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Important news about insurance and risk management for hospices and home health care agencies.

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Bruce Williams
Update
P.O. Box 2726, York, PA 17405
1-800-233-1957

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End of Life Care Decision Making

Robert W. Markette, Jr., JD CHC
Gilliland & Markette, LLP

One of the least common and most difficult cases in which a patient will be admitted to hospice is an admission in conjunction with a family's decision to remove a patient from a ventilator or other life support.

A family's decision to remove a loved one from life support can lead to acrimony within the family that can spill over to the provider. Similarly, the family members who made the decision can later change their minds.

Both of these scenarios can lead to the provider being caught in the middle of a lawsuit between family members, becoming the subject of a complaint to state or federal regulators or being sued directly. It can lead to individual employees being named in professional complaints as well.

With these potential risks it is important that providers who are involved in these cases understand the legal issues involved and how to protect themselves. The key form of protection will be the efforts to document the family's decision, the patient's desires, and the legal authority of the parties involved.

Patient Decision Making and Refusal of Care

When an individual is competent, the individual has the right to refuse care, including the decision to refuse lifesaving treatment. When an individual lacks the capacity to make his own decisions, the provider must either determine what the patient's decision regarding lifesaving measures would have been if he were competent or determine who has authority to make health care decisions for the patient.

State laws, in one form or another, provide ways for the individual to make their decisions known in advance. If an individual has failed to exercise this option, state laws usually provide a means to determine who has authority to make decisions for a patient.

Advanced Directives

Advanced directives are a category of legal documents that allow a person to make health care decisions in advance or to designate someone to make health care decisions for them in advance. Advanced directives include living wills and durable health care powers of attorney.

A living will is a form of advanced directive in which an individual states his decision regarding the continuation or withdrawal of life support measure, before they become necessary and the patient

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About the Author:
Robert Markette is a partner at Gilliland & Markette, LLP, a firm located in Indianapolis, Indiana, which focuses on representing home health and hospice providers in all aspects of their operations from Medicare and health law issues to employment and labor issues.

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can no longer be consulted. They may not be called living wills in every jurisdiction, but that is the definition we will use in this article. When presented with a situation where a patient has a living will, you should request a copy for your file. This provides verification of the existence of the living will as well as allows you to verify its validity and the specific wishes of the individual.

Each state defines what constitutes a living will. Although these requirements may vary from state to state, one factor remains consistent - a living will must comply with the statutory requirements to be valid. These requirements usually include specific execution requirements.

Many states have adopted forms for these documents. This makes it easier for providers to identify a valid living will.

There are a number of potential sources for problems with a living will. It may not be properly executed or may not meet some other requirement of state law. Occasionally you will be presented with a living will that was drafted in another state. If the other state's requirements are different from your state's requirements, the living will may not be valid in your state. Some states will recognize out of state living wills, but others will not. In any situation where you are not certain of the validity of a living will, you should consult with counsel and document counsel's conclusions.

Another area where a living will can fail is in failing to address the specific situation. This is not as common as it used to be, but a poorly drafted living will can create questions about whether the individual expressed his wishes regarding the specific situation. If he did not, then the living will may not be helpful.

Because of this problem, living wills have been supplanted by durable powers of attorney for health care and other means to appoint a health care representative. This type of power of attorney allows an individual to designate a person to make health care decisions for them. It is called a durable power of attorney, because it continues to be effective even after the individual ceases to be competent. Designating a health care decision maker in this way eliminates the potential ambiguity, because the decision maker can evaluate any unique or unanticipated situation and make a decision.

State law specifies what constitutes a valid durable health care power of attorney or designation of a health care representative. If a designation does not meet the requirements of state law, it is not a valid appointment. If an individual states that they have been designated as the patient's health care decision maker, you should request a copy of the document appointing them. You will want to keep a copy for your records.

You can then determine, or have your attorney determine, that the designation meets the requirements of state law as an effective power of attorney. It also serves to confirm the individual was designated to make health care decisions. A power of attorney could grant financial or other decision-making authority, but withhold health care decision-making authority. This is important, because an individual may only make decisions that are within the scope of his or her decision-making authority under the power of attorney.

Statutory Designations

In cases where there is no advance directive, you must determine who has the authority to make the decision to withdraw lifesaving treatment for the patient. When an individual has failed to designate someone with authority to make health care decisions, you should check whom your state law designates. It is important to check, not just assume, because state laws will not only designate persons with authority, but they may disqualify persons as well.

Most state statutes addressing this issue create a hierarchy of persons with authority. Providers simply go down the list until they find a category that describes one of the individuals present.

One of the first individuals on a list of individuals who may consent to treatment is a court appointed guardian. If a person claims to be a court appointed guardian, they will have documents from the probate court designating them as a guardian. It is important to review these, because courts can appoint a guardian for many reasons. A guardian may be a guardian of the individual's estate, in which case he will only have financial decision-making authority. The guardianship documents will state what powers the guardian has been granted. As with any similar document, you will want to retain a copy for your files.

The guardian may only make decisions within the scope of the authority granted by the court. If the individual does not have health care decision-making authority, he cannot validly make the decision to withhold or withdraw life support. Some states require that the guardian have specific authority to withhold or withdraw life-sustaining treatment. If not, they do not qualify to make the decision to remove the patient from a ventilator, even if they have medical decision-making authority.

State law will usually designate a hierarchy amongst the eligible decision makers. In most states, the person designated under a durable power of attorney for health care is first, followed by a court appointed guardian with health care decision-making authority, followed by other specified individuals. The other specified individuals are usually a spouse, parents, siblings, etc. If you are presented with more than one potential decision maker, you should consult your attorney.

If the individual who is designated under state law is not a guardian or someone designated by the individual pursuant to a written document, you will want to document this fact in the patient's file as well as documenting who is the decision maker, the basis for their authority, and their decision.

Documenting Actions

Once you have determined and documented who is the decision maker, you will document their decision. Ultimately, the physician is the individual who will issue the order to withdraw life saving measures. You will document the order as you would any order. Even though the doctor ultimately issues the order, you are the provider that will carry out the order and you want to be sure you have documented

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End of Life Symptom Management

Barbara Stover Gingerich RN MS FACHE CHCE

End of Life Care Symptom Management is multifaceted. In addition to pain, patients can present with a wide variety of symptoms, affecting several systems.

Respiratory system symptoms range from breathlessness to severe dyspnea. Gastrointestinal system symptoms include loss of appetite, nausea, vomiting, diarrhea and constipation, which often leads to severe weight loss. In addition, patients can experience severe fatigue, cachexia [wasting away], leading to loss of strength and generalized physical weakness. As the condition progresses, the neurological system might also be affected and patients present with a decline in cognition, inability to focus, perception loss and delirium. As the condition progresses, the accompanying physiologic changes produce these varied symptoms. This often results in anxiety being experienced by both the patient and his loved ones.

The overall focus of the care team is on patient comfort and supporting family and significant others through the terminal illness. During this period of care there are a multitude of care needs and symptoms to manage. It is also necessary for the care team to focus on other, sometimes less evident symptoms and care needs. This is especially important for a patient who has been on ventilator support, or confined to bed for an extended time.

Upon removing patients from ventilator -assisted support, palliative care clinician observations of patients in one study reported that patients exhibited tachypnea [rapid, in these cases accessory muscle breathing], and signs of discomfort such as agitation or anxiety. These occurrences in turn caused increased anxiety and distress in the family and significant others present [O'Mahony, 2003]. Symptom management issues selected for discussion in this article include: maintaining oral mucosa, preventing skin breakdown, relieving agitation and providing generalized comfort care needs.

Maintaining the Oral Mucosa

Dry Mouth

A dry mouth [xerostomia] is often prevalent in patients at this stage. This can occur for a number of reasons, including medication side effects, dehydration, mouth breathing, radiation treatments and/or infections. Regardless of the reason for the dry mouth, the supportive care approaches are similar. If the patient is able to tolerate fluids by mouth, then sips of water, ice chips or hard candy [lemon or other sour flavors] can be provided frequently. However if the patient is not able to tolerate fluids by mouth, an intravenous fluid replacement might be an option. This will depend on whether the infusion therapy produces undesired side effects, such as increased respiratory secretions. If agreeable to the patient and family and there are no contraindications, then the administering of intravenous fluids sufficient to maintain hydration can be provided. If intravenous fluid replacement is not an option, then caregivers can swab the mouth frequently [every one to two hours] with a moistened sponge or swab. This can be with plain water, lukewarm, not icy cold, or when tolerated, other diluted fluids that the patient has liked in the past. There are also prescription artificial salivas that can be prescribed for the purpose of maintaining the oral mucosa. Should the patient be on oxygen, humidified oxygen should be administered to prevent further drying out of the oral mucosa. It is important not to forget to keep the lips moist as well, through the application of Vaseline, ChapStick, or another lip balm/salve of the family's choosing.

Excess Saliva

Occasionally patients produce excess saliva during the end of life stage of care. This is often due to a mouth or airway anomaly or a poorly functioning swallowing reflex. This symptom is usually seen as excessive drooling, which can be very disturbing to both patients and families. While one approach is to treat this symptom with prescription medications [often an anticholinergic agent], there are other care approaches that can also be helpful in managing this symptom. These include suctioning or frequent swabbing of the mouth with a dry, soft moisture-absorbing material.

Thrush

Another oral problem that can present is a candidal infection of the mouth, more commonly called thrush. This appears as white cottage cheese-like plaques inside the mouth and can also be accompanied by tenderness, dysphagia, and altered taste. The treatment for thrush [candidiasis] is antifungal therapy. These suspensions can be swabbed onto the plaque-like areas with a swab moistened with the liquid medication from three to four times a day. The liquid suspension should be refrigerated and the side effects and ingredients checked for contraindications.

Preventing Skin Breakdown

Skin Care

Keeping the skin clean and dry and preparing for incontinence of bowel and bladder forms the basic foundation for good skin care. The caregiver should make certain the bed linen is clean and dry and keep crumbs and wrinkles from coming in contact with the patient's skin. It is essential to inspect the skin for potential areas of breakdown, examining for color changes, scratches, and abrasions and to pay special attention to bony prominences, including the back, shoulders, heels, elbows and hips.

When bathing the patient, the caregiver should pat rather than rub the skin dry, with a soft non-abrasive towel. Using cream, body oil, lanolin or vegetable oil on bony prominences and massaging gently to increase circulation to these areas at high risk for skin breakdown are also beneficial.

Toileting Care

When cleaning the patient after each bowel or bladder evacuation, take time to clean and to dry thoroughly. If the patient

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is incontinent, then the caregiver should place disposable pads on the bed beneath the patient and make sure to remove them as soon as they become soiled. The area that is soiled by the patient's incontinence will probably need an additional protector barrier. An ointment can be applied externally for an added layer of extra protection. It is a good idea to check patients frequently for soiling and kept clean and dry around the clock.

Positioning

In order to prevent skin tears and abrasions, it is important not to drag the patient over the sheets, but to gently lift the patient when repositioning. The caregiver should change the patient's position frequently, every one to two hours, if possible, using a position schedule in order to rotate positions consistently. Provide and use materials for propping the patient, such as pillows, Jobst gel cushion or similar products, wedges or rolled blankets and towels. Use an alternating pressure mattress when available. Other available supportive devices that can be used for positioning and support are fleece pads, egg crate mattresses or lamb's skin padding.

Relieving Agitation

Sometimes the patient appears to be agitated and this can often be very upsetting to the family and significant others. Providing a calm, gentle reassuring presence sometimes helps to decrease the agitation. It is also possible that providing a gentle massage or playing soft calming music can positively affect the agitation. When possible, keep the patient in a familiar environment, and remove any sharp or hard objects that have the potential to come in contact with the patient during periods of agitation. It can also be helpful if the patient hears a familiar voice, or sometimes a familiar scent has a calming effect. It is important to explain to the family that agitation is not uncommon and to take steps to relieve the family's anxiety and perhaps agitation. In addressing the family's needs, provide emotional support, listen closely to their concerns and respond appropriately. It some cases, medication is prescribed to relieve the anxiety, agitation and delirium [if it is present].

Providing Comfort Care

In keeping with the provision of good oral hygiene and skin care for the patient receiving end of life care, all basic activities of daily living and personal care need to be provided. The relief of pain and management of symptoms are key to quality care. If the patient is cool to touch, often due to decreased circulation, providing extra blankets or a warming blanket [set low] on the bed might be in order. However, to prevent burns, caregivers should test the warmth prior to applying it to the patient's vulnerable skin.

It is also necessary to be aware of non-physical needs. The availability of family members to remain with the patient, thus providing a sense of presence, can be a very essential aspect of care at this time. The sense of presence, someone with you, can be a great comfort, as can providing physical touch by holding the patient's hand or stroking their forehead. Encourage family to remain with the patient and to talk quietly to the patient, and if the patient does not have visitors to be there, a volunteer or staff can take the time to sit down and be with the patient.

Summary/Conclusion

Maintaining the dignity of the patient and providing symptom management through the end of life process is an essential component of care. It is also important to support the family and loved ones. This is often easier to do when they are present with the patient. However, the provider's ongoing bereavement and grief support program can provide this individualized support to family and significant others. If the decision has been made to remove a loved one from life support and transfer them into a community-based care setting, such as hospice, it is important that health care providers be aware of this decision and be available to reassure the family and significant others through the end of life process. The health care provider's focus on making the patient comfortable and minimizing the impact of presenting symptoms can assist the family through the emotional end of life process while quality patient focused care is carried out.♥

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Controlling Non-Owned Auto Exposure

Betty Norman, BSN, MBA, CPHRM

Most hospice, home care, and other community-based organizations have a significant auto liability exposure due to the fact that their employees and volunteers spend a large amount of time traveling between home, offices and patient residences.

These trips can be any day of the week, any time of the day, and in many different weather conditions, all of which are difficult to control given the nature of the business. The use of motor vehicles by employees and volunteers is a liability exposure that can be controlled through proper risk management, however.

Employee/Volunteer Screening

Written policy should require that driving records are reviewed to assure an employee has a current driver's license and has had no more than three moving violations, or more than one chargeable accident in the past 36 months, no major convictions (driving under the influence or alcohol or drugs) within the past seven years, and no license suspensions or revocations within the past seven years.

It is important that the background screening for all employees and volunteers include a motor vehicle record (MVR) check. The MVR checks should then be repeated on an annual basis. Consideration should be given to including a question about the employee/volunteer's driving record in the initial application form.

The organization should ensure that its relevant job descriptions outline the essential job functions for each position. Driving should be considered an "essential function" of the job description for those employees who are required to make home visits to patients. If maintaining a certain driving record is an essential function or duty of holding a particular position within the agency, the job description should appropriately address this. The employer should introduce the job descriptions to all new employees in orientation, ensure their accuracy by allowing employees to review the job descriptions annually, and integrate job descriptions in the employee evaluation/performance management process.

A photocopy of a current, valid driver's license should be obtained along with evidence of current auto liability insurance that meets the state's minimum requirements. The employee/volunteer should verify the vehicle that they will be using for work purposes and provide a copy of a current insurance declaration page for that vehicle.

To avoid any confusion should an accident occur, there should be documented criteria (a priori), acknowledged by both the organization and its employee/volunteer, which objectively establishes, before any mishap occurs, what activities are considered to be within the course and scope of their job responsibilities. The criteria should adequately address commuting activity, as well as any permitted activities such as patient transport, errands, or social activities.

The employee handbook should clearly document how the employee is paid, or the volunteer is credited with service hours, i.e., from the time that they "begin" until the time that they "end" their work day.

It is important to establish agreed upon guidelines and boundaries at the onset of employment. The job description and employee handbook should outline what activities are considered a part of the routine job responsibilities of each position, or with the normal "course and scope" of the job. Adherence to these policies should be closely monitored and enforced. When policies such as these are not enforced, the organization will begin to see "policy drift," where deviation from policy becomes the norm. Each employee should sign a statement indicating they have reviewed their job description and the employee handbook, and this documentation should be maintained in their personnel file.

As mentioned in a previous article on professional boundaries, caring for individuals within their own home setting allows an employee or volunteer the opportunity to develop a relationship with the patient and their family/caregiver. This sometimes makes it difficult to maintain appropriate professional boundaries. The relationship between patient and caregiver is an important one and a healthy patient-clinician relationship is important to maximizing goals and enhancing patient outcomes.

Scheduling

To the extent possible and enforceable, the organization should know where its employees and volunteers are during the course of their day/shift. As employees and volunteers are given patient assignments they should develop a schedule that allows management to track their activities and movement from client to client. This is important from both a personal safety and a liability perspective.

If an employee or volunteer is allowed some flexibility in their schedule, defined "windows" are better than indefinite schedules, i.e., the employee or volunteer will visit this patient "the morning of this date" rather than "sometime this week." If an emergency or other unscheduled visit is necessary, the organization should consider a requirement that the visit be recorded/documented as soon as the employee is called out.

Orientation & Training

Another risk management tool is to establish a comprehensive driver safety program, which will help to decrease the organization's liability from a non-owned liability standpoint. The program should cover all operators of motor vehicles for company purposes and include:

- Annual driver oriented/awareness program. A driver safety education video is available from Glatfelter Insurance Group at www.hccis.com.
- Verification of driver's license.
- Verification of auto insurance coverage.
- Annual review of MVRs. The MVR should show no more than three moving violations or chargeable accidents within the past 36 months. There should be no suspended or revoked license within the past seven (7) years. There should be no Class A violations (DUI, reckless driving) within the past seven (7) years.
- Employees/volunteers who have unsatisfactory MVR reports should be removed from driving positions.
- Employees/volunteers should be encouraged to perform periodic preventative maintenance per manufacturer suggested guidelines of their vehicles and follow safe driving practices (e.g., use of seatbelts, no eating or use of cell phones while the vehicle is in operation, etc.)
- Policy should clearly state (and the employee/volunteer should acknowledge) if the use of a particular vehicle is authorized or prohibited for the organization's business. This would include vehicles owned by the organization, those owned by the employee or volunteer, borrowed vehicles, or vehicles owned by the patient or the patient's family.

Summary

In summary, auto liability claims can have a significant impact on an employer's bottom line. It is important to adequately evaluate the risks associated with the number of employees and volunteers who drive motor vehicles as a routine part of their job responsibility. Employees and volunteers should understand that the employer's hired non-owned auto coverage is excess over their own auto insurance coverage, so they should make sure they have adequate coverage for the type of driving that they do on a regular basis. Implementing the strategies outlined above can lead to a more effective risk management program. ♥

COMPLIANCE CONCERNS:

Red Flag Alerts: What They Are and What to Do

Barbara Stover Gingerich RN MS FACHE CHCE

Initially it was the Federal Trade Commission (FTC), the federal bank regulatory agencies, and the National Credit Union Administration (NCUA), which came together to issue the Red Flags Rules that required financial institutions and creditors to develop and implement written identity theft prevention programs. These rules were founded in the regulatory statutes within the Fair and Accurate Credit Transactions (FACT) Act of 2003.

When the Fair and Accurate Credit Transactions (FACT) Act of 2003 was enacted, the applications of its requirements were focused on "financial institutions" and "creditors" with "covered accounts." However as the timeframe for implementation has drawn nearer the application of the Red Flag Rules has expanded to include the health care sector.

Definition Applications

With the application spreading out to the health care setting, it is imperative that health care providers be knowledgeable about the Red Flags and the need to establish identity theft prevention programs. Identity theft prevention programs are designed to find potential identity theft patterns, practices, or activities [red flags], and to respond to the findings.

There are several elements of the application of the FACT Act that apply to health care providers. The Act defines transaction accounts affected including accounts where a deposit is made or on which the owner makes payment. The definitions indicate that transaction accounts include checking accounts, negotiable order of withdrawal accounts, savings deposits subject to automatic transfers, and share draft accounts. The definitions also define a creditor as any organization that regularly extends, renews, or continues credit; any entity that regularly arranges for the extension, renewal, or continuation of credit; or any assignee of an original creditor who is involved in the decision to extend, renew, or continue credit. Health care providers have patients who pay on their accounts over an extended period of time. In this way, the health care provider is extending credit by allowing payments to be made on the account.

And while health care is not listed in the primary list of types of companies to whom the FACT Act applies, it is noted that when non-profit or government entities defer payment for goods or services, they too, are to be considered creditors, with covered accounts defined as any of the following: credit card accounts, mortgage loans, automobile loans, margin accounts, cell phone accounts, utility accounts, checking accounts, and savings accounts. For example, when arrangements are made for families or patients to pay on a balance, this is considering deferring payment for services provided. In addition, due to their potential risk of identify theft, small business or sole proprietorship accounts are also considered covered accounts [http://www.ftc.gov/bcp/edu/pubs/business/alerts/alt050.shtm [a]].

Compliance

Compliance requires that the organization develop a written program that is managed/overseen by the Board of Directors or senior employees and identifies and detects the relevant warning signs – or "red flags" – of identity theft. While program size and complexity can be in keeping with the types of account transactions, size of the business and its operations, the identity theft prevention program does need to include policies, protocols, staff training, and oversight of any service providers. The program needs to include appropriate responses to be taken and steps established to prevent and mitigate the crime, along with ongoing plans for updating and reviewing the program and its effectiveness. A key approach in developing an identity theft prevention program is to examine the red flags identified by the FTC and use these to individualize the organization's monitoring activities or program checklist.

The Red Flags

The FTC has identified 26 red flags that they have further combined into five categories. These categories are:

1. alerts, notifications, or warnings from a consumer reporting agency
2. suspicious documents
3. suspicious personal identifying information, such as a suspicious address
4. unusual use of – or suspicious activity relating to – a covered account
5. notices from customers, victims of identity theft, law enforcement authorities, or other businesses about possible identity theft in connection with covered accounts [http://www.ftc.gov/bcp/edu/pubs/business/alerts/alt050.shtm[b]].

Red Flag alerts from each of these five categories include activities, such as the following: alerts, notifications, and warnings from a credit reporting company such as fraud or activity duty alerts on credit reports, credit freeze notices when requesting credit, address discrepancy notice or unusual credit activity on existing accounts or new accounts. Should an account be closed relative to account privilege abuse, this is another red flag alert activity. This could mean for example, a patient, who is paying off his account via a monthly credit card charge is reported to have a discrepancy in his address.

When looking for signs of suspicious documents, there can be document sections that appear altered or forged or the person presenting the documents might not appear to match up with the photo identification the person is using. Other suspicious documents red flags could include signatures that do not match on checks or credit card charge slips, or checks that appear to be damaged and reassembled.

When a person lacks identification authenticating information or presents with photo identification that does not match up, these are examples of suspicious personal identification information. Other inconsistencies that could be red flags in this category are an address that does not

Health care providers need to establish identity theft prevention programs.

match up with a credit report, telephone numbers, addresses, or personal information which has been identified previously as fraudulent, inconsistency in date of birth, non-existent identifying information [address, phone, name], telephone numbers that are associated with paging or answering services or mail drop or prison addresses. Another area of personal identification of a suspicious nature involves the use of a Social Security Number that is not legitimate to the person presenting it, and includes those that are listed on the Social Security Administration Death Master File, or as not issued yet or issued to someone else. There are Social Security Administration issuance tables available for reference and verification of Social Security Numbers. Health care providers might encounter this Red Flag alert area, when the patient's Social Security Card Numbers are not matching with other information, or the Social Security number has been issued to another individual.

Account activity could be considered suspicious when customers ask for new cards or to add users to the account right after changing their address. When the user fails to make either the initial payment or any payments after the first payment on a new account, it would be an indication that the account is being used in a manner associated with fraudulent practices. This also can be the case when the account is used for large expensive purchases or cash advances. Account activity that is not in keeping with the account holder's pattern of use, in both purchases made or payments submitted, might also be indicative of identity theft activity. Other related red flag potential activities include active use of an account, which has been inactive of long duration, mail being returned as undeliverable while ongoing use of the account is taking place, customers asking about where their statements are, as they are not receiving them or customers questioning charges on an account and indicating they are not authorized charges.

The final category of red flag alert is notices that come in from other sources, that either the individual is a victim of identity theft or that an account has been opened and used fraudulently. These notifications might arise from the individual customer, police or other authority or other similar sources. Patients are at risk for identity theft and should be alerted. In some cases, the provider's social work staff might be able to help patients who are at risk.

Developing Your Organization's Plan

Section 114 of the FACT Act requires the organization to design and implement an Identity Theft Prevention Program that includes written policies and protocols for identification, prevention, reporting and responding to potential identity theft red flags and other identity theft risk exposures identified in the program.

One approach for organizations is to integrate the new policies and protocols into an existing program. There are several potential programs from which to choose. These include the Quality Improvement Program, the Corporate Compliance Plan or the Health Insurance Privacy and Accountability Act [HIPAA] security and privacy initiatives.

The first step is to make the Red Flags Plan a simple plan that integrates Red Flags Rule elements into a monitoring policy that delineates the reporting and follow-up response and actions to be taken. The policy must include oversight by the Board of Directors and management by a senior administrative position within the organization. The Board of Directors or a Board committee should be involved in the development of the program and the Board of Directors or a Board committee should approve the program.

Once the policy and the monitoring and reporting aspects have been decided upon and established, the next key step is to educate staff about the Red Flags Rule and the details in the policy and reporting plan. Staff needs to be aware of what is meant by a Red Flag and what their role is in reporting any potential Red Flag activities that they encounter in the course of care and service delivery. The training needs to include independent contractors and temporary staffing agencies that supply individuals to provide services on behalf of the organization.

The tracking, aggregating and trending of Red Flag reporting and responding by staff and the organization is an additional important step to incorporate into the Red Flags Program. The tracking, aggregating and trending can follow similar reporting as the organization's quality improvement indicators and could be either included within the monthly and quarterly quality improvement reports or in a stand-alone Red Flag Program Report. These reports relative to compliance with the red flag regulations must be shared with the Board of Directors or appropriate Board committee at least annually. The program itself should be evaluated at least annually with appropriate revisions made based upon the data collected throughout the year.

Application Summary

Remember these are the critical steps. [1] Identify and incorporate into the organization's identity theft prevention program relevant patterns, practices, and specific forms of activity that are "red flags" signaling possible identity theft as noted in the Red Flags Rule and as appropriate to the organization's business practices. [2] Develop the policies and protocols to detect the activities identified and obtain and verify personal data, including addresses and telephone numbers. [3] Respond appropriately and promptly when any red flag is detected. These responses can include closer scrutiny, reporting to law enforcement or verifying information through primary sources. [4] Review and update the identity theft prevention program on an ongoing basis in order to stay current with potential changing identity theft activities and regulations. [Burr, JB et al, 2008] ♥

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each step very carefully. If a dispute arises, you may be served with court orders and other documents. You will want to document these as well. Whenever you receive anything regarding a case like this from a court, you will want to have your attorney review them.

Conclusion

Whenever you are caring for a family that is in the midst of making a decision to remove a patient from a ventilator as part of an admission to hospice, you need to be very careful to identify the decision maker, document their authority, and document their decision. You are not the provider who will issue the orders, but you will ultimately be the provider who follows the orders and you want to be certain to document that the decision was properly made by the proper individuals. This is because of the risk that the family might change their minds later. When this happens, the provider often gets caught up in a family dispute that ensues. This can lead to being sued and other legal problems that can potentially be avoided by documenting the aforementioned items.

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Who to Contact

Hospice and Community Care Insurance Services • P.O. Box 2726, York, PA 17405
1-800-233-1957 • Fax: 717-747-7021 • **hccis.com**

Members who insure directly with us (not through another agent or broker), please request Certificates of Insurance, submit claims, make policy changes, or ask questions about your policies, by contacting the Customer Service Representative responsible for your state.

Tracy Guinn, Ext. 7597
Western States: AK, AR, AZ, CA, CO, HI, IA, ID, IL, IN, KS, LA MI, MN, MO, MT, ND, NE, NM, NV, OK, OR, SD, TX, UT, WA, WI, WY

Sheila Simmons, Ext. 7595
Eastern States: AL, CT, DC, DE, FL, GA, KY, MA, MD, ME, MS, NC, NH, NJ, NY, OH, PA, RI, SC, TN, VA, VT, WV

Insurance Brokers, please contact the Underwriter responsible for your state.

Mike Hetrick, Ext. 7535
West: AK, AZ, CA, HI, ID, NV, OR, UT, WA

Greg Lindstrom, Ext. 7561 – *Southeast:* FL, NC

Sheree Van Natter, Ext. 7566
Northeast: CT, DC, DE, IN, KY, MA, MD, ME, MI, NH, NJ, NY, OH, PA, RI, VA, VT, WV

Sheri Eckenrode, Ext. 7588 – *South Central:* LA, TX

Sarah Vail, Ext. 7541
Midwest: AL, AR, CO, GA, IA, IL, KS, MO, MN, MS, MT, ND, NE, NM, OK, SC, TN, WI, WY

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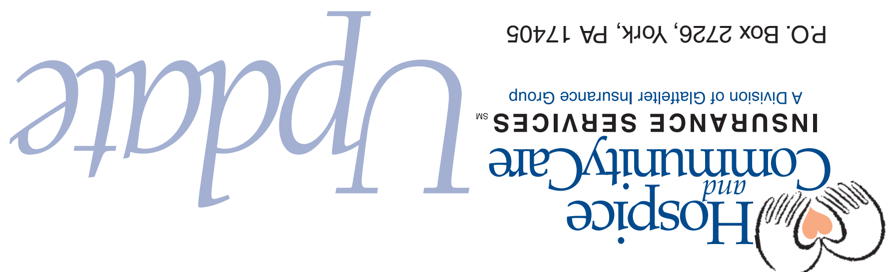

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