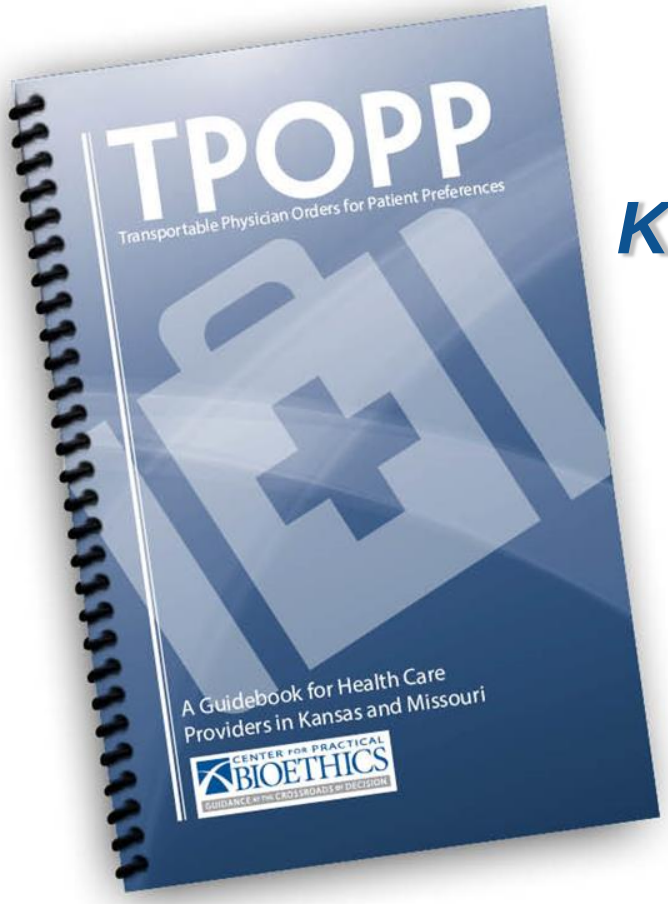


# Transportable Physician Orders for Patient Preferences

## *Kansas-Missouri TPOPP Coalition*

**Sandra Silva, JD**
**Vice President of Education**
**TPOPP Managing Director**
**Center for Practical Bioethics**

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TPOPP
Transportable Physician Orders for Patient Preferences

# Objectives

- **Understand the evolution of the POLST paradigm in the United States over the past 20 years**

- **Identify the core elements of the POLST paradigm upon which TPOPP is based**

- **Appreciate the importance of a community coalition**

- **Discuss the elements and their application in building a local/regional TPOPP coalition**

# What people say they want from the system at end of life

- Free of pain/other physical suffering
- Do not want death prolonged
- Do not want to die on machines
- Do not want to be a burden on their family

# What is currently happening?

- 2.45 million deaths in 2011 in the U.S.
- 25% home, 25% long term care
- 50% of those happen in the hospital
  -- 75-90% of hospital deaths occur after a decision to either remove or not start some form of artificial life support
- Short hospice length of stay
  -- 35% of people are on hospice < 7 days
  -- Median LOS 19 days

NHPCO Facts and Figures 2011


# Physicians Orders for Life Sustaining Treatment

www.polst.org

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# What is POLST?

- Converts patient preferences for treatment into:
  - An actionable medical order
  - That moves **with** the patient across the continuum
  - Respected by care providers along that continuum
- >40 states presently working on paradigm development
- Different names in different places (MOLST, POST, TPOPP), all have the same POLST paradigm elements

# National POLST Paradigm Programs

**www.polst.org**

***As of 1994**

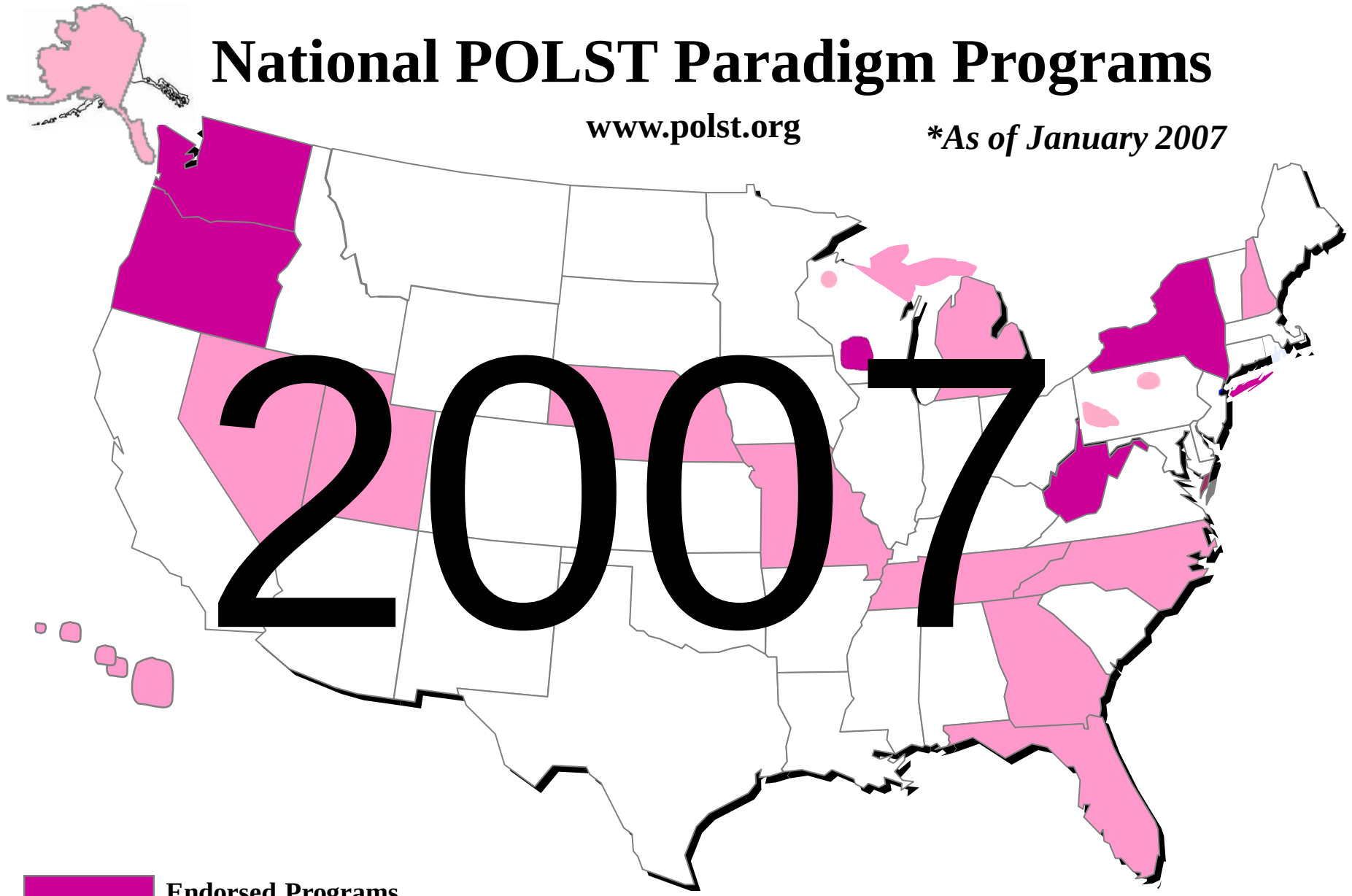

**Developing Programs**

**No Program (Contacts)**

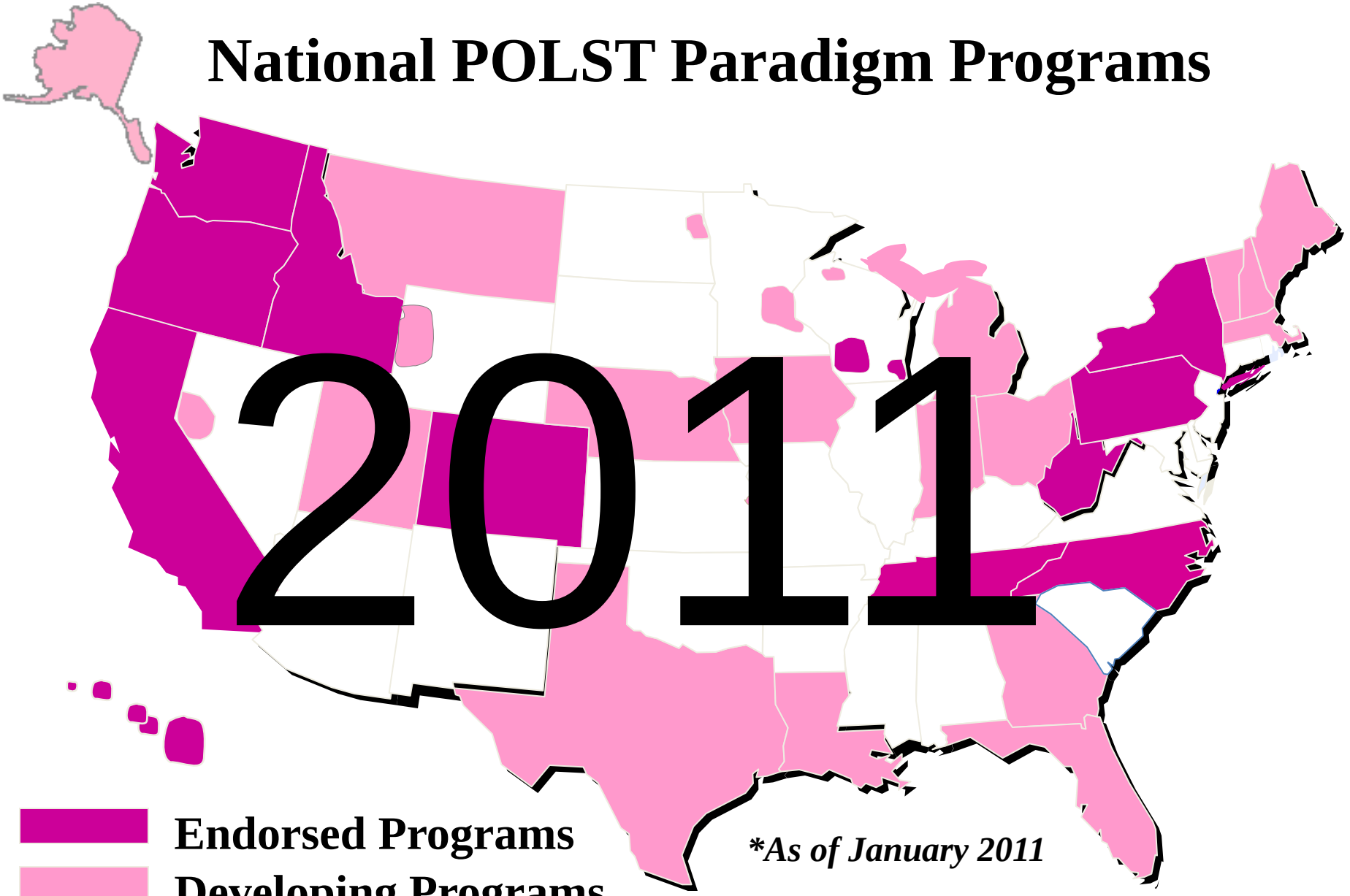
# National POLST Paradigm Programs

**www.polst.org**

***As of January 2007**



# National POLST Paradigm Programs




**Endorsed Programs**

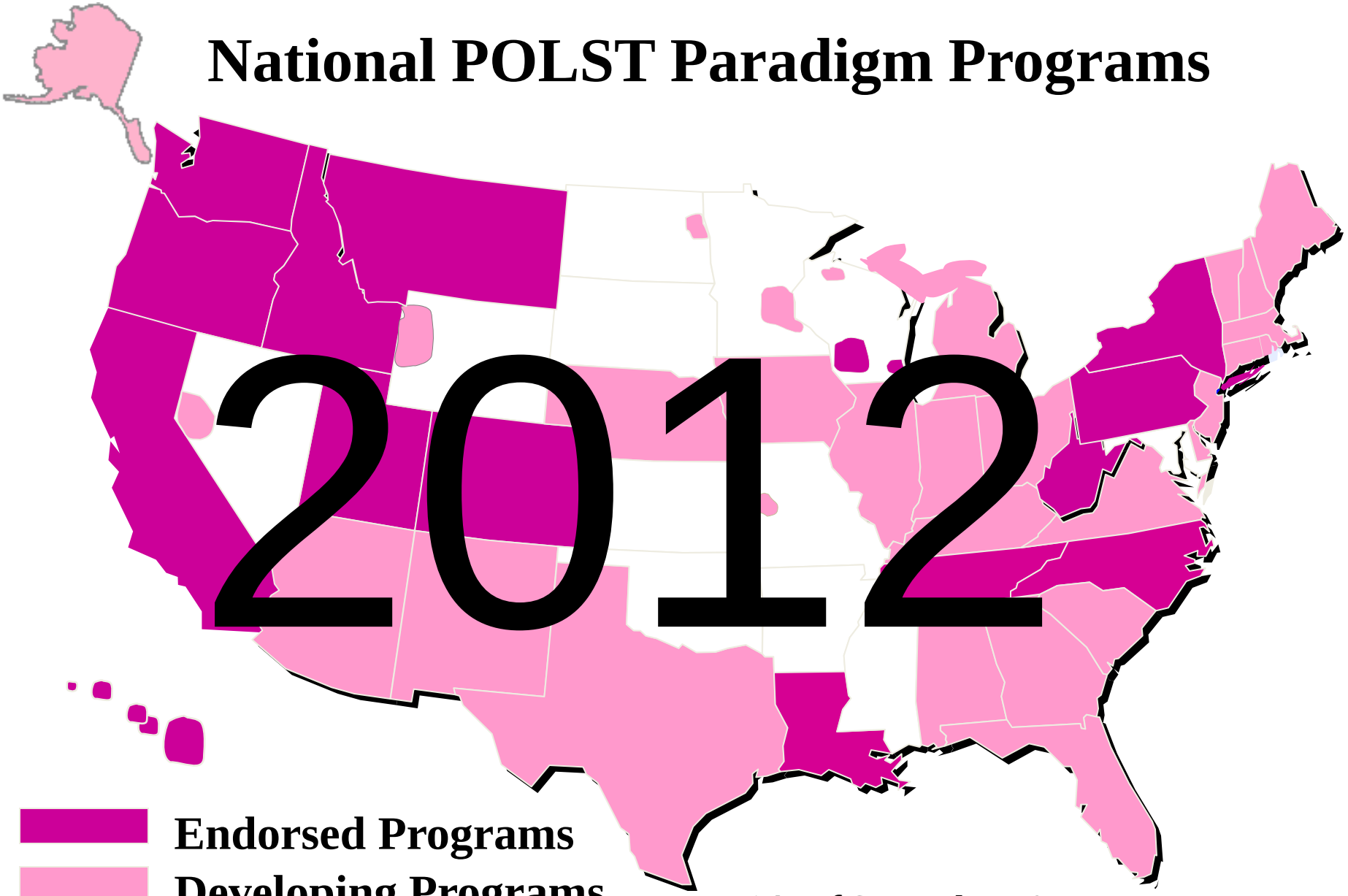
**Developing Programs**

**No Program (Contacts)**

***As of January 2011**

*Designation of POLST Paradigm Program status based on information available by the program to the Task Force.*

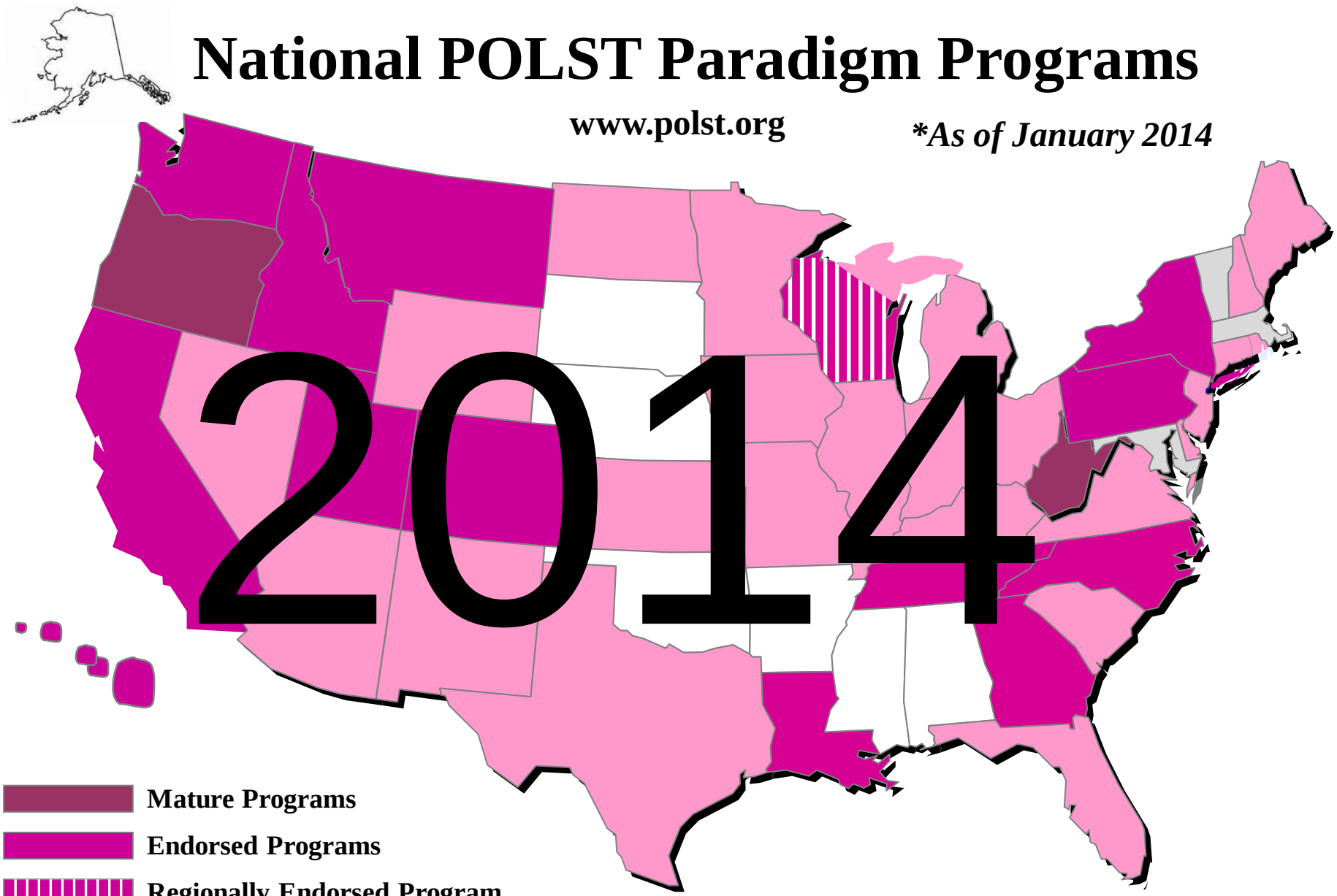
# National POLST Paradigm Programs



# National POLST Paradigm Programs

www.polst.org

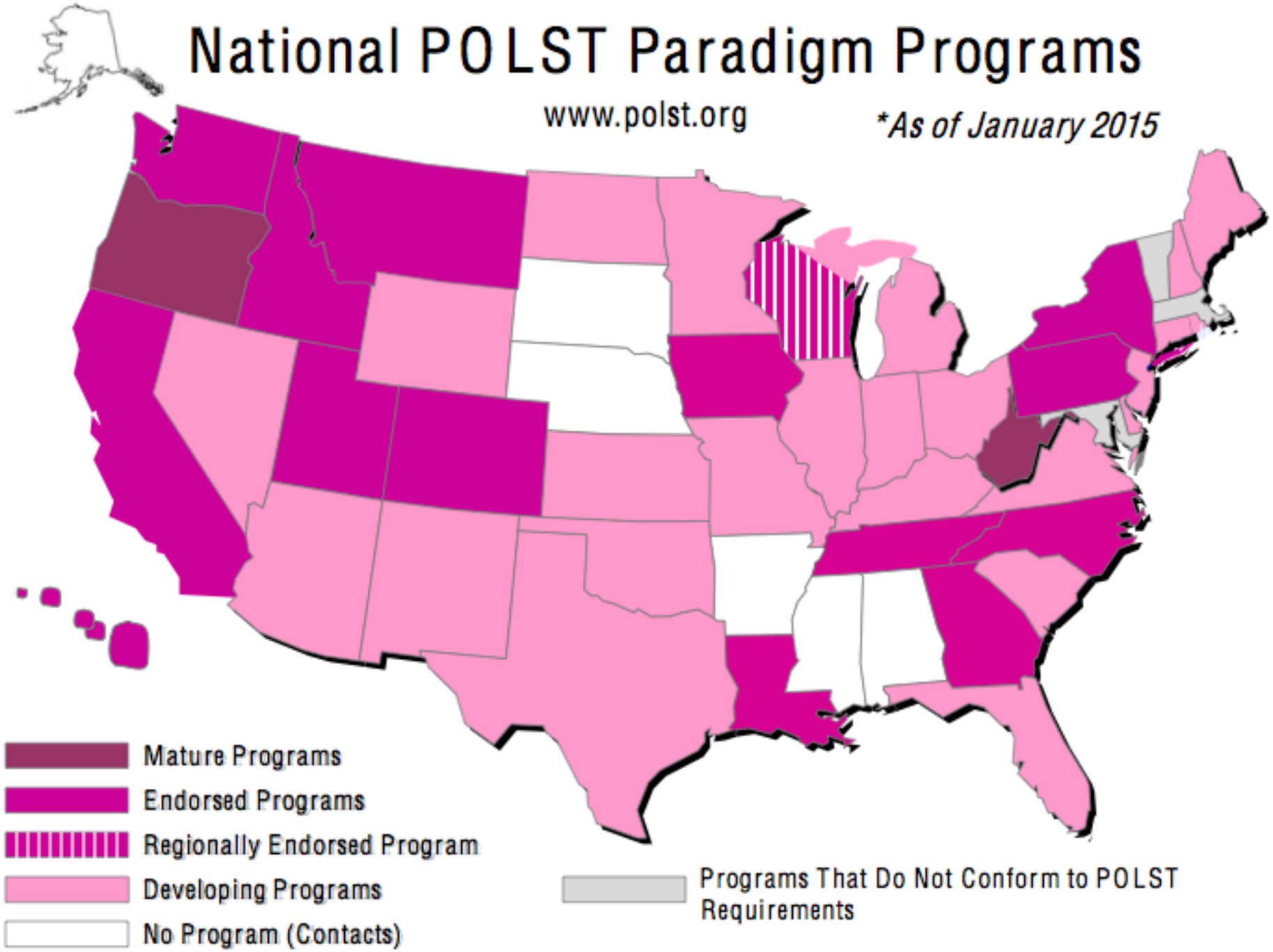
**As of January 2014*



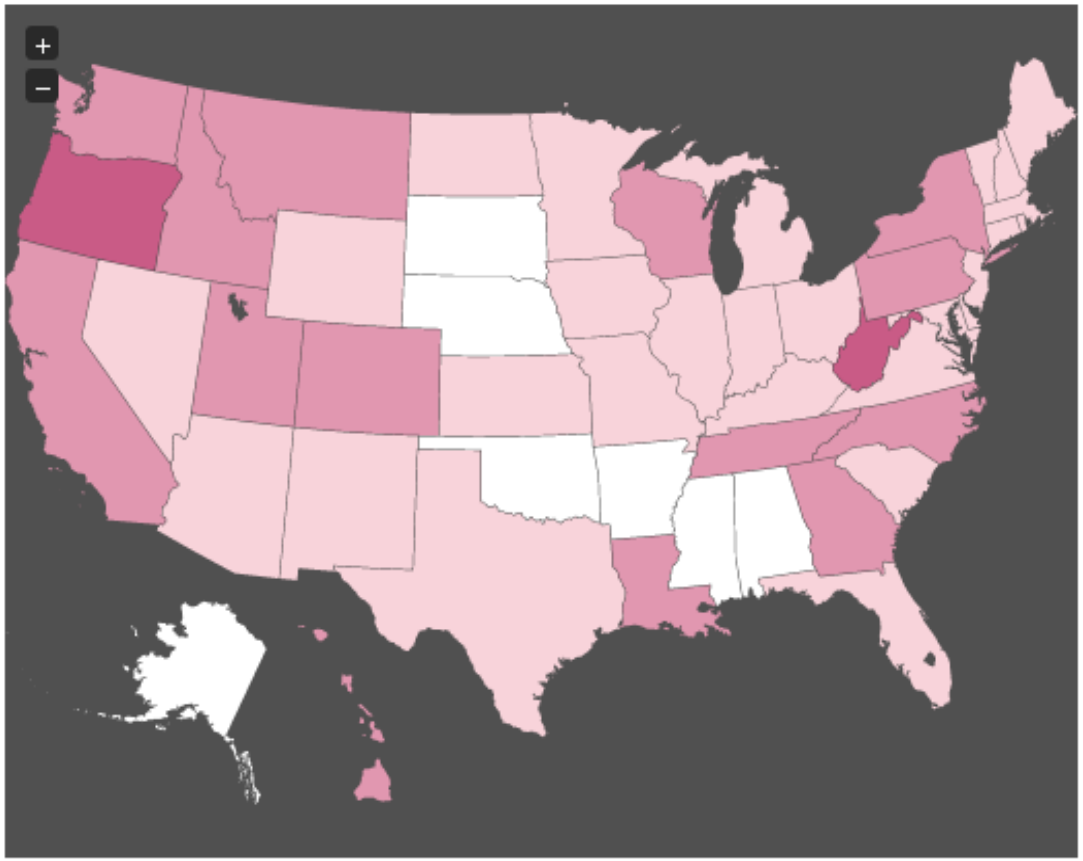
# National POLST Paradigm Programs

www.polst.org

*As of January 2015



# Programs in Your State



All | Mature | Endorsed | Developing | No Program

## MISSOURI

**Program Status:** Developing

Program Website

Center for Practical Bioethics

Program Contact

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Kansas-Missouri TPOPP Coalition
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Harzfeld Building
1111 Main, Suite 500
Kansas City, MO 64105
Phone: 816-979-1366
ssilva@practicalbioethics.org

# Differences between TPOPP and advance directives

| Characteristics | TPOPP | Advance Directives |
|---|---|---|
| Population | For the seriously ill | All adults |
| Time frame | Current care | Future Care |
| Who completes the form | Health care professionals | Patients |
| Resulting form | Medical orders (TPOPP) | Advance directive |
| Health care agent or surrogate role | Can engage in discussion if patient lacks capacity | Cannot complete |
| Portability | Provider responsibility | Patient/family responsibility |
| Periodic review | Provider responsibility | Patient/family responsibility |

# TPOPP Screening Question

Would I be surprised if this person were alive within the next 12 months?

***Yes?*** Then it's time for the TPOPP Talk

# Who Might Have a TPOPP Form?

- **Those who**:
  - -- Live with advanced progressive chronic illness
  - -- Might die within the next year
  - -- Wish to further define their care wishes

- ***TPOPP is NOT appropriate for:***
  - -- A person with stable medical condition or disabling problem with years of life expectancy
  - -- Anyone who does not want it

***TPOPP is a voluntary decision***

# Share Decision Making Patient/Physician/Caregivers

- Standard of care approach
- Focused on Patient specific Goals of Care
  - Advance Care Planning tools integrated into orders
  - Physician Order set flows from expressions of preferences and values of the patient
  - Special consideration given to beneficial and effective treatments to avoid unwanted interventions

# Starting with *your* values…


**Step 1**

Advance Care Planning

Sharing what's important
Talking about preferences
Naming an Agent
Setting goals

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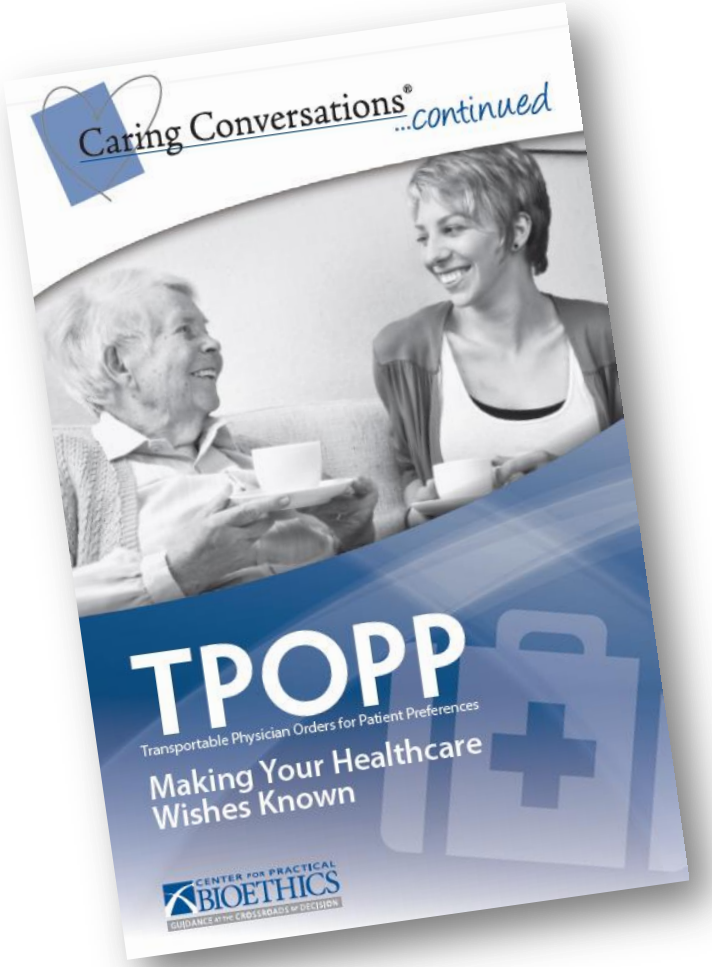
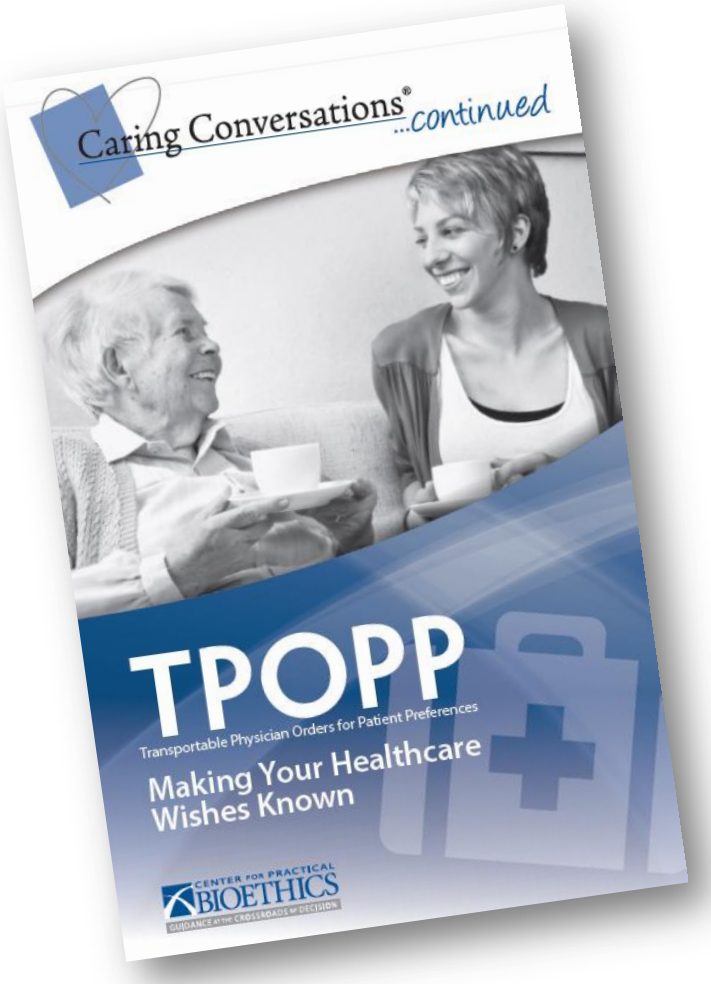



# *Continuing*...your Caring Conversations®

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***.




# *Continuing*...your Caring Conversations®

**Step 2**

…as goals change...

Patient and family engage in focused talks about EOL care with doctors and the healthcare team

# Chronic illness non-cancer trajectory--what people need to know

- If a person wants to die at home, not on machines, they need to know their trajectory and make a plan for the next "crash"

  -- Requires the system and the physician to recognize the trend and discuss it

  -- Requires planning from the hospital, the physician's office, the nursing home

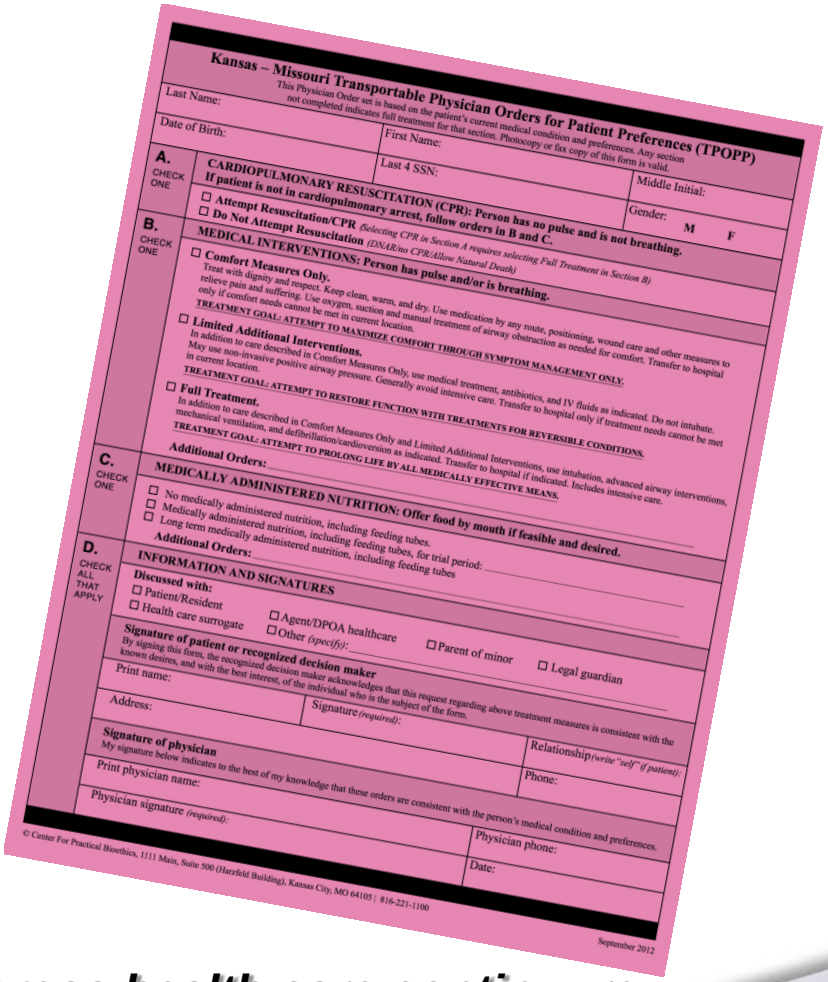
  -- Requires the support of systems in a coordinated effort for preferences to be known across the continuum

# All the Best Intentions

- Can do great Goals of Treatment planning in hospital, goals clear and understood
- The the patient goes home...
- Goals lost in transition
- Patient incapacitated and sick again
- Wheel reinvented, patient wishes may be respected, may be not

# TPOPP Form

- **Section A: Resuscitation Status**
  - -- For Full Blown cardiac arrest
    - * Attempt Resuscitation
    - * Do Not Attempt Resuscitation
- **Section B: Medical Intervention**
  - -- Still with pulse and breathing but with rapid health deterioration
    - * Comfort Measures Only
    - * Limited Additional Interventions
    - * Full Treatment
- **Section C: Medically Administered Nutrition**
- **Section D: Signatures**



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

This Physician Order set is based on the patient's current medical condition and preferences. Any section not completed indicates full treatment for that section. Photocopy or fax copy of this form is valid.

Last Name: | First Name: | Middle Initial:

Date of Birth: | Last 4 SSN: | Gender: M F

**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 — **MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.**

☐ **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.

☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only, 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 only if treatment needs cannot be met in current location.
TREATMENT GOAL: ATTEMPT TO RESTORE FUNCTION WITH TREATMENTS FOR REVERSIBLE CONDITIONS.

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions, 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.

**Additional Orders:**

**C.** CHECK ONE — **MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.**

☐ No medically administered nutrition, including feeding tubes.
☐ Medically administered nutrition, including feeding tubes, for trial period: _____
☐ Long term medically administered nutrition, including feeding tubes

**Additional Orders:**

**D.** CHECK ALL THAT APPLY — **INFORMATION AND SIGNATURES**

**Discussed with:**
☐ Patient/Resident ☐ Agent/DPOA healthcare ☐ Parent of minor ☐ Legal guardian
☐ Health care surrogate ☐ Other *(specify)*: _____

**Signature of patient or recognized decision maker**
By signing this form, the recognized decision maker acknowledges that this request regarding above treatment measures is consistent with the known desires, and with the best interest, of the individual who is the subject of the form.

Print name: | Signature *(required)*: | Relationship *(write "self" if patient)*:

Address: | Phone:

**Signature of physician**
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

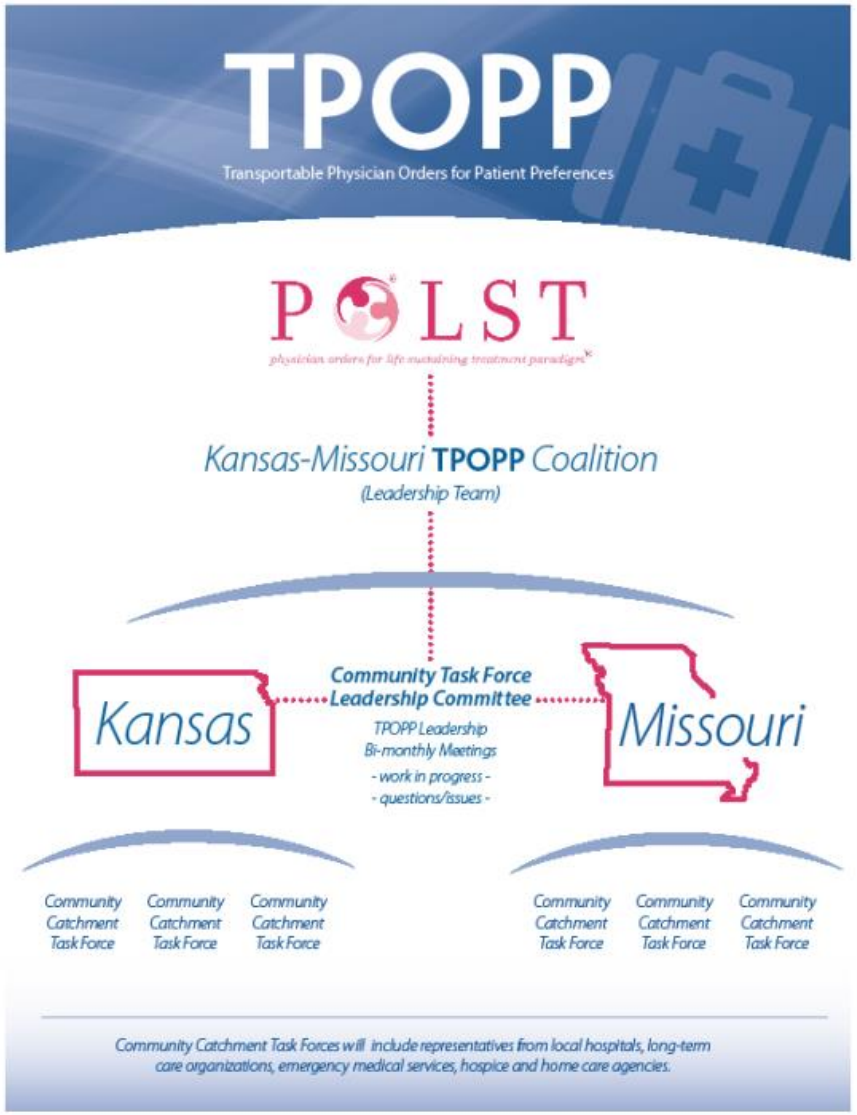
Print physician name: | Physician phone:

Physician signature *(required)*: | Date:



September 2012

- ***This document moves with the patient across health care continuum***


TPOPP
Transportable Physician Orders for Patient Preferences
POLST
physician orders for life sustaining treatment paradigm
Kansas-Missouri TPOPP Coalition
(Leadership Team)
Kansas
Community Task Force
Leadership Committee
TPOPP Leadership
Bi-monthly Meetings
- work in progress -
- questions/issues -
Missouri
Community Catchment Task Force
Community Catchment Task Force
Community Catchment Task Force
Community Catchment Task Force
Community Catchment Task Force
Community Catchment Task Force
Community Catchment Task Forces will include representatives from local hospitals, long-term care organizations, emergency medical services, hospice and home care agencies.

# Building the Bi-State Coalition

- Standard of Care Implementation
- 2009: KC Metro TPOPP taskforce
- 2010-2011: Small pilot Topeka, still on ground there today
- Provider interest across the bi-state area
  - Kansas: Wichita, Osborne, NW Kansas (16 counties)
    El Dorado, Manhattan, Hays, Kingman, Newton
  - Missouri: Joplin/Neosho, Springfield, Washington
- Kansas-Missouri TPOPP Coalition formed
  - -- Build infrastructure
  - -- Provide tools
  - -- Share Lessons Learned

# Community Coalition Model –
## Hospitals, LTC, EMS and home care

**No *single* institution or discipline alone can create a TPOPP initiative.**

**Each institution and discipline commits to TPOPP's implementation in a community creating the community standard across the continuum of care**

***Individual commitment to a group effort—that is what makes a team work, a company work, a society work, a civilization work.***

*~~ Vince Lombardi*

# Community Coalition Model Works!

- Study of Integration of POLST in CA (2012)

  -- More Nursing home residents in areas with *community coalitions* had POLST forms than those without community coalitions.[1]

  -- Community coalition intervention facilitated uptake of POLST in hospitals.[2]

[1] Wenger NS, Citko J, O'Malley K et al. Implementation of physician orders for life sustaining treatment in nursing homes in California: Evaluation of a novel statewide dissemination mechanism. J Gen Intern Med 2012;28:51–57.

[2] Sugiyama, T, Zingmond, D, O'Malley K et al. Implementing Physician Orders for Life-Sustaining Treatment California Hospitals: Factors Associated with Adoption, J Am Geriatr Soc, 2013 Jul 18

# *Working together…*

***In your wildest dreams, if what we were doing were successful, what would it look like?***

- When we succeed:
  - -- We will make a major improvement in matching the care provided to the care patients desire
  - -- We will improve how and where patients and families experience end-of-life
  - -- We will improve coordination across the care continuum for our most vulnerable loved ones while ***respecting their voice***

# www.PracticalBioethics.org

➔ Programs

➔ TPOPP

# Questions?

**May you be happy.**

**Thank you!**

**May you be well.**

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