KANSAS-MISSOURI

TPOPP

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

A Guidebook for Health Care Providers in Kansas and Missouri

CENTER FOR PRACTICAL BIOETHICS

Table of Contents

CENTER FOR PRACTICAL BIOETHICS

Part 1: Transportable Physician Orders for Patient Preferences (TPOPP/POLST) Initiative

TPOPP/POLST is grounded in the belief that individuals have the right to make their own health care decisions and to shared decision making. The Transportable Physician Orders for Patient Preferences (TPOPP/POLST) Initiative is designed to improve quality of care for those living with serious illness and/or frailty by translating patient/resident goals and preferences into medical orders. TPOPP/POLST achieves this by establishing communication between the patient/resident or recognized decision-maker (e.g., the Health care Agent, proxy, or other designated decision-maker) and health care professionals/ providers, thus ensuring informed medical decision-making. In sum, TPOPP/POLST:

- Promotes a person's autonomy and independence by documenting a person's treatment preferences and having them translated into medical orders.
- Enhances the HIPAA-compliant transfer of patient records between health care professionals and health care settings throughout the continuum of care.
- Clarifies treatment intentions and minimizes confusion regarding a person's treatment preferences.
- Reduces repetitive activities in compliance with the federal Patient Self-Determination Act.
- Promotes and facilitates appropriate interventions and treatments by emergency medicine and EMS personnel.

Development of the TPOPP/POLST Program

A diverse, volunteer, Kansas City Regional task force convened in 2008, aimed at improving care for the seriously ill in Kansas and Missouri, and created the Transportable Physician Orders for Patient Preferences (TPOPP/POLST) initiative. The

TPOPP/POLST Initiative was adapted from the National POLST Program. Developed in the early 1990's, POLST communicates medical orders describing an individual's preferences for treatments, while living with advance disease and frailty. POLST was designed for use across all care settings, including hospitals, institutional long-term care settings, community-based care settings, and among all providers (i.e., from EMS, first responders and acute care to home health, community-based care, hospice, rehabilitation, and sub-acute).

Examples of treatments addressed include:

- Cardiopulmonary resuscitation (CPR or "code status").
- Intubation, mechanical ventilation, defibrillation/ cardioversion.
- Use of IV fluids, antibiotics, and non-invasive positive airway pressure.
- Use of oxygen, suction, and manual treatment of airway obstruction as needed for comfort.
- Medically administered nutrition.
- Treatments consistent with comfort-focused goals.

A decade of research has proven that the POLST program more accurately conveys end-of-life treatment preferences that are more likely to be followed by medical professionals. The POLST program has been a key vehicle in successful efforts to increase the effectiveness of advance care planning and decrease ineffective treatments, including unwanted and unwarranted hospitalizations. For more information about POLST, visit: www.polst.org. TPOPP/POLST achieved endorsed status from the National POLST Paradigm in 2016.

Goals of the TPOPP/POLST Program

The goal of TPOPP/POLST is to improve the communication of a person's preferences regarding selective treatments, thereby ensuring higher family/patient satisfaction and goal-concordant care. To accomplish this, the TPOPP/POLST Program was designed to:

- Document a person's treatment preferences regarding:
  - Full Treatments, with the goal of attempting to sustain life by all medically effective means.
  - Selective Treatments, with the goal of attempting to restore function while avoiding intensive care and resuscitation.
  - Comfort-focused Treatments, with the goal of maximizing comfort through symptom management.
- Translate those treatment preferences into an actionable, transportable set of medical orders.
- Communicate an individual's care preferences across health care settings.
- Improve Emergency Medical Services (EMS) personnel's ability to treat according to the individual's preferences and instructions.
- Consolidate documentation into one document while complying with state laws and regulations, and the Patient Self-Determination Act.

Core Elements of the TPOPP/POLST Program

The TPOPP/POLST Program is based on communication between the patient/resident or recognized decision-maker (e.g., the Health care Agent or Durable Power of Attorney for Health care) and health care professionals to ensure informed medical decision-making. Medical orders derived from these conversations should be documented in the TPOPP/POLST form.

This form, functioning as a medical order, is valid when signed by a Kansas or Missouri physician or authorized practitioner, and the patient or patient representative. The purpose of the form is to create a set of actionable medical orders regarding a patient's selective treatments that accompany the patient across health care settings, effectively communicating treatment preferences to providers across a continuum of care. The TPOPP form:

- Is recommended for individuals with advanced, chronic, progressive disease, clinical frailty, and/or terminal conditions. Individuals who wish to further define their treatment preferences beyond an advance directive may consult with their provider to execute a TPOPP/POLST provider.
- May be used to indicate a preference to receive all medically indicated treatments or to limit medical interventions including attempts at cardiopulmonary resuscitation (CPR).
- Provides explicit direction about resuscitation status ("code status") if the patient is without a pulse and/or is not breathing (apneic).
- Includes directions about other treatments that the patient may or may not select (e.g., decisions about future hospitalizations, ICU care, medically administered nutrition, intubation, and mechanical ventilation).
- Accompanies the patient to and from all settings, and should be reviewed periodically when:
  - Transfer occurs from one care setting or care level to another.
  - There is a substantial change in the person's health status.
  - Treatment preferences change.
  - A new decision-maker or health care provider is appointed.

- Is based on the individual's current medical condition and should reflect:
  - Explicit instructions provided by the patient and/or advance directives.
  - An understanding of the individual's values when specific instructions are not provided or unknown.
  - A thoughtful discussion about past and present health conditions, prognoses, and all medically effective treatment options that may change over time and require updates to the form.
- Accompanies the patient to and from all settings, and should be reviewed periodically:
  - Includes the training of health care professionals regarding the goals of the TPOPP/POLST program and the execution of the TPOPP/POLST form.
  - Works with health systems on a continuous basis to ensure the forms proper implementation.
  - Assists patients/families, interested in clarifying their advance care planning goals and instructions, with resources to inform medical providers about how those advance directives impact medical orders, i.e., TPOPP/POLST.
  - Features a plan for ongoing tracking of the program and its implementation.

The TPOPP/POLST form and program helps ensure the honoring of medical orders across settings regardless patient acuity. The TPOPP/POLST form should reflect, as best as possible, the patient's current condition, and informed by advance care planning documents. The TPOPP/POLST form, as a comprehensive medical order set, is distinct from advance directives and is, thus, represented as a white form, with a bright pink border, reflecting medical orders and other pertinent information.

Other End of Life Documents vs. The TPOPP/POLST Form

Other Documents

a. For all adults

b. Completed ahead of time to address a person's wishes in a potential future state of illness.

c. Applies only when decision-making capacity is lost

d. Contains no actionable medical orders

e. Often does not accompany patient

TPOPP/POLST Form

a. For those with advanced, chronic, progressive disease or terminal conditions

b. Applies right now and translates patient wishes in the current state of illness into medical orders

c. Not conditional on losing decision-making capacity

d. Constitutes actionable medical orders

e. Accompanies patient across care settings

Note: A completed TPOPP form is one possible outcome of serious illness care planning. For physician resources on how to conduct serious illness care planning conversations, visit the Ariadne Labs website at ariadnelabs.org/serious-illness-care, VitalTalk at vitaltalk.org/resources, CAPC (https://getpalliativecare.org/), The Center for Practical Bioethics' Caring Conversations at practicalbioethics.org, and PREPARE For Your Care at prepareforyourcare.org/en/welcome or prepareforyourcare.org/es/welcome

Who Should Complete a TPOPP/ POLST Form?

Health care professionals should discuss patients' end-of-life wishes with their patients who have advanced progressive chronic illness, are terminally ill or are interested in further defining their care wishes beyond a traditional advance directive. Health care professionals should then record patients' decisions on a TPOPP/ POLST form. Specifically, health care professionals should discuss TPOPP/POLST with their patients if the patient/resident:

- Wants all medically indicated treatments.
- Chooses to limit life-sustaining treatments.
- Wants to avoid all life-sustaining treatments.
- Wants to avoid cardiopulmonary resuscitation (CPR) by requesting a "Do Not Resuscitate Order" (DNR order).
- Has advanced chronic condition(s) or terminal illness.
- Resides in a long-term care facility and/or in the community and is eligible for long-term care.

Part 2: How to Complete a TPOPP/POLST Form: A Section by Section Review

The TPOPP form is divided into five sections:
The first three sections deal with medical treatments related to (A) cardiopulmonary resuscitation (B) – Initial Treatment Orders for someone who is not in full cardiopulmonary arrest and (C) – Medically Administered Nutrition. The fourth section (D) addresses additional orders or instructions for Sections (B) and (C).
These additional orders are to clarify any specific directions related to intensity and duration for Selective Treatments and Medically Administered Nutrition. The fifth section addresses information and signatures regarding the provider who has executed the order, the patient/patient representative who

voluntarily acknowledges the order and other appropriate documentation to support the order as written.

To be valid, all sections of the medical order (except for D: Additional Orders or Instructions) must be completed and include the signatures of the authorized medical provider and the patient or patient representative. First responders should initiate treatment orders consistent with those recorded on the TPOPP/POLST form unless medical supervision for the responder advises otherwise. Validly executed TPOPP/POLST forms should be considered the most current clinical information for the patient's treatment plan. If multiple TPOPP/POLST forms exist, the most recent form supersedes all previous orders.

Section A: Cardiopulmonary Resuscitation (CPR)

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)*

Section A orders apply only when the person is in cardiopulmonary arrest (i.e., has no pulse and is not breathing). This section does not apply to any other medical circumstances. For example, this section does not apply to a breathing person in respiratory distress. Similarly, this section does not apply to a person with an irregular pulse and low blood pressure. For these situations, the first responder should refer to Sections B and C and follow the indicated orders.

If cardiopulmonary resuscitation (CPR) is desired and appropriate, then the "Attempt Resuscitation/CPR" box is checked. Full CPR measures should begin and 9-1-1 should be called.

If the TPOPP/POLST order indicates CPR is not to be carried out due either to care plan goals (e.g., palliative care or hospice services) and/or patient preferences then the "Do Not Attempt Resuscitation (DNAR/No CPR/Allow Natural Death)" box is checked. CPR should not be performed.

Current Medical Evidence Regarding Outcomes of CPR

Treating health care professionals need to be as aware of the patient's goals of care as much as possible and share pertinent medical evidence and effective treatment options with patients and their representatives to facilitate the shared decision-making process. (See 13, 20, 21)

CPR was developed in the 1960s as a method of attempting to restart the heart in the event of sudden, unexpected clinical death. Originally intended as an intervention for unexpected or accidental events in otherwise healthy persons, CPR has become an expected intervention in most disease states, despite evidence that outcomes are poor for persons living with advanced heart failure or those who are frail and/or living in advanced stages of illness. Clinical staff should discuss with patients and decision-makers effective treatments that are appropriate for the diagnoses, progressive disease states and current conditions of the patient, including those with limited life expectancy and poor prognosis. Aggressive, curative, life prolonging, rescue treatments may pose serious risks and harms for some patients living with advanced illness.

The last section of this guide provides numerous references regarding research on this topic. (See references 1, 3, 4, 5, 11, 13, 14 & 19) In general, for TPOPP/POLST appropriate patients, CPR is likely to be an ineffective treatment option. This should be thoroughly examined in a shared decision-making discussions on a regular basis. The TPOPP/POLST order is a dynamic document that should be reviewed and updated regularly as the patient's condition changes. Significant risks, burdens, and complications exist for those living with advanced illness and frailty when an attempt at resuscitation takes place.

Those complications include fractured ribs, punctured lungs, brain damage, and permanent unconsciousness. These risks should be thoroughly discussed prior to the execution of the medical order.

CPR has been found to produce the most positive outcomes in persons who suffer an unexpected and unanticipated cardiac event that is observed and can be responded to quickly. The ability for trained medical personnel to respond quickly is critically important, within a few seconds or minutes of the onset.

Responsiveness to defibrillation is also an important factor. Research indicates that cardiac events when asystole (flat-lining) occurs, among patients living with heart failure or other life limiting illnesses, particularly those who are frail and over the age of 80 do not provide benefit to the patient[1] Many persons appropriate for TPOPP medical orders reside in long-term care facilities where CPR, immediate emergency response and rapid transport to emergency care may be limited or unavailable.

Nearly 90% of cardiac arrests occur outside a hospital setting and survival rates after EMS intervention for those patients is around 10%. Inside the hospital, survival rates increase to about 24% due to immediate availability of advanced cardiac life support (ACLS).

Section B: Initial Treatment Orders

B. CHECK ONE	**INITIAL TREATMENT ORDERS:** Follow these orders if patient has a pulse and/or is breathing.
	Reasses 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.

Section B orders apply to emergency medical circumstances for a person who has a pulse and/or is breathing. Treatment responses range from “full” to “selective” to “comfort-focused.” Accompanying each treatment option is a GOAL statement clarifying the treatment’s intent that should be shared with the patient/representative and clarified for each option.

If the treatment’s intent is to sustain life by all medically effective means, the “Full Treatment” box is checked and, in medical emergencies, 9-1-1 is called. Treatment includes use of intubation, advanced airway intervention, mechanical ventilation, cardioversion, transfer to hospital and use of intensive care, as indicated.

If the goal is to restore function while avoiding intensive care and resuscitation efforts, then the box "Selective Treatments" is checked. These treatments include non-invasive positive airway pressure and may include antibiotics and IV fluids as indicated. Note: Intensive Care should be avoided if treatment needs cannot be met at the current location. Patient, family and staff at institutional facilities should understand how this will be managed on-site and how policies/procedures and protocols will ensure the goal is met. For example, (non-)emergency transport to an acute setting may be required to achieve the goal. On-site health care professionals will first administer the level of emergency medical services (EMS). Support from medical control or facility staff may be needed to execute on the treatment. Comfort focused treatment is always provided regardless of indicated level of EMS treatment.

If CPR election is made in Section A. then "Full Treatments" must be selected under Section B.

Selective Treatments indicates a decision to receive less aggressive and non-rescue treatments for reversible conditions. Treatments include oral or IV medications, IV fluids, oxygen, cardiac monitoring or other medical treatments. Intubation and mechanical ventilation are not used. Less invasive airway interventions such as BiPAP and CPAP could be considered, if it were determined that using these treatments for a limited time could help restore normal breathing function. Transfer to a hospital will occur if it is medically indicated to do so but with the intent to avoid intensive care (unless it is needed for a specified time-limited trial).

Comfort-focused Treatments indicates a patient's desire to receive only those interventions that enhance and maximize comfort.

Use medication by any route, positioning, wound care, and oxygen, suction and manual treatment of airway obstruction (choking) as needed for comfort. Do not transfer to a hospital unless comfort needs cannot be met in the current location. Sometimes it is necessary to transfer patients to the hospital to control their symptoms and suffering. Examples include wound care (immediate and ongoing pain relief, control of bleeding, cleaning, wound closing and dressing as needed to optimize hygiene, positioning for comfort), manual airway opening and stabilization of any fracture by splinting and/or surgery (with the goal to control pain).

Note: A person may also indicate a preference for DNR or "Allow Natural Death" in section A, but then select "Full Treatment" in section B. In this case, the implication is a desire for aggressive treatment up to but not including resuscitative response to a cardiac event.

Goal Statements: Health care professionals assisting with TPOPP form completion should clarify each goal statement accompanying the treatment options. The patient and the patient's recognized decision-makers should be engaged in the discussion to ensure that they are understood and consistent with the patient's treatment preferences.

Eliciting Values and Goals of Care: Pose the following question for the patient and recognized decision-makers: "In light of what we know about your health condition and your preferences, when the time comes that your illness progresses, which of the following choices best fits with what you'd want to have as a medical approach to care?"

Four examples of responses include:

1. My goal would be to pursue anything that might keep me alive, even if it meant being on machines, like a respirator, indefinitely, and even if it meant I had to be in an ICU or another facility that has patients on respirators.

> Explore this response. Clarify what the patient or recognized decision-makers mean by "being kept alive". Check for congruency between this section and other sections of the form. Congruency may lead the patient to electing certain medications and long-term medically administered nutrition. Emergency transport should be expedited.

This response corresponds most directly to the "Full Treatments" box in section B.

2. My goal would be for the medical providers to use treatments that had a reasonable chance of restoring function and/or returning me to my normal level of functioning. It would be okay for me to have painful testing or to go on artificial life support machines like a ventilator for a reasonable period of time IF the medical providers felt that those treatments had a good chance of making me better, but I wouldn't want to get stuck on the machines.

> Explore this response. Clarify what the patient or recognized decision-makers mean by normal level of functioning, reasonable periods of time, and "good chance". What does "getting stuck" mean to them?

This response corresponds most directly with the "Full Treatments" box in section B. Specify on the "Additional Orders" line in section D that they desire only a "time-limited trial of full treatment, accompanied by ongoing discussion with treating providers."

3. My goal would be for the medical providers to use treatments that had a reasonable chance of restoring function and/or returning me to my normal level of functioning. However, I would not want a whole lot of painful procedures or testing or to go on artificial life support machines like a ventilator. If I became THAT sick, I would want to receive comfort-focused treatments at that point.

> Explore this response. Determine the patient of recognized decision-makers' understanding of what it means to restore levels of function or reverse conditions.
> Check for congruency.

This response corresponds most directly to the "Selective Treatments" line in section B.

4. My goal would be for all medical treatments to be focused solely on symptom management to maximize comfort, regardless of how sick I am.

> Explore this response. Do all recognized decision-makers/ family supporting the patient understand and agree with what the patient is saying? Do the patient's answers on the TPOPP/POLST form seem congruent with this goal or not? If

not, keep talking. Congruent answers for someone answering this way would NOT include being a full code and would NOT include wanting intubation/ICU. Rather, they would only include comfort measures and, if comfort could not be maintained in the current environment, transfer to the hospital.

This response corresponds most directly with the "Comfort-focused Treatments" box in section B.

Section C: Medically Administered Nutrition

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

Patients with progressive illnesses, including advanced dementia, often experience a decline in eating, drinking and appetite with subsequent weight loss. In late stages of illness, this may be related to the medical condition itself or other conditions such as dysphagia, delirium, or even the natural dying process. The onset of such conditions can be a distressing time for patients, families and medical providers. Discussions about medically administered nutrition (MAN), usually by means of tube feeding, occur during these times. In discussing these choices, patients, families and medical providers should be aware of the medical evidence to date regarding the use of MAN in late-stage diseases such as advanced dementia or metastatic cancer-causing cachexia (See references 2, 6-10):

- Studies show that MAN can actually increase the risk of aspiration and its complications;
- A common cause of death for persons with feeding tubes is aspiration pneumonia;
- Tube feeding does not appear to prolong life in patients with advanced dementia;

In section C of the TPOPP/POLST form, patients who can make their own decisions regarding long-term MAN may check the appropriate box that fits their preferences. However, boxes in this section should be checked only after all feeding options are fully explained to the patient and recognized decision-makers, and after the patient recognized decision-makers and physician have thoroughly discussed the patient's preferences and goals.

If medically feasible, fluids and nutrition should always be offered to the patient orally. A defined trial period of medically administered nutrition may allow the patient/recognized decision-makers time for the course of an illness and its progression to become more definitive. This will allow an opportunity to clarify treatment goals, assess risks and burdens, and determine intensity and duration of services.

Boxes in this section allow for a spectrum of treatments to be identified and allow for the patient to refuse medically assisted nutrition, which may rightfully be declined, but also allows for the patient/decision-maker to delay or defer a decision on this issue until another time. In that case, the box "Not discussed or no decision made" would be checked. The efficacy of medically assisted nutrition is often impacted by the type and severity of illness or diagnoses and comorbidities of the patient. If the "Not discussed/No decision" box is checked, the treating provider should regularly review this section, particularly if DNR is checked under Section A or Selective Treatments or Comfort-focused Treatments are checked in Section B.

A number of Medically Assisted Nutrition (MAN) efficacy studies are referenced in the bibliography section of this Guide. (See references 15-18) These references include the American Geriatric Society's position statement on feeding tubes for persons living with advanced dementia along with studies citing evidence of benefit for certain diseases, and for certain durations. The emotional, cultural and religious considerations of patients and family deserve to be thoroughly explored by the practitioner and care team in these sensitive discussions. Research evidence has, in the past pointed to response bias among some practitioners particularly in assessing the risk of MAN induced aspiration and pneumonia. Practitioners unfamiliar with benefits and risks of MAN may be well served by referring patients and families to practitioners more skilled in the assessment and treatment of those at higher risk of complications.

Section D: Additional Orders or Instructions for Sections B and C

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.]

In this Section of the TPOPP/POLST form, patients may clarify and explore additional medical orders or instructions not specified in Sections B and C of the form. For example, if the treatment goal is to restore function while avoiding intensive care as indicated in the Selective Treatments box in Section B, then any medical treatment can be included the Additional Orders section so long as it comports with this goal.

The physician or medical provider should work directly with the patient to ensure that additional orders are consistent with the information selected by the patient in Sections A through C.

Section E: Information and Signatures

C. CHECK ONE	**INFORMATION AND SIGNATURES** (E-signed documents are valid)		
	Discussed with: ☐ Patient ☐ Agent/DPOA Health Care ☐ Patient 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:	**Signature:**	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:		**Phone:**
	Signature of authorized provider:		**Date:**

Upon completion of the form, the medical provider must check the box indicating with whom he or she discussed the orders and have the patient or appropriate recognized decision-maker sign the form.

The physician or authorized licensed provider must then provide his or her name and contact information, and sign and date the form. In doing so, the provider indicates to the best of his or her knowledge that these orders are consistent with the person's current medical condition and preferences. Additional information supporting the basis for the orders should be reflected in the medical record.

Without a medical provider's signature, the orders are not valid. Clinicians who are not specifically authorized to sign this form by licensure or state law may assist in its development, but only an authorized provider may sign the form. A provider's verbal orders are valid as allowed by institutional or community policy. Compliance with that policy is essential. Effective date and contact information is also required for the orders to be valid. A faxed signature is valid.

The TPOPP form includes notations that the original form should accompany the person whenever transferred or discharged. Transporting a form with the patient between care settings enables receiving health care professionals to have current, accurate information regarding the medical orders and the patient's preferences for treatment and increases the likelihood that these orders will be followed in the new care setting. Health systems with electronic record capability may scan the TPOPP form to ensure the orders are accessible.

Side 2: Advance Care Directives and Emergency Contacts

ADVANCE CARE DIRECTIVES & EMERGENCY CONTACTS

Review of Advance Directives (Check all that apply)

☐ Health 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: _____

The TPOPP from does not replace advance care planning documents. Rather, it is a physician order set which reflects the patient's preferences for life-sustaining treatment in the patient's current state of health. The existence of advance care planning documents, particularly a Durable Power of Attorney for Health care Decisions, can be noted on the TPOPP form by checking the appropriate box in section E.

If a Durable Power of Attorney for Health care Decisions document has been completed, the name of the Agent with contact information can be included.

Oftentimes a team of health care providers engage with patients and families about chronic illness planning. Other health care professionals may assist with the conversation and completion of the TPOPP form such as a nurse, social worker or chaplain. Their names, titles and contact information may be reflected on the form in the space provided.

What to Do with a Completed TPOPP Form Transportability

TPOPP forms are designed to travel with the individual between care settings. The form should be kept in a consistent location in the electronic health record or chart. When the individual is transferred between care settings, a copy of the form should be kept in the medical chart. The original form should accompany the individual and be presented to each provider (first responder, hospital or other care setting). A copy of the original form is also acceptable. When the individual is at home, the TPOPP form should be kept in a conspicuous location (e.g., near refrigerator, phone, bedside) and presented to EMS personnel upon arrival. Every time there is a change in location of care, the order set should be reviewed and updated if necessary or reissued if goals change. The most recent document should take precedence.

Part 3: Frequently Asked Questions (FAQ)

How much of the form should be completed?

The TPOPP order set is designed to be completed in its entirety, however Section B may be left blank, but the patient will receive full treatment regardless of the box checked in Section A.

Section C offers an option for the completion of a valid TPOPP/POLST without having a treatment order for medically administered nutrition at the time of execution. However, pertinent instruction/orders for Section C may be clarified in Section D. Incomplete forms uniformly reflect the need for additional or ongoing discussion and clarification of goals of care in order to provide guidance to clinicians and practitioners across settings.

Is there any reason to complete the TPOPP/POLST form if the patient chooses full cardiopulmonary resuscitation?

Yes. Reviewing the entire TPOPP form with a patient serves to educate the patient regarding additional choices for treatment and goals of care. Furthermore, inconsistencies in goals and preferences that need to be reconciled may emerge through discussion of the TPOPP form. For example, a patient may indicate a desire to never undergo intubation and mechanical ventilation under any circumstance. However, the patient may not realize that intubation and mechanical ventilation will be required as part of resuscitation for cardiopulmonary arrest.

Can a patient choose to have an Attempt CPR order and also choose an order for no intubation?

No. These preferences are inconsistent and reflect a lack of understanding of CPR. Choosing CPR implies accepting the entire array of treatments in an emergency situation without limitations.. Successful CPR requires intubation to manage the pulmonary component and chest compressions/shocking for the cardiac component. In other words, cardiac arrest will cause pulmonary arrest, and both must be treated.

All patients who prefer no intubation should also have a DNR order. However, the discussion regarding a Do Not Intubate (DNI) order is in the context of an individual who still has a pulse and/or is breathing. Thus, in this context, a patient who chooses not to be resuscitated may still consent to external defibrillation, Heimlich maneuver, clearing of the airway, etc.

Should all patients who choose DNR also be DNI (Do Not Intubate)?

No. DNR applies to patients who experience acute cardiopulmonary arrest, where no breathing or pulse can be detected, whereas DNI applies only to intubation for patients who experience impending pulmonary failure (i.e., severe respiratory distress). Patients may not want CPR and thus have a DNR order but may benefit from ventilator support and therefore may elect intubation. This may result in limited trial or long-term intubation and mechanical ventilation. These distinctions are complex and should be thoroughly discussed.

What is a trial period of intubation and ventilation?

A time-limited trial of intubation and mechanical ventilation provides the patient a choice of therapy for an agreed upon time frame to determine if the underlying acute impending pulmonary failure is reversible. This should be clarified by adding text in Section D (Additional Orders or Instructions). The patient may not wish long-term mechanical ventilation because the goal of the intervention is reversal of the condition. The potential need for tracheotomy, preferences for alternate treatment such as BIPAP and CPAP and the provision of symptomatic treatment for dyspnea (labored breathing) should be reviewed. The patient's preferences, as well as goals of care should be documented in the patient's chart and may be clarified on the TPOPP form in Section D.

Does a trial period of intubation raise ethical issues?

Time-limited trials are ethically and clinically appropriate as well as legally protected. There is no ethical or legal distinction between the withholding or the withdrawing of treatments intended to sustain life by medically effective means.

Does a DNR order imply that a patient does not want treatment?

No. Do Not Resuscitate (DNR) does not mean Do Not Respond. An informed patient recognizes that a DNR is limited to restricting CPR attempts because the patient is both pulseless and not breathing. In the presence of advanced or serious illness, CPR may provide no benefit and may actually injure the patient. Patients with a DNR may want and often need a variety of other supportive medical treatments other than resuscitation when experiencing pulmonary distress and advanced heart failure. TPOPP/POLST orders reflect those treatment preferences and goals.

Can the format of the TPOPP form be changed if the patient or doctor does not like the form?

No. The TPOPP/POLST form cannot be changed except by formal processes revising the form in consultation with National POLST. The standardized document follows the prescribed elements of the National POLST. Section D. (Additional Orders or Instructions) affords opportunity by the authorized practitioner in clarifying orders in Sections B. and C. If an individual seeks to make an explicit directive not captured in the form, the instruction may be expressed in an advance directive that may be referenced on the reverse side of the form under Advance Care Directives and Emergency Contacts.

If a provider is unable at the time of patient presentation to get confirmation from the individual or their represenatative that the TPOPP form is valid, how should the health care professional proceed?

Health care professionals should presume that the physician orders are valid and executable if the form is properly completed regardless of the patient's mental capacity at the time of presentation, unless there is clear clinical evidence to the contrary. Additional confirmation may be warranted if circumstances present such evidence to the provider. In those cases:

1. As much as possible, assess the patient's decisional capacity at the time of completion of the TPOPP form. This may be evidenced by the fact that in addition to the physician's dated signature, the patient or recognized decision-maker's voluntary acknowledgement is properly completed and signed.

2. Review patient records or transfer papers if available for evidence of documentation that a conversation occurred between the patient and provider at the time of the form's completion.

3. If no verification documentation is available and questions persist, verify with the physician who completed the TPOPP form. Physician contact information can be found on the form in section E.

4. If capacity is intact at the time of patient presentation, the provider may initiate a goal-based discussion per the protocol. Patients with capacity may void the orders at any time.

Is a copy of the TPOPP/POLST form acceptable?

Yes.

Is a faxed/scanned copy of the TPOPP/POLST form acceptable?

Yes.

Is a stamped signature on the TPOPP/POLST form acceptable?

No. Only hand-written or valid electronic signatures (per institutional EMR record system) should be on the form.
Authorized Physician/Practitoner signatures secured through verbal orders must comply with agency or provider policy and signed in timely fashion.

Is an electronic version of the original signed TPOPP/POLST form acceptable?

Yes.

Why is the TPOPP/POLST form pink on the rim?

The color allows first responders and providers to quickly recognize the standardized form and complies with the element of distinction required by National POLST.

How can the TPOPP/POLST form's pink colored border be maintained?

When the individual is transferred between care settings, a copy of the TPOPP/POLST form should be kept at the initial location. The original pink bordered TPOPP/POLST form should accompany the patient and be placed in the patient's record in the new setting.

Does the existence of a TPOPP/POLST form mean that the patient has made a decision to forgo CPR and has a DNR?

No. The TPOPP/POLST program is based on ensuring goal-oriented discussions that integrate patient preferences and informed medical decision making. It is NOT based on limiting medical interventions. A TPOPP/POLST form signifies that a thoughtful conversation has occurred regarding a range of treatment options resulting in a set of physician orders that reflect the patient's preferences and current medical condition. The orders may range from selecting

all medically effective treatments in an attempt to sustain life to treatments maximizing comfort in allowing for natural death. The form should be considered dynamic and reflect the patient's current condition and treatment preferences.

How does TPOPP/POLST differ from Advance Directives like the living will or durable power of attorney?

The TPOPP/POLST form contains actionable medical orders for seriously ill patients informed by and based on patient directives and treatment preferences. When patients with TPOPP/POLST forms present to providers, the orders are presumed to be incorporated in concordance with patient directives. Any new orders should include the TPOPP/POLST order set information so they can appropriately guide care provided by EMS personnel in pre-hospital settings.

Is the TPOPP/POLST program successful in the community and in health settings?

Yes. The TPOPP/POLST program is based on the National POLST program. Growing evidence points to the success of this model, some of which may be found at www.polst.org.

Where do I go to learn more about National POLST Policies?

For information about policies pertaining to the National POLST, go here: www.polst.org/policies-2/

How does the TPOPP/POLST Form compare to the Kansas DNR Directive?

See below for a comparison.

Document Features	Kansas DNR Directive	TPOPP - Medical Order
Governed By	Statutes K.S.A. 65-4941 et.al.	Scope of Practice and Standard of Care and community consensus (DNR orders not required by KS law to be in a particular form)
Target groups	Capacitated adults who wish to refuse CPR for personal, health or religious reasons. (No illness criteria or other health directives required)	Persons with or without capacity living with advanced illness or frailty who by other advance health care directives indicate treatment preferences for all, selected or no CPR interventions (or meet AHA criteria for no benefit/harm*) or have elected a comfort care plan or have a representative to speak on their behalf in accordance with state law to concur with a provider authorized to write CPR medical orders.
Settings	Hospital to Nursing Home (and back)	All outside hospital settings—home, community dwellings, residential care facilities, etc.
Initiated by	Declarant (Patient with capacity)	Physician or authorized licensed professional on behalf of patients with advance illness/frailty in compliance with scope of practice, law/regulations.
Health Status of Patient	Not required for declaration.	Serious illness and/or advanced frailty (see POLST Intended Population)
Requirements to execute/validate. **Signatures** **Witnessing**	Capacitated Patient must sign or instruct proxy to sign. Physician signature required unless declarant claims religious exemption. Required (K.S.A. 65-4944	Signature of physician/authorized licensed professional required. Signature of patient or representative required for validity to acknowledge/ concur with medical order. Medical orders are not witnessed.
Adherence to Form	Must be substantially in the form prescribed by statute	Form adopted by consensus to accommodate transportability across settings. Twenty-two states use standard of care approach
Immunity protections	Immunity from liability subject to K.S.A. 65-4944	None by statue; governed by standard of care
Rescue Measures Addressed	Addresses only CPR	Addresses Full code or DNAR and range of treatments to guide responders (Full to Comfort) based on patient current condition and directives. Medically assisted nutrition and/or others also covered.
Applicability to persons without capacity	Directive law is not applicable to those without capacity	Applies to all target group populations including those with Class III Heart Failure subject to "No Benefit" or "Harm" designation for CPR*

** See Integrated 2010, 2015, 2020 American Heart Association Guidelines for CPR and Emergency Cardiovascular Care https://cpr.heart.org/en*

How does the TPOPP/POLST Form compare to the Missouri OHDNR Purple Form?

See below for a comparison.

Document Features	Kansas DNR Directive	TPOPP - Medical Order
Governed By	Statutory citation 190.600-190.621 RSMo (9/07)	Scope of Practice, Standard of Care and clinical consensus (Any valid DNR orders may be honored per MO DHSS guidance Long-term Care Bulletin [Summer 2010] and EMS Bureau Memo 2018)
Target groups	Capacitated adults or those represented by an agent for whom the individual has granted authority to refuse CPR in the event of cardiac or respiratory arrest.	Persons with or without capacity living with advanced illness or frailty who: 1) by other advance health care directives indicate treatment preferences for all, certain types or no CPR interventions (or meet CPR medical criteria for no benefit/harm*), 2) have elected a comfort care plan, or 3) have a representative to speak on their behalf in accordance with state law to concur with a provider authorized to write CPR medical orders.
Settings	All outside hospital settings.	All outside hospital settings—home, community dwellings, residential care facilities, etc.
Initiated by	Patient with capacity or agent with powers granted in notarized appointment.	Physician or authorized licensed professional on behalf of patients with advance illness/frailty in compliance with scope of practice, law/regulations.
Health Status of Patient	Not required for declaration.	Serious illness and/or advanced frailty (see POLST Intended Population)
Requirements to execute/validate.	Capacitated Patient must authorize, or agent power granted via advance directive. Physician signature required.	Signature of physician/authorized licensed professional required. Signature of patient or representative required for validity to acknowledge/concur with medical order.
Adherence to Form	Must be in the form prescribed by statue for immunity protection.	Form adopted by consensus to accommodate transportability across settings. Twenty-two states use standard of care approach. Acceptable per MO EMS Bureau Memo July 10, 2018.
Immunity protections	Immunity from liability subject to 190.606 RSM0 (9/07)	None by statute; governed by standard of care.
Rescue Measures Addressed	Addresses only Full or No CPR attempt	Addresses Full code or DNAR and range of treatments to guide responders (Full to Comfort) based on patient current condition and directives. Medically assisted nutrition and/or others also covered.

** See Integrated 2010, 2015, 2020 American Heart Association Guidelines for CPR and Emergency Cardiovascular Care https://cpr.heart.org/en*

Part 4: Bibliography

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CENTER FOR PRACTICAL BIOETHICS

Vision

Ethical discourse and action advance the health and dignity of all persons.

Mission

To raise and respond to ethical issues in health and health care.

Our Core Value

Respect for human dignity.

We welcome your interest in Transportable Physician Orders for Patient Preferences (TPOPP/POLST). 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 TPOPP@PracticalBioethics.org.

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