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Poyner Spruill LLP's International Award-winning Newsletter for the North Carolina LTC Community

New Online End-of-Life Planning Tool Now Available to NC Citizens and Health Care Providers

by Ken Burgess

A new tool is now available for North Carolina citizens and health care providers that will help everyone understand end-of-life health care planning options and processes available under North Carolina law. The new website can be found at www.agift-toyourfamily.org.

It includes two public service announcements (a longer and shorter version) designed to encourage everyone to think about end-of-life planning and creating advance directives such as living wills and health care powers of attorney. The site also includes copies of North Carolina's living will and advance directives statutory forms, a robust Question and Answer Section, and numerous other reference materials. The "stars" of the website, however, are two e-learning courses that walk viewers step-by-step through completing a living will or health care power of attorney, complete with graphic assistance so the viewer can follow along easily.

Portions of the website have also been translated into Spanish, and the site will be periodically updated with additional materials. The website was over three years in the making and was funded by nearly $40,000 in donations and grants, and hundreds of hours of volunteer time.

Sponsors of and donors to the website include The N.C. Bar Foundation Endowment; Poyner Spruill, LLP; the N.C. Medical Society, the N.C. Association for Home Care & Hospice; the N.C. Bar Association Health Law Council; and the Bar Association's Trust and Estates Section, among others.

Although the site was designed primarily for laypersons, it's also a great tool for health care providers to use in training staff and volunteers on end-of-life issues, and in providing helpful information to residents, families, family councils, and other groups related to the facility. And it's a great tool for community training programs sponsored by health care providers of all types. Remember that under the federal Patient Self-Determination Act, all covered health care providers are expected to host periodic training for their communities about advance directives options available under state law. This website is a great way to carry out that obligation by incorporating it and the e-learning courses into community educational programs and events.

The planning committee for the website is also exploring making the two Public Service Announcements available to providers on a thumb drive or other electronic medium for showing in facilities, physician offices, hospitals, and other health care provider sites.

Finally, the N.C. Healthcare Facilities Association's FutureCare Foundation is currently exploring a series of local community programs that will feature the website and other information on N.C. advance directives options and allow attendees to meet with local attorneys, medical professionals, and clergy to discuss their individual end-of-life choices and actually create or revise advance directives as part of the program. This is still in the planning stages, so stand by for more information.

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And the World Goes 'Round

By Ken Burgess

We come into this life with two things — a beating and a kiss. From our mother's womb, we are slapped on the ass by a stranger — a cruel start to life — then handed to our mama for our first kiss, followed by breakfast at her breast.

And the world goes 'round

For most of my young life, growing up the shy, chubby child of a ninth-grade-graduate farm mechanic and a GED-accomplished bookkeeper, I yearned for the day when I could leave our small town, the farms around our house, the week-to-week paychecks, and the struggle that all small-town, uneducated southern folks knew as their daily bread. I escaped all that through a great imagination, the school library, and in summertime, the book-mobile that came around to the Baptist Church in our town every two weeks. It was full of pirate stories, tales of European aristocracy, fish that could talk, and a thousand other things that were far, far different from cutting grass, pulling potatoes from the neighbor's garden, picking cucumbers for a nickel a bushel from someone else's field, and the nothingness that was country life.

And the world goes 'round

Then, I got my dream. I finished school, went to college and law school, and started a career. Back then, I never really pondered what my education cost my farm mechanic father and book-keeper mother. I just went on, 'cause the world goes 'round.

Over the years, my dreams of leaving Nash County took me to jobs in Raleigh, Washington, D.C., and San Francisco. I traveled to 48 of these great United States, to Canada, Mexico, Thailand, China, Nicaragua, and Australia. I walked the streets of Rome, Florence, Paris, and Milan. I swam the seas of Mexico and the south of France, dined in Beijing, Bangkok, and Boston. I wrote, I lectured to thousands of people, and I traveled. And occasionally, I came home to tell about it all.

And the world goes 'round

In 1991, my Grandma Ellis, a lady I adored, died while I was on a boat in the Outer Banks, a big yacht owned by my friend. In 2002, my daddy died while I was in San Francisco. That year, I had canceled my Thanksgiving trip home because he said I had a new job and would be home for Christmas anyway, so why spend the money. He died alone on December 2, 2002, and the last time I saw him, he was in his coffin, not at Thanksgiving and not at Christmas.

And the world goes 'round

Last year, I wrote a story in *Shorts* called "Make Me a Channel of Your Peace." In it, I talked about my family, my friends, and my fears. I also talked about the illness from cancer of our beloved stepfather, Frank Pittman. And I said that we knew he would survive and we'd all be stronger for it. But I was wrong. Frank died on Mother's Day in May 2013, and life changed for us all – for my mother, for his daughters, for my sisters, and for me.

For 11 years, Frank gave us the peace of knowing that our Mother was loved and very well cared for. They traveled, they kissed, they danced and they acted like 20-year-olds, not 70- and 80-year-olds. But then he died and everything changed.

And the world goes 'round

After Frank's passing, my very independent mother moved in with my sister. She's always the one to step up in a crisis. I bought some Nash County land next to my sister's house, and before I could think about what I was doing, I started building a new house for me and Mama. At first, it was just a romantic, emotional idea. But then things started moving fast. Last week, I visited the site of the new house with Mama, and it hit me — I'm leaving Raleigh, moving an hour from my job, and Lord help me, moving in with Mama.

My daddy always told me — I can hear him like it was yesterday — "Son, you can travel the world and back again, but the day will come when you'll wanna' feel Nash County soil between your toes." I guess he was right, but he forgot to tell me just how scary coming home can be.

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Last week, I saw the foundation of the new house rise out of the ground. I looked to my left and saw my niece's house where the grandbabies live. A bit farther to the left, I saw my sister's house and to the right my Aunt Millie's house. I looked up the hill to the old white house where my cousin lives and realized that Mama and I were building a house where, for decades, her ancestors worked as sharecroppers, not owners. And I just laughed to myself and thought, "the world goes 'round."

So, come January, nearly 50 years after the backyard swing, the books and bookmobiles, the dreams of leaving home, the dinners in China and Canada and Columbia, I'll be living back in Nash County. I'll be living with Mama on the very land our family worked for decades, but never owned. I'll live in the shadow of her ancestors and mine, and in the whisper of the pines that line our country road, I'll hear my Daddy say, "Son, I told you so."

We come into this life with two things – a beating and a kiss. If I am blessed, I will be the lucky man who knows that the first face I ever saw was my mama's and the last face she may ever see will be mine – in our living room, in our new house, in Nash County, on land she once worked but never dreamed she would own, and with her beloved family a rock's throw away.

When my friends in Raleigh tell me I'm nuts, that I'm complicating my work and social life by moving an hour away to the country, that a 56-year-old man shouldn't be living with his mother, I fret and I worry that they are right.

Then, I close my eyes and remember a chubby, shy little boy sitting in a backyard swing reading *Moby Dick* and *Treasure Island, Catherine the Great* and *Black Beauty*. I remember pulling potatoes and cucumbers for a nickel a bushel. I remember the people, the schools, the jobs, the marriages, and births and deaths that have defined my life and the lives of those I love.

I think of my Grandma Ellis, my Daddy Jack, and the others who sacrificed so I could have college and law school and jobs and trips. Those who freed me to abandon a backyard dreamer's swing in Nash County to actually live those dreams. I think of those, some long gone and some still here, who wove the fabric of my life, however good or bad it may be. And those who gave me, bit by bit, this small piece of land in Nash County and a house with my mama, next to my sister and my niece and the grandbabies and my aunt.

I also think of my nephew and niece, and their babies, and the babies of those babies yet to come. And I wonder if they'll keep this little house, this plot of ancestral land or, like me, rush to leave it, only to find they really can't.

Then, I just smile to myself . . .

Because the world goes 'round.

Ken's Quote of the Month

"Every new beginning comes from some other beginning's end."

~ Semisonic/Dan Taylor

What Is "Past Quality of Care" in a CON Review?

by Pam Scott

A recent certificate of need (CON) decision has muddied the waters further on the question of what constitutes past quality of care in a CON review. The case involved the Certificate of Need Section's (CON Section or Agency) decision on competitive applications filed in 2012 seeking to develop hospital acute care beds and a separate application to relocate a hospital operating room in the Cumberland/Hoke County service area. A significant issue in the case was whether the Agency correctly concluded that the disapproved applicant did not conform with the statutory review criterion relating to quality of care, commonly known as Criterion 20. That criterion requires a CON applicant already engaged in the provision of health services to "provide evidence that quality care has been provided in the past." In evaluating an applicant's compliance with Criterion 20, the CON Section typically has focused on whether an applicant had any immediate jeopardy-level deficiencies within the 18 months before the application date at any facility in the county where the new beds or other facility being applied for are located. In the Cumberland/Hoke acute care bed case, the presiding administrative law judge (ALJ) rejected the Agency's approach, finding that it was not supported by the Criterion 20 statute and that it was based upon an unlawful unpromulgated rule.

In the Cumberland/Hoke Review, the disapproved applicant had been subject to immediate jeopardy citations and findings that it was out of compliance with several Medicare Conditions of Participation (CoPs) several months before its application was submitted. In his decision issued September 17, 2013, the ALJ acknowledged that during the CON review, this applicant was subject to a Systems Improvement Agreement with the Centers for Medicare & Medicaid Services, which ended after the CON Section issued its decision. However, the ALJ pointed to certain events indicating the applicant was in compliance with all CoPs when the CON Section issued its decision, including a Joint Commission full survey determining that the applicant was in compliance with all CoPs before the CON application was filed; the Agency's entry into a settlement agreement with the disapproved applicant in a separate CON review after receiving confirmation of Joint Commission accreditation which resulted in the issuance of a CON to develop 65 acute care beds; a survey by the N.C. Licensure and Certification Section finding the applicant in compliance with all CoPs more than two months before the Agency's decision; and an e-mail from the Licensure Section to the CON Section confirming the applicant's compliance with CoPs shortly before the Agency decision. The ALJ noted that in prior reviews the CON Section had found applicants conforming with Criterion 20 despite immediate jeopardy citations, provided there was information indicating the applicant was compliant at the time of the CON decision.

In rejecting the CON Section's interpretation of Criterion 20, the ALJ concluded that the law focuses on a demonstration of quality care generally and does not require a perfect record. The ALJ ruled that the disapproved applicant should have been found conforming and that the Agency incorrectly applied Criterion 20 in determining that a full validation survey was necessary for the disapproved applicant to demonstrate compliance. However, the applicant approved by the CON Section ultimately prevailed under the ALJ's decision, based upon comparative superiority, including on the quality care issue.

This most recent decision on quality of care in the CON context conflicts somewhat with a decision by another administrative law judge in the Wake County nursing home case which we wrote about earlier this year. In that case, the ALJ accepted the Agency's general approach of looking to past survey findings in connection with Criterion 20 but concluded that a CON applicant that is an existing provider must demonstrate a history of providing quality care at its facilities across the state (rather than just locally per the CON Section's policy) in order to be awarded a CON.

Appeals to the N.C. Court of Appeals are pending in both of these cases, so it appears the question of what Criterion 20 requires an applicant to show to demonstrate past quality care may well be decided there. Meanwhile, this most recent ALJ decision stands for the proposition that the CON Section's approach applied in the Cumberland/Hoke Review is unlawful. Only time will tell whether the CON Section elects to tweak its Criterion 20 analysis or application forms in response to the ALJ's decision in the Cumberland/Hoke Review.

CON applicants or competitive participants in CON reviews will need to weigh the details and distinctions of these two ALJ decisions in determining how best to proceed in analyzing and explaining a provider's past quality of care in CON applications and/or comments filed supporting their own application or addressing that of a competitor. Nursing facility providers and other long term care companies submitting CON applications should consider consulting with legal counsel before submitting CON applications to help make sure their applications appropriately and completely reflect a commitment to quality care in compliance with Criterion 20 in light of these recent ALJ decisions on this issue.

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CMS Issues New Surveyor Guidance on Initiating CPR in Nursing Homes and Facility CPR/DNR Policies

by Ken Burgess

In a highly publicized recent case in California, a registered nurse working in an independent living facility refused to initiate cardiopulmonary resuscitation (CPR) on an elderly resident who was experiencing respiratory distress. The nurse refused to start CPR even when the 911 dispatcher begged her to start CPR or to find someone, even a bystander, who would do so. The nurse still refused, stating that the facility had a no-CPR policy at the time.

This case caused consternation among long term care providers around the country. In our own practice, we've had numerous requests to review skilled nursing facility (SNF) Do Not Resuscitate (DNR) and CPR policies because of this case.

On October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) issued new surveyor and provider guidance on CPR/DNR policies and practices in SNFs that leaves no doubt about 1) an SNF's obligations to provide CPR consistent with residents' advance directives and 2) the requirement that SNFs have policies and procedures consistent with this requirement.

In the guidance, which is effective immediately, CMS makes clear the following:

1. Under both OBRA regulations governing SNFs and regulations promulgated under the federal Patient Self-Determination Act for most health care providers, SNFs have an obligation to initiate CPR for a resident suffering cardiac/respiratory distress unless:
    a. The resident has an advance directive declining CPR (including a valid DNR order)
    b. The resident has no advance directive, meaning that the facility should default to full care, including CPR, absent a directive by the resident or his/her legal surrogate declining CPR
    c. The resident evidences obvious signs of clinical death (i.e., rigor mortis, dependent lividity, decapitation, transaction, or decomposition)
    d. Initiating CPR could cause injury to the rescuer;
2. All SNFs must have staff trained in CPR under American Heart Association guidelines at all times and on all shifts;
3. Simply calling 911 when residents suffer cardiopulmonary distress is not sufficient; and
4. All SNFs must have policies and procedures consistent with these requirements.

CMS further states that SNFs may not establish and implement facility-wide "no CPR" policies because this violates residents' rights to formulate advance directives under FTag 155 and the federal Patient Self-Determination Act. CMS acknowledges that available data shows the rate of success from CPR in the elderly population is low, somewhere between 2% to 11%. However, CMS also notes that the SNF population is changing, with many more younger residents coming to SNFs for short-term therapy and rehabilitation. According to CMS, its 2012 Nursing Home Data Compendium shows that roughly one in seven SNF residents in 2011 were under the age of 65.

What Providers Should Do

In light of this new CMS guidance and the recent attention we've noted in surveys on end-of-life issues, SNFs should do the following:

1. Review your CPR/DNR policies to ensure they are consistent with the CMS guidance.
2. Train all staff on those policies and procedures and do this periodically.
3. Review your facility admissions processes to ensure that admissions personnel understand and follow them. Admissions personnel are often on the front line in determining and documenting an incoming resident's advance directives and end-of-life wishes. Make sure they understand the difference in living wills, health care powers of attorney, and DNR orders and that they read and understand these documents. Also make sure they spot any inconsistencies in those documents and resolve them with the resident, his/her legal surrogate if the resident is not competent, the attending physician, family members, and/or facility management, as appropriate.
4. Ensure that you have a reliable, consistent system for all staff to know immediately a resident's end-of-life wishes so that CPR can be initiated or withheld immediately in a crisis, consistent with the resident's expressed wishes. Most research shows that brain injury or brain death can occur or begin within four to six minutes of a respiratory failure, so time is of the essence.

Finally, for SNF providers who also have an adult care home or independent living unit or wing, remember that CMS regulates only those facilities that are certified for Medicare and/or Medicaid. So this new CMS guidance does not apply to noncertified adult care homes or independent living units. The requirements for CPR in those types of facilities are governed solely by state law.

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