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Encrypt laptops and smartphones to prevent data breaches

Loss or theft of mobile devices presents greatest risk

In April 2010, the laptop computer of a hospice nurse in the Chicago area was stolen. The theft of a mobile device is not that unusual. In fact, 50% of data breaches that affect 500 or more individuals reported to Health and Human Services are related to theft of portable or easily moved devices such as laptops, flash drives, and desktop computers, according to a report from the Health Information Trust Alliance, a national consortium of health care professionals that focuses on health care data security.¹

The Health Information Technology for Economic and Clinical Health (HITECH) Act's Breach Notification Rule does not require an organization to report a breach incident, such as the theft of a device with protected health information, if the data are encrypted. For this reason, along with the fact that laptops, tablets, and smartphones are often used by hospice clinicians, encryption of mobile devices that contain PHI

ExECut IVE SummARy

With the increased enforcement of privacy and security rules put in place by the Health Information Technology for Economic and Clinical Health (HITECH) Act, as well as the common use of mobile devices such as laptop computers, tablets, and smartphones in hospice care, the use of encryption to protect patient information is crucial.

- Encryption should be system-based rather than device-based to enable features such as remote shut down, remote hard drive wiping, and location tracking.
- Clearly written policies with consequences for ignoring security procedures must be in place.
- Limiting the number of records accessible on a laptop minimizes the risk of a data breach.

is critical, say experts interviewed by *Hospice Management Advisor*.

Unfortunately for the hospice in Chicago, the nurse's laptop was stolen while it was on and the electronic records system was open. Potential access to more than 500 patients' records meant the hospice had to report the breach to federal authorities as well as every patient.

The theft of a laptop while in use points out the need for well-developed policies and procedures as well as encryption, says **Greg Solecki**, privacy and information security officer for Community Care Services at Henry Ford Health System, which includes hospice, and vice president of Henry Ford at Home in Detroit, MI. "The good news is that in most cases of a laptop theft, the target is the laptop, not the information

stored upon it," he says. "However, our policy requires that clinicians can never let a laptop out of their sight if it is on."

If a clinician is talking with family members and making notes on the patient's chart while sitting in the living room, then walks into the bedroom to check on the patient, the laptop must go with the clinician, points out Solecki. "This is especially important if there are multiple family members or friends that are in the home," he says. Henry Ford policies call for immediate discipline of an employee who doesn't follow proper procedure to protect PHI. "The level of discipline depends on if the action was willful or negligent and the consequences of the action," he explains. "We used to always give people the benefit of the doubt, but we are stricter now, because enforcement of HIPAA privacy and security rules at the federal level are much stricter."

Encryption is not specifically required by the initial HIPAA rules or by the HITECH rules, points out **Heather P. Wilson**, PhD, principal of Weatherbee Resources, a hospice and home health consulting firm in Hyannis, MA. "What has changed is the breach notification requirement that defines a breach as the loss of 500 or more patients' records in an unencrypted format," she says. "If the data are encrypted, there is no breach."

Another change that occurred with the passage of HITECH is increased enforcement, warns Wilson. Prior to the HITECH Act, enforcement of privacy and security requirements was not always consistent, she says. "Smaller organizations often weighed the cost benefits of investing in steps such as encryption versus the chance that you'd have to pay a small fine," she says. "Not only did the HITECH Act increase fines, but it also gave State Attorneys General the power to enforce the rules, which expanded the number of people available for enforcement." For these reasons, the best way to minimize the risk of a data breach is to encrypt all devices that hold patient data, she suggests.

Passwords not enough

One step that many hospices took when the HIPAA Security Rule was first implemented was the use of passwords, but passwords alone are not enough to protect data, warns **Brian Payne**, chief executive officer at Winston-Salem Hospice and Palliative CareCenter in North Carolina. "All of our computers and smartphones are encrypted so

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Editorial Questions
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clinicians must use a login name and a password to get into the data,” he says. Although the extra steps to access information do add time, employees understand the importance of protecting patient information because the hospice conducts thorough employee education, he points out. (See **employee education tips**, below.)

In addition to investing in encryption for all devices used throughout the hospice, the organization also has invested in some features that increase security if the mobile device is stolen, explains Payne. “If a clinician reports the theft of a laptop, tablet, or smartphone, we can erase the hard drive remotely,” he says. “Even though

Personalize protection of patient health information to improve employee education

A hospice can have encryption on all devices that include patient information as well as a full set of policies and procedures regarding the protection of patient information, but staff education is critical to ensure safety of data, says **Brian Payne**, chief executive officer at Winston-Salem Hospice and Palliative CareCenter in North Carolina.

“I was at a hospice in Miami, FL, before coming to North Carolina and identity theft was a major concern in that area,” explains Payne. Although all health care employees understand that they are supposed to protect patient information, most don’t think about the consequences that a loss of patient information can create, he says. “I believe in letting people know exactly what a patient or a patient’s family would go through if a data breach resulted in identity theft,” he says. At orientation and data security inservices, employees hear the financial and legal details an identity theft victim must handle for years after the patient’s information is stolen. “Most employees say that they had no idea what the results of identity theft are and that they would never want to go through that themselves,” he says. By personalizing stories and showing what patients and their families would have to handle, employees understand the importance of protecting patient information more clearly than merely reviewing policies, he adds.

Precautions employees are told to protect patient information include:

- **Keep mobile devices with you at all times.**

“Don’t leave a laptop or tablet in a car, even if you are just running into a store to pick up something quickly,” says Payne. “Carry it into a store, a restaurant, or coffee shop, even if you’re not going to use it.”

- **Don’t leave applications open.**

“If you are going to walk away from the laptop or you are not going to use it while helping a patient, close it,” says Payne. “Once our applications are closed, a password and login must be used to access the information again.” If the device is stolen or lost, the information is still protected.

- **Be aware of your surroundings.**

When making notes in a patient’s record, know who is around you and what they might be able to see on your screen, says Payne. “This is less of a challenge in a home because there is only one patient and the people are generally family members,” he admits. “Nursing homes, however, present a different challenge,” he says. When a clinician is seeing a patient in a nursing home, especially one with more than one patient in a room, the clinician needs to think about other people in the area, he points out. “We suggest that clinicians sit on the opposite side of the bed from the other patient’s side of the room, in a position that allows them to see who comes in the room,” he says. “The laptop should always be positioned so that the clinician is the only one who can see it.”

- **Prepare to educate patients.**

Employees also need to educate patients about how the hospice protects their information, says Payne. “Patients are more savvy about protection of their information so when a nurse uses her iPad or iPhone camera to photograph a document that needs to go into the patient’s record, she must be able to explain that the photograph is placed in the patient file, which is encrypted,” he says. “When patients hear that only the nurse or other clinicians involved in the patient’s care can see the record, they are reassured.” ■

encryption protects the data, the ability to delete it gives an additional layer of protection.”

Another way to protect patient data on mobile devices is to limit the number of patient records that are stored on the device, suggests Payne. “Our clinicians have the records of the patients they see on a daily basis but they don’t have access to the full database throughout the day,” he says. The only time clinicians are connected to the hospice’s full database is at the end of the day when they connect by telephone line to the main office to synchronize records, or upload the updated records from the day and collect the patient records they will need for the next day, he explains. “By limiting the patient information on the laptop, we further limit our exposure for a breach.”

At Henry Ford, the challenge is getting clinicians to remove patient records from their laptops once the patient is discharged, says Solecki. “Some clinicians are better than others at clearing inactive files, so we do have the ability to remotely remove patient files from the devices,” he says. “We can remove all records from the device, then the clinician can reload active patient files.”

The ability to manage data on a particular device from a remote location is important and can only be achieved if you encrypt information at the system level, points out Solecki. “We started with encryption of the individual laptop hard drives but moved to system encryption to better protect the files,” he says. “Although we have not activated all of the features at this time, we will have the ability to remotely shut down the device and even locate a stolen or lost device.” Of course, the question that needs to be answered when using a device tracking feature is “who will go get the device?” he admits. “I don’t see retrieval of one laptop as a priority for police.”

Check mobile devices regularly

The process of adding encryption to every mobile device used by clinicians can be a daunting task because staff members are not in one central location, admits Solecki. “We had originally envisioned a mass encryption effort in which we encrypted all the devices at one time, but we changed our approach to two at a time,” he says. This approach makes it possible to lend a clinician a laptop to use while the device is serviced and encryption added, he says. “Of course, all new laptops or smartphones issued to clinicians have encryption upfront.”

Staff members at Winston-Salem Hospice are not supposed to use their laptops, tablets, or smartphones for personal use, so when the devices are brought into the information technology department for routine maintenance and software upgrades, the IT staff checks the device carefully, says Payne. “We scan mobile devices to see what types of downloads or changes to software that might increase the risk of losing patient data have been made,” he says. By making sure the device is only used by the employee as part of the day-to-day job responsibilities, the hospice minimizes the risk of someone else accessing PHI, he adds.

Flash drives are another mobile device that must be addressed, says Solecki. “Most of our clinicians have no need to copy files to a flash drive, but some people may need data to produce quality benchmark reports, conduct a financial analysis, or analyze data as part of research,” he points out. “If a Henry Ford employee needs to use a flash drive to store information, the only approved drive is an IronKey flash drive,” he says. Use of one particular, encrypted drive is a system-wide standard and the hospital system provides the devices, he adds.

Encryption can slow a laptop’s performance and some clinicians find the use of passwords and logins every time they open their computer to be annoying, but most realize the importance, says Payne. Ensuring a high level of data security also represents a financial commitment, but as Payne points out, “You have to think about the cost of one lawsuit or one significant fine versus the opportunity to prevent the data loss upfront.” ■

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media training essential for all spokespeople

Crisis plan should include unified message

[Editor's note: This is the second of a two-part series that looks at effective media relations. This month, we look at tips and strategies for handling media relations during a crisis. Last month, proven strategies that result in media coverage of hospice events, services, and announcements were described.]

A national study that questions the ethics of some hospice organizations, a proposed bill that cuts hospice reimbursement, or a patient across the country whose situation sparks a right-to-die debate may not seem like a crisis to a hospice manager who focuses on local issues and patients, but the reality is that they can become issues that your local media will want to highlight.

Local media may be focusing on the national issue, but they want to put a local perspective on the issue, which means a reporter may show up unannounced, says **Stephanie Smith**, director of communications at Hosparus in Louisville, KY. Although the reporter's call or visit might not be a true crisis, every hospice needs to have a plan to deal with the unexpected, she says.

A good crisis communication plan can be implemented in a wide range of situations, says **Merrily Orsini**, MSSW, managing director of Corecubed, an integrated marketing, design, and public relations company based in Louisville, KY. "If you have a crisis and you have a plan in place, you can respond quickly and get your message out before everyone else."

The first step to a good crisis communication plan is media training prior to a crisis, says Orsini. "It is essential that anyone in the organization

that might be called upon to be a spokesperson undergo media training," she says. Knowing not to say "no comment" and being able to consistently put forth the key messages the hospice wants to convey are critical to open communication with media, she adds. "It is also important for every person who speaks to the press to assume they will be quoted."

A crisis communication plan should include:

- Identification of one to two people in the organization who will be the designated spokesperson.
- A unified message that the spokesperson will communicate.
- A process to respond immediately to the crisis situation.

"I always tell people to imagine and to plan for the worst situation imaginable," says Orsini. "If a nurse is accused of killing a patient, for example, what can you do to minimize the effect on the entire hospice?" she asks. "In this situation, you always offer condolences to the family, and then say you are aware of the accusations and you are working with authorities to investigate," she suggests. The amount of information you may be able to provide, based on the circumstances, may be limited, but be sure you are open and honest about what you can share, she says. "Of course, limit the information you share to what the public needs to know, but bring in the human element of the crisis to show your compassion."

Making sure that only your designated spokespeople talk to members of the press starts with every employee's first day on the job, points out Smith. "Our hospice policy is that all media contacts at all times come through me," she says. This policy is covered at orientation, is included in the employee handbook, and is reinforced in e-newsletters to employees, she says. "Employees are good at remembering the policy when they are at work but I have to remind them that the policy applies even if they are friends or neighbors of reporters." ■

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Spanish pain brochure explains symptoms

Good communication leads to proper diagnosis

In response to an increasing demand for Spanish-language resources to educate Hispanic Americans about all aspects of chronic

pain, the Baltimore, MD-based American Pain Foundation has produced a free brochure available in Spanish and English titled “Explain Your Pain.”

The brochure helps patients engage in productive dialogue with their health care providers.

“Explain Your Pain” is a resource to address the cultural and language barriers that prevent Hispanic Americans from seeking help with pain management. According to **Ricardo Vallejo, MD**, director of research at Millennium Pain Center in Bloomington, IL, and a spokesperson for the American Pain Foundation, many Hispanics are taught that complaining about pain is a sign of weakness. They often wait to report pain, and when pain becomes chronic, it impacts the psyche of the patient, adds Vallejo.

The American Pain Foundation describes chronic pain as ongoing or recurrent pain that lasts beyond the usual course of an acute illness or injury, or more than 3-6 months, and negatively affects a person’s well-being. If untreated or under-treated, pain can negatively impact a person’s quality of life and make daily activities difficult.

tools to improve communication

In addition to educating Hispanics on the importance of reporting pain early to manage it effectively, tools for communication between patients and providers are needed.

“Explain Your Pain” gives an outline of a body on which the patient can shade areas where pain occurs; a 0 to 5 happy/sad face pain chart; a pain checklist with descriptive words; and a pain questionnaire.

Vallejo says the list of terms in the checklist such as “shooting,” “tingling,” “numb,” “deep,” or “sharp,” translated into Spanish, puts the symptoms into words that help physicians discover the nature of the pain, which leads to a proper diagnosis and treatment.

“You can determine if it is neuropathic pain coming from nerve entrapment or some other condition,” explains Vallejo.

The patient/health care provider communication is important because a magnetic resonance image (MRI) or X-ray does not explain how a patient feels pain, he says. Up to 67% of patients experiencing pain can have a normal MRI, says Vallejo. If a person’s car does not start, the mechanic doesn’t ask for a photo of the engine to make the appropriate repair, he adds. In health care, imaging is not the best way to determine the source of the pain either, Vallejo maintains. Instead, a

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To download the free brochure “Explain Your Pain” or obtain more information contact:

• **American Pain foundation**, 201 N. Charles St., Suite 710, Baltimore, MD 21201-4111. Tel: (888) 615-7246. The brochure can be downloaded at www.painfoundation.org/explainyourpain (English) or www.painfoundation.org/describasudolor (Spanish).

thorough patient history, physical examination, and sometimes the help of images are needed. However, most important is the patient’s description of the pain, says Vallejo.

“Understanding the nature of the pain can help the physician make the proper diagnosis,” he says. “With the proper diagnosis, a treatment plan can be established that is specific for the individual.” ■

Educate yourself to manage care for growing senior population

Opportunities, challenges abound

As the baby boomers reach retirement age, the senior population in this country is growing by leaps and bounds.

By 2030, the United States will have an estimated 72.1 million older adults, representing a growth of almost 20% says **Anthony J. Balsamo, MD**, orthopedic surgeon and director of the Geriatric Fracture Care Program at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA.

An increasing number of people are going to need help managing chronic diseases, accessing community resources, and navigating the complicated health care system. This change brings opportunities for case managers, but it also means challenges in providing the kind of care coordination that the senior population needs.

“Health care spending already consumes more than 17% of the gross national product. We’ve got to provide evidence-based cost-effective medical care for this large generation of seniors who are coming along and the care has to be coordinated to get them in and out of the hospital and living safely in the community as rapidly possible,” Balsamo says.

Specific needs and limitations

The needs of the elderly are different from those of younger patients, and the entire process of care is different for them, says **Moreen Donahue**, DNP, RN, chief nurse executive and senior vice president of patient care services at Danbury (CT) Hospital. After receiving a federal grant, Danbury Hospital developed a family-centered geriatric nursing care curriculum to give its nurses and case managers the skills and competencies to care for its growing elderly population. “Many nurses completed their training before the nursing curriculum included geriatrics and providing care for the elderly as a specific population,” Donahue says. “This course offers our nurses and case managers an opportunity to increase their knowledge in caring for an increasing population of older patients.

As they develop a care plan for the elderly, case managers must understand the specific needs and limitations of their patients and take them into account when creating a care plan. Elderly patients might experience failing eyesight, loss of hearing, and problems with their balance. Many have cognitive issues and physical mobility problems. Being away from the home setting and in the hospital is disorienting for them. “Case managers need the expertise to plan for an appropriate level of care for seniors and to help their families make the best decisions,” Donahue says.

Because elderly patients often have trouble comprehending and retaining information, case managers should involve the family in the plan of care and the discharge instructions, Donahue advises. Often this involvement means that hospital case managers need to do more frequent rounding and be available when the family can be there. They can make sure the patient understands the medication regimen. “When they work with older patients, case managers have to become more flexible in meeting the needs of the patient and family members,” Donahue says.

Many times when the elderly have an acute event that results in a hospital admission, their next level of care is different from the level of care before hospitalization. Often the elderly person needs additional assistance after discharge and telephonic care coordination interventions to make sure they adhere to their treatment plan.

Seniors who are living at home often need more support than younger patients to ensure that they can continue to live safely in the community, adds **Diana Lehman**, RN, BSN, CHIE, director of case management for Independence Blue Cross in

Philadelphia. “The Medicare population tends to have more comorbidities than commercial members, and their condition is complicated by complex polypharmacy issues. They are often confused about their medication and need help in following their treatment plans. They are overwhelmed by all the instructions they get in the hospital and often need assistance with transportation to physician visits,” she says.

Because of the unique needs of the senior population, case managers and social workers at Independence Blue Cross work exclusively with Medicare patients and carry a smaller caseload than case managers who work with the commercial population. “The frequency and intensity of interventions is greater with the Medicare population. They need more community resources than younger patients, and our case managers often have in-depth discussions about their medication regimen and how to follow their treatment plan, Lehman adds.

Case managers need to understand how the events that result in hospitalization could have affected the senior’s physical mobility and cognition, and they should take that issue into consideration when they create a discharge plan, Donahue says. “Lengths of stay are getting shorter and shorter. This means case managers must have the expertise to be able to quickly assess the specific needs of the elderly and get a plan in place to address those needs,” she says.

Older patients might experience reactions to drugs that don’t affect younger patients, Balsamo says. For example, older patients taking hydromorphone for pain management might become groggy and disoriented, with an increased risk of falls. If they have to stay in bed because of the disorientation, they can lose muscle tone and develop pressure ulcers, prolonging or impeding their recovery.

If elderly patients are being discharged back to home, especially when they live alone, case managers should educate them and their family members about the importance of good lighting, remove scatter rugs to prevent falls, and install hand rails in the bathroom, says **Patti Dorgan**, LCSW, ACSW, director of direct services for the Pima Council on Aging in Tucson, AZ.

Help access community resources

In situations in which the seniors’ family members live in a different state, case managers often need to provide a great deal of support to the senior and his or her family, Dorgan says. “The

whole health care system is difficult to navigate, particularly for seniors. Most seniors and their family members don't know the whole range of community resources that are available to them," she says.

The Pima Council on Aging offers workshops for caregivers in which they teach them medical advocacy, how to take charge of their loved one's care, and how to navigate the system to find their elderly relatives the care they need, Dorgan says. The organization has a caregiver support program, staffed by social workers who help families access community services. If appropriate, they refer the families to a caregiver specialist who provides individual care coordination.

"We educate the families on the options available and help them decide what options will work best for their loved ones," Dorgan says. "Many seniors don't want to ask for help, particularly the generation that grew up during the Depression. They look on it as government assistance. There are a lot of wonderful programs available to help them with their daily needs, but they need help in accessing them." ■

Leadership conference focuses on volunteers

NHPCO program offered on-line

The National Hospice and Palliative Care Organization (NHPCO) has announced July 30 to August 3, 2012 as the dates for the 2012 Volunteer Leadership Virtual Conference. Hosted on-line, the educational program is exclusively focused on hospice volunteerism.

Highlights include:

- Live-broadcast plenary sessions featuring national speakers.
- Specific sessions for both new and seasoned volunteer leaders/managers.
- Specific day, August 2, dedicated to volunteers, affording them the opportunity to enhance their skills and participate in a national hospice event.
- Poster presentations and an exhibit hall on-line.
- Real-time networking in easy-to-use chat rooms.

Registration fees are based on the number of Internet connections that an organization uses to

access the content. In order to ensure that programs of all size are able to participate, NHPCO has created a sliding-fee scale based on a program's 2010 Annual Patient Census (which is also used to calculate provider organization's NHPCO dues). Visit www.nhpc.org and select "Professional Resources" and "Education and Conferences," then choose "Conferences" to find the link to "Virtual Volunteer Conference 2012." ■



CMS finalizes 2012 medicare home health payment changes

Flexibility added to certify requirement

Payments to home health agencies (HHAs) are estimated to decrease by approximately 2.31% or \$430 million in calendar year (CY) 2012, the net effect of a 1.4% payment update, the wage index update, and the case-mix coding adjustment, according to the Centers for Medicare and Medicaid Services' (CMS).

CMS also reduced Home Health Prospective Payment System (HH PPS) rates in CY 2012 to account for additional growth in aggregate case-mix that is unrelated to changes in patients' health status. CMS has finalized a 3.79% reduction to the home health PPS rates for CY 2012 and an additional 1.32% reduction for CY 2013.

Structural changes to the HH PPS were made by removing two hypertension codes from the case-mix system, lowering payments for high therapy episodes, and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same amount of total aggregate payments. These changes are intended to increase payment accuracy and reduce the growth in aggregate case-mix that

is unrelated to changes in patients' health status.

Under current Medicare policy, a certifying physician or an allowed non-physician practitioner must see a patient prior to certifying a patient as eligible for the home health benefit. The rule now allows physicians who cared for the patient in an acute or post-acute facility to inform the certifying physician of their encounters with the patient in order to satisfy the requirement. ■



Parents less likely to choose supportive care

Aggressive therapy perceived as hope

Parents are more likely to choose aggressive chemotherapy for their children who are in the palliative stage of cancer than the health care professionals caring for the children, according to a study published in the *Canadian Medical Association Journal*.¹

A total of 77 parents and 128 health care professionals participated in the study, which compared the strength of parental and health care professionals' preferences. Important factors influencing the decision between therapeutic options were child quality of life and survival time among both parents and health care professionals. Hope was particularly important to parents. Parents significantly favored chemotherapy (54.5%) compared with health care professionals (15.6%).

Researchers included parents of children whose cancer had no reasonable chance of being cured and health care professionals in pediatric oncology in the study. Separate interviews were administered to all participants. Visual analogue scales were shown to respondents to illustrate the anticipated level of the child's quality of life and the expected duration of survival. Health care professionals were also shown a scale to illustrate the probability of cure. Respondents were then asked which treatment option they would favor given these baseline attributes. In addition, respondents

reported what factors might affect such a decision and ranked all factors identified in order of importance.

Despite the high importance ranking parents assign to their child's quality of life, parents reported that they would accept chemotherapy even if it reduced both quality of life and survival time. This finding shows the complexity of decision-making and the researchers suggest that "parents may focus more on hope for their child compared with health care professionals, who are more aware of eventual outcomes given their experiences with many similar children." ■

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Survey of medical records demonstrates effectiveness of POLSt

Treatment preferences honored 94% of time

According to newly published research, a program created to communicate the treatment preferences of those with advanced illness or frailty ensures those preferences are honored 94% of the time. The Program, called Physicians Orders for Life Sustaining Treatment (POLST), was launched in Oregon almost 20 years ago.

POLST enables patients to document preferences to have or decline treatments in the form of medical orders. Since that time, the program has expanded to several other states across the nation. The latest research on the POLST program is printed on-line in the *Journal of the American Geriatrics Society*.¹

The study was designed to assess whether the treatments provided were consistent with what was documented on the POLST form. A review of medical records and POLST forms for 870 living and deceased patients found that POLST orders about resuscitation were honored 98% of the time, and orders to limit medical interventions were honored 91.1% of the time.

"The research builds upon our previous find-

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For more information about the POLST Program, visit:

• **POLST**, Physicians Orders for Life-Sustaining Treatment Paradigm.
Visit: www.ohsu.edu/polst/index.html. To review the POLST forms developed by various states, click on the "Programs" tab, then select "POLST Paradigm Forms."

ings that suggest the POLST program offers significant advantages over traditional methods like advance directives and Do Not Resuscitate orders to communicate patients' preferences about life-sustaining treatments," said lead author, **Susan Hickman**, PhD, an associate professor at the Indiana University and Oregon Health & Science University schools of nursing.

When patients identify treatments they do not want, the POLST form directs clinicians to use more extensive interventions to enhance comfort if needed. A majority, 74%, of the medical interventions provided to patients with POLST orders for "comfort care only" were focused on enhancing comfort, such as sending a patient to the hospital after a fall. Near the end of life, 24% of POLST orders were re-written to reflect a change of preferences, primarily for more comfort-focused care.

"This study renews AARP's conviction that POLST is a useful strategy for ensuring that people's treatment preferences are honored in their setting of care," said **Naomi Karp**, Senior Strategic Policy Advisor at the AARP Public Policy Institute. "Its striking results bolster the growing body of evidence that POLST does two important things for people with advanced illness or frailty: It helps elicit and document their treatment goals and choices, and it enhances the odds that they will get the care they want. AARP's own research on state POLST efforts provides a road map for the many states looking to start POLST programs, and this new clinical research provides evidence that those states are on the right track towards improving care for frail older citizens."

POLST also helps people avoid unwanted hospitalizations. "This study shows that the patient's comfort remains a high priority. Sometimes that means moving a patient who preferred to stay at the nursing home to the hospital for a short time to treat an accidental injury or uncontrolled symptoms," said **Margaret Murphy Carley**, Chair of the Oregon POLST Task Force and Executive Director of the National POLST Paradigm Task Force.

The next steps for the researchers are to study

the process of completing a POLST form to learn how to best support patients and families in making difficult decisions about treatment in the face of serious illness. ■

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Study shows issues with discharge instructions

Written instructions can be illegible, unclear

Patients and their caregivers sometimes have difficulty recalling details of their discharge instructions, a new study finds.¹

Family caregivers recalled hearing very little information about the patient's hospital discharge, the study finds.

"I think that was frustrating to them at times," says **Janice B. Foust**, PhD, RN, an assistant professor in the College of Nursing and Health Science at the University of Massachusetts Boston and a nurse research associate at the Visiting Nurse Service in New York.

Communicating with informal caregivers is difficult from the hospital staff's perspective because there often are multiple people involved, Foust notes.

There are practical implications, such as trying to determine who the true caregiver is. Sometimes discharge staff will give instructions to the person visiting the patient at that moment, but this might not be the caregiver who will be helping the patient carry out the discharge plan.

"Find out who will work closely with the patient at discharge," Foust says.

"It's an important step to ask patients who else they would like to be involved in discharge planning and who else should know about this information," she says. "There needs to be collaboration with patients because it's their health, and they should give permission as to who should receive these discharge instructions."

Foust's research has found that home health agencies also report significant issues with how hospital discharge instructions are handled. Home health clinicians commented on problems with

illegible instructions, incomplete instructions, and missing instructions.¹

“The earlier the home care agency is involved in the care, the better,” Foust says. “If they are involved while the patient still is hospitalized then it likely is of benefit and will make for a smoother transition.”

Home health clinicians are a valuable resource and support for patients, and they should be more proactively included in the hospital discharge process, she says.

Conversations between the hospital’s discharge team and the home health team can be enormously beneficial to patients and improve the care transition, Foust adds.

“Home health clinicians observed that sometimes discharge instructions get set aside once a patient is at home,” Foust says. “Hospitals could make the instructions easier to stand out, maybe with a bright color.”

Also, hospitals could follow-up the written instructions with podcasts or other educational support for patients and caregivers.

When there are written instructions, it’s important the writing is legible so the home health clinician can easily read and understand them, Foust suggests.

“Home health clinicians sometimes noted that families could use more support and preparation,” she adds.

It also would be helpful if hospitals provided patients with a more detailed action plan at discharge, Foust says.

“This would help home health clinicians know who to contact when there’s a finding, an early sign or symptom,” she adds. “Home health agencies have policies in place about how to contact the hospital, but the hospital discharge instructions could reinforce what is of concern and how and when to contact them.”

These strategies might help to prevent hospital readmissions, and they reinforce the collaboration between the home care agency and the hospital.

“I think the home health agency can be a tremendously important part of somebody’s post-

hospital transition,” Foust says. “When we speak specifically to transitions from hospitals and as people are recovering, home health is a valuable resource and can provide support for people who need to recover at home.” ■

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Patients/surrogates vastly overrate likelihood of survival

By Leslie A. Hoffman, RN, PhD, Department of Acute/Tertiary Care, School of Nursing, University of Pittsburgh

Synopsis: Most (83%) patients/surrogates stated they preferred full code status but only 4% could identify the components of CPR; 16% stated preferences that differed with the medical record.

Participants in this study were 100 patients/surrogates and their physicians in a 26-bed medical ICU located in an academic medical center. Patients/surrogates were questioned regarding their knowledge of cardiopulmonary resuscitation (CPR), code status preferences, and goals of care. Physicians were queried about goals of care and treatment plans. Interviews were conducted by a critical care fellow who selected participants from a randomized list of bed numbers generated each study day. The final sample included 20 patients and 80 surrogates. Fifty patients/surrogates recalled discussing CPR preferences with a physician, and 51 recalled discussing goals of care.

SOURCE

For more information about discharge planning, contact:

• **Janice B. Foust**, PhD, RN, Assistant Professor, College of Nursing and Health Science, University of Massachusetts Boston, 100 Morrissey Blvd., Boston, MA 02125. Tel: (617) 287-7535.

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Most (83%) stated they preferred full code status, but only 4% could identify the three main components of in-hospital CPR (defibrillation, chest compressions, intubation). Almost all charts (98%) documented code status. For 16%, discrepancies existed between patient/surrogate's stated preference during the interview and orders in the medical record. Patients/surrogates estimated survival to hospital discharge following in-hospital cardiac arrest with CPR at 71.8% (range, 10% to 100%) and the higher the prediction of survival, the greater the frequency of preference for full code status. Of six possible goals of care, approximately five were affirmed by each patient/surrogate and physician, but 67.7% of patients/surrogates differed from their physicians about the most important goal of care.

Commentary

When making decisions about code status orders, it is important to communicate effectively so that patients and families receive care that respects their preferences. Discussions about code status can be challenging and misunderstandings can lead to unwanted interventions. Findings of this study suggest that patients/surrogates rate their understanding as "high" but in reality do not fully understand what is involved in procedures commonly used in critical illness (e.g., CPR), and the likely outcome. Patient/surrogate estimates of survival after CPR in the ICU were extremely high (71.8%) compared to an evidence-based likelihood of 16% for ICU patients and 18% for patients on general wards. When queried about what was involved in CPR, most (65%) participants believed they had good knowledge of what CPR involved and most (71%) were able to identify use of chest compressions. However, far fewer identified cardiac defibrillation (32%) or the potential for intubation (7%). Study findings did not identify whether the problem related to clinicians not clearly describing possible outcomes or patients/surrogates indicating they understood when, in fact, they did not.

Discussions about decision making at the end-of-life are inherently challenging. Of note, the majority (80%) of participants in this survey felt it was helpful to talk about chances of survival after CPR and helpful (70%) to specifically discuss the goals of care. The take-home message from this study is that patients/surrogates may have an incomplete or incorrect understanding that is not recognized without probing questions. In this age

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of television dramas in which the "patient" almost always fully recovers, it is perhaps not unexpected that patients/surrogates have an incomplete understanding, as evidenced in this study. ■

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