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/POLST through the policy approval process, help organize LTC facility for education/training and administrative implementation.

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

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

• Implementation: Procedures
  o Identify valid/complete TPOPP/POLST 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/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.
  o How TPOPP/POLST orders are placed on the EMR/Patient Operating System.
• Implementation: The TPOPP/POLST Conversation
  o 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.”
  o 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
  o The TPOPP/POLST 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/POLST form) prior to signing TPOPP/POLST form thereby creating a medical order.
  o How and where will healthcare team members access blank TPOPP/POLST forms to use during TPOPP/POLST 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/POLST forms.
  o Commit to respond to survey requests at set intervals to gather data to be aggregated 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 Facility commits to semin-annual or annual education