Legal Documents

NorthShore
University HealthSystem

Home and Hospice Services

LEGAL DOCUMENTS

Notice of Health Information Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit NorthShore University HealthSystem, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of this notice of health information practices
- Inspect and obtain a copy of your health record
- Request an amendment to your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

OUR RESPONSIBILITIES

This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised notice and publish the revision on our website. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact Concierge Services at **(847) 570-2002**. We respect your right to privacy. If you believe your privacy rights have been violated, you may file a complaint with Concierge Services or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your health information for treatment.
For example: We will provide your physician, the hospital or a subsequent healthcare provider with copies of various reports from your medical record that should assist him or her in treating you.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.
For example: Members of the professional staff or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

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Home and Hospice Services

OTHER DISCLOSURES PERMITTED WITHOUT AUTHORIZATION WITH OPPORTUNITY TO AGREE OR OBJECT

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative or another person of your choice about your location and general condition.

Facility directory: Patients will be listed in the hospital directory with disclosure to persons who ask for the individual by name. Only the patient's name, location in the facility and condition in general terms will be disclosed unless the patient opts out of this listing at the time of registration.

Clergy: Patients will be listed on the religious census available to community clergy or designated representatives unless the patient opts out of this listing at the time of registration or upon follow-up from the hospital clergy.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment for healthcare.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We do not rent or sell patient information. If a patient wishes to opt out of receiving further information, he or she may call the Marketing Department at **(847) 570-3187**.

Fundraising: We may contact you as part of a fundraising effort. If you prefer not to receive fundraising letters from us, please let us know by contacting the NorthShore University HealthSystem Foundation at **(224) 364-7200**.

OTHER DISCLOSURES PERMITTED WITHOUT AUTHORIZATION AND WITHOUT OPPORTUNITY TO AGREE OR OBJECT

Business associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associate so that he or she can perform the job we have asked him or her to do. To protect your health information, however, we require all business associates to appropriately safeguard your information.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroner, funeral director and organ procurement organizations: We may disclose personal health information to a coroner or medical examiner for identification purposes, to determine cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose personal health information to a funeral director as authorized by law in order to permit the funeral director to carry out his or her duties. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donations and transplant.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or postmarketing surveillance information to enable product recalls, repairs or replacement.

Health oversight activities: We may disclose health information to a health oversight agency for activities related to the oversight of the healthcare system.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. We may report vital events such as birth or death, as well as other occurrences when required by Illinois state law.

Report of abuse, neglect or domestic violence: We may notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law.

Specified government functions: In certain circumstances, the federal regulations authorize the provider to use or disclose your protected health information to facilitate specified government functions.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Hospice Patient/Client Rights

As a hospice patient/client, you have the right to be informed of your rights and responsibilities both orally and in writing, in a manner that is easily understood, before initiation of care/services, and the hospice must protect and promote the exercise of these rights. If/when a patient/client has been judged incompetent the patient's/client's guardian may exercise these rights as described below. As they relate to:

Patient/Client Rights, you have the right:

- To receive services appropriate to your needs and expect the hospice organization to provide safe, professional care at the level of intensity needed without unlawful restriction by reason of age, sex, race, creed, color, national origin or disability.
- To have access to necessary professional services 24 hours a day, 7 days a week.
- To be informed of services available directly or by contract.
- To be informed of the ownership and control of the organization.
- To be informed regarding the organization's liability insurance upon request.
- To voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the organization, and must not be subjected to discrimination or reprisal for doing so.
- To an investigation of your complaint by the organization regarding treatment or care that is (or fails to be) furnished, or the lack of respect for the patient's/client's property by anyone furnishing services on behalf of the organization, and documentation of the existence of the complaint and the resolution of the complaint.
- To be advised of and given in writing the toll-free telephone number of the State Home Health Hotline and The Joint Commission hotline, the hours of operation and purpose and appropriate use, including complaints, concerns and lodging complaints concerning implementation of advanced directives requirements.

Patient/Client Care, you have the right:

- To be involved in your care planning, including education of the same, from admission to discharge, and to be informed in a reasonable time of anticipated termination and/or transfer process.
- To receive reasonable continuity of care.
- To be informed of your rights and responsibilities in advance concerning care and treatment you will receive, including any changes, the frequency of care/services, and by whom (disciplines) services will be provided.
- To be informed and make decisions about the nature and purpose of any care, treatment and technical procedure that will be performed, including information about the potential benefits and burdens as well as who will perform the procedure.
- To receive care/service from staff who are qualified through education and/or experience to carry out the duties for which they are assigned.
- To receive effective pain management and symptom control for conditions related to the terminal condition.
- To be involved in developing his/her hospice plan of care.
- To refuse care or treatment.
- To choose his/her attending physician.
- To be referred to other agencies and/or organizations when appropriate or by request and be informed of any financial benefit to the referring agency.
- Not to receive experimental treatment unless agreed upon and understood.
- To receive information about services covered under the hospice benefit and scope of services the hospice will provide and limitations of service.

Respect and Confidentiality, you have the right:

- To be treated with consideration, respect and dignity including provision of privacy during care.
- To have your property treated with respect.
- To have staff communicate in a language or form you can reasonably be expected to understand and when possible, the organization assists with or may provide special devices, interpreters or other aids to facilitate communication.
- To maintain confidentiality of your clinical record in accordance with legal requirements and to anticipate the organization will release information only with your authorization or as required by law.
- To be informed of the organization's policies and procedures for disclosure of your clinical record.
- To have a confidential clinical record with access or release permitted in accordance with CFR parts 160 and 164.

Financial Aspects of Care, you have the right:

- To be informed of the extent to which payment for the hospice services may be expected by Medicare, Medicaid or any other source, including any other federally funded or aided program known to the organization.
- To be informed of charges not covered by Medicare and/or responsibility for any payment(s) that you might have to make.
- To receive this information orally and in writing within 30 calendar days of the date the organization becomes aware of any changes.

Self-Determination, you have the right:

- To refuse all or part of your care/treatment to the extent permitted by law and to be informed of the expected consequences of said action.
- To be informed in writing of rights under state law to formulate advance directives.
- To have the organization comply with advance directives as permitted by state law and state requirements.
- To be informed of the organization's policies and procedures for implementing advance directives.
- To receive care whether or not you have an advance directive(s) in place, as well as not to be discriminated against whether or not you have executed an advance directive(s).
- To be informed regarding the organization's policies for withholding of resuscitative services and the withdrawal of life-sustaining treatments as appropriate.
- To be free from any mental abuse, physical abuse, neglect or exploitation of any kind, including injuries of unknown source and misappropriation of property.
- To a legal representative, designated by you in accordance with state law, to exercise your rights.

Hospice Patients Receiving Inpatient Services, you have the right:

- To a home-like atmosphere and patient areas designed to preserve dignity, comfort and privacy.
- To free access and unrestricted visiting privileges, including children of any age, 24 hours per day, 7 days per week.
- To adequate accommodations for your family members to remain with you 24 hours per day.

Call our 24-hour number (847) 475-3002 with questions or concerns so we can provide timely care.

NorthShore
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Home and Hospice Services

Hospice Patient Responsibilities

WHY THIS MATTERS

- When you agree to hospice services, you have certain responsibilities; it is important that you know what your responsibilities are when you consent to these services
- Failure to meet your responsibilities can result in cancellation of services

CONSENTING TO SERVICES AND MEETING CRITERIA FOR HOSPICE CARE

- To qualify for hospice services, you must agree to:
  - o Sign all required consents and releases
  - o Remain under the care of your doctor while receiving services
  - o Participate in the plan of care developed by your doctor and the hospice team and follow directions from the doctor and the team*
  - o Accept hospice care providers without regard to race, color, religion, sex, age, gender preference, handicap or national origin
  - o Work with the hospice agency to address any billing, insurance or payment issues that might arise, and promptly pay any bills generated
  - o Provide accurate, up-to-date information about your insurance, and report any changes to your insurance plan while you are receiving hospice services
  - o Never share your hospice medications with others, and use these medications as directed

COMMUNICATION

- You are responsible for sharing certain information with the hospice team, including:
  - o Complete, accurate information about your illness, medications, health history, hospitalizations, and other matters pertinent to your health and well-being; any changes to your address, phone or insurance/payment information; changes to your advance directive; and information on any other healthcare agencies providing care to you at home
  - o Any need to change or cancel appointments with your hospice team as soon as possible
  - o Questions and concerns you have about information shared with you by your doctor or the hospice team
  - o Problems or complaints you have about your hospice services
  - o Unexpected changes in your health condition
  - o Your thoughts about hospice services, and what you need or expect
  - o Any problems with someone else taking the medications provided for you by hospice
  - o A call to hospice before calling 911 or an ambulance; **hospice does not guarantee payment for ambulance services unless approved**

SAFETY

- While under the care of the hospice team, you agree to be respectful and considerate of hospice staff and their belongings
- You agree to provide a safe environment in which they can work by:
  - o Telling them if you have guns or other weapons in the home, and keeping these items locked away during visits
  - o Placing dogs and cats in a separate room during visits
  - o Informing them of any problems with bugs or rodents in the home
  - o Not smoking any form of tobacco, marijuana or e-cigarettes during hospice visits
  - o Providing a clean area in which staff can work during home visits

**Choosing to refuse or stop any treatment related to your hospice plan of care can result in possible changes to your insurance coverage for services.*

State of Illinois
Illinois Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIPcode)		

A — CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

Check One

❑ **Attempt Resuscitation/CPR** ❑ **Do Not Attempt Resuscitation/DNR**

(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

When not in cardiopulmonary arrest, follow orders B and C.

B — MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

Check One *(optional)*

❑ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

❑ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

❑ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

C — MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One *(optional)*

❑ Long-term medically administered nutrition, including feeding tubes.

❑ Trial period of medically administered nutrition, including feeding tubes.

❑ No medically administered means of nutrition, including feeding tubes.

Additional Instructions (e.g., length of trial period)

_____

_____

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Agent under health care power of attorney

❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature ***(required)***	Name (print)	Date
_____	_____	_____

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature ***(required)***	Name (print)	Date
_____	_____	_____

E — Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name ***(required)***	Phone ( ) _____ - _____	
_____		
Authorized Practitioner Signature ***(required)***	Date ***(required)***	Page 1
_____	_____	

Form Revision Date - April 2016 **(Prior form versions are also valid.)**

****THIS SIDE FOR INFORMATIONAL PURPOSES ONLY****

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	**Date Prepared**

Completing the IDPH POLST Form

- **The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a POLST Form

This POLST form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another, or
- or there is a substantial change in the patient's health status, or
- or the patient's treatment preferences change, or
- or the patient's primary care professional changes.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT