approval**
  - Introduce TPOPP/POLST to appropriate LTC policy and governing committees.
  - Obtain approval for implementation at the facility or system level.

- **TPOPP/POLST Integration into LTC Facility Policy/Procedures**
  - LTC facility policy must recognize TPOPP/POLST 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.
  - The LTC facility should implement appropriate policy and procedures specific to TPOPP/POLST.
  - Crosswalk TPOPP/POLST with policies on advance directives, end-of-life, resuscitation status, handling of OHDNR orders.
  - Crosswalk TPOPP/POLST with medical facility bylaws as appropriate to include notation regarding TPOPP/POLST where necessary.

- **Implementation: *Procedures***
  - Identify valid/complete TPOPP/POLST forms
    - At admission;
    - At Care Plan conferences.
  - How form is stored and verified as part of the record.
    - System insures that residents who have a TPOPP/POLST form can be identified.
    - System must handle the storage of a TPOPP/POLST 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/POLST form at discharge/transfer and who does not have a TPOPP/POLST form when returning to the facility.
  - How TPOPP/POLST orders are placed on the EMR/Patient Operating System.

- **Implementation: *The TPOPP/POLST Conversation***
  - Identify residents who can benefit from a TPOPP/POLST discussion.
    - Anyone with a limitation in code status;
    - Review patient's Three Key Variables profile for Diagnoses, Functional Status, and Resource Utilization (re: CAPC Serious Illness Strategies for Health Plans and Accountable Care Organizations [2017])
    - Anyone who is in a "high risk for hospital readmission based on diagnosis."
  - Identify persons in the organization who would have the TPOPP/POLST conversation with residents/families and who would assist in updating form.
    - Medical director
    - Attending physician
    - Nurse Practitioner
    - Physician Assistant
    - MDS nurse
    - Attending physicians
    - Nursing coordinators
    - Nursing team leaders
  - The TPOPP/POLST conversation is not a "one and done" event but may require several distinct conversations and include several care team members.
  - Physician must be an integral part of the conversation team and verify with resident/representative (signature on TPOPP/POLST form) prior to signing TPOPP/POLST form thereby creating a medical order.
  - How and where will healthcare team members access blank TPOPP/POLST forms to use during TPOPP/POLST conversations?

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

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

- **Implementation: *Education***
  - 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
  - Facility commits to semin-annual or annual education