

# Nursing & Assisted Living Facility Professional *NOW IN OUR 11TH YEAR!*

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SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

## THE ADELMAN ADVANTAGE by Rebecca Adelman

# Managing Expectations – End-of-Life Care



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organization and analysis, Excelas helps keep our clients' resources invested where they belong — in patient care. Thank you, Excelas, for the collaboration on this Blog. Stay tuned for innovation from this collaboration!

Over 835,000 Americans reside in ALFs, and the majority of those are over 85 years-old. Of note, most claims arise from care issues during the first two weeks or the last two months of residency in an ALF or skilled nursing facility (SNF). A case analysis illustrated tools for reducing claims and litigation risks relating to end-of-life expectations, including staff training, communication among providers and with families, and documentation policies and procedures.



### Case Discussion

A female was admitted to a memory care unit. Chronic conditions on admission included coronary artery disease, Alzheimer's dementia, hypertension, hyperlipidemia, and osteoarthritis. In addition, poor food intake was noted, and she was well below weight for her stature. Initially the resident was a Full Code status. During the nine-month ALF residency she had four hospitalizations for falls, respiratory infection, and change in mental status. Two weeks prior to death, she was changed to DNR/no interventions. The cause of death included congestive heart failure, myocardial infarction, and coronary artery disease.

Claims against the facility included falls with injury, medication errors, and failure to thrive. During a deposition, when the daughter was asked about her expectations of the facility on admission, she testified she "didn't know what to expect." She had no discussion with her mother about her wishes regarding care or her prognosis. She was unaware of her mother's wishes for end-of-life care. The daughter stated that the family did not discuss these issues, but added she expected her mother not to have any falls, expected her mother to have rehabilitation, and did not expect her to die.

*Continued on page 2*

Why did the daughter file a lawsuit? The facility knew about her mother's condition and options and goals were not discussed with the family. The daughter felt the community over-represented what it could do. The lawsuit settled for \$245,000, with additional costs including, but not limited to, nine months of litigation, the insured's deductible, defense costs, costs of hospital admission, and hours relative to community human resource costs. Unquantifiable costs included impact on staff and well-being, cost to the institution, impact on insurance premium, and potential reputational damage to the facility. "Unmet expectations by residents and family members regarding clinical conditions, prognosis, and the trajectory of illness leads to confusion, anger and dissatisfaction. When a negative outcome occurs, evidence establishes that families want to blame someone. These feelings drive decisions about hiring an attorney and pursuing a claim", says Ms. Adelman.

### Tools for Reducing Risk

As evidenced in this case study, realistic expectations for end-of-life care are essential. The need for clear communication and shared decision-making with the family upon admission to the ALF/SNF can improve satisfaction and the grief process. It was noted that 90% of DNRs are put in place by surrogates, as many residents are in cognitive decline. Discussing and documenting EOL issues and plans with residents and families ensures patient centered care, which may include palliative care and hospice care. Ms. Adelman adds that "By understanding and managing expectations along the continuum of care, not only is risk mitigated but residents, families and staff experience better end-of-life care and are more fulfilled."

### Palliative and Hospice Care in Senior Living

Ms. Adelman stressed the importance of communicating the differences between palliative and hospice care to the resident's family. While each of these options focus on quality of life and symptom relief, palliative care is available as soon as a long-term diagnosis is received. Hospice care, which is a type of palliative care, is available to anyone with a

terminal illness whose doctor determines they have less than six months to live.

**Palliative care** is a resource for patients living with a serious, long-term illness. The intent is to improve the quality of life through symptom management and can be provided along with curative treatments. The palliative care team is multidisciplinary and includes the patient, family, doctors, nurses, social workers, nutritionists, chaplains, and others to assist in providing social, emotional, and practical support. Palliative care can be provided in any setting.

In instances when hospice care is initiated, the Centers for Medicare & Medicaid Services (CMS) has clear **guidelines** on creating and coordinating successful plans of care. The CMS Fact Sheet states "The primary goal of hospice care is to meet the holistic needs of an individual and his/her caregiver/family for whom curative care is no longer the preferred option. To support this goal, the hospice provider develops an individualized plan of care (POC), established by an Interdisciplinary Group (IDG) and overseen by a Registered Nurse (RN) coordinator."

### Documentation

Medicare requires that the Hospice Plan of Care include the following elements:

1. Interventions to manage pain and symptoms
2. A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs
3. Measurable outcomes anticipated from implementing and coordinating the POC
4. Drugs and treatments necessary to meet the needs of the patient
5. Medical supplies and appliances necessary to meet the needs of the patient
6. The IDG documentation of the patient's or representative's level of understanding,

involvement, and agreement with the POC, in accordance with the hospice's own policies, in the clinical record

The Social Security Act requires that hospices submit data through the Hospice Item Set, which in turn is publicly reported through the Hospice Quality Reporting Program. Even if a resident is not covered by Medicare, documentation guidelines, which provide a clear picture of the patient's condition and symptoms to support the terminal prognosis, are applicable.

### False Claims Acts

Although not discussed in this presentation, facilities must also be cognizant of the appropriate use of hospice. The Department of Justice has filed multiple cases under the False Claims Act with allegations including:

- Admitting patients not hospice appropriate
- Maintaining patients not actively dying
- Kickbacks to physicians to bolster referrals
- Categorizing patients in higher intensity levels (i.e. General Inpatient Care @ \$1,045.66/day vs. Routine Home Care @ \$199.25/day)

Documentation plays a key role in these cases. In audits conducted by Excelas, red flags included:

- No certification present or initial certification not performed in a timely manner
- Subsequent/recertifications not timely
- Physician narrative statement not present or valid
- No plan of care
- Face to face requirements not met
- No certification for dates billed

While the 11<sup>th</sup> Circuit Court of Appeals agreed in September of 2020 that a difference of physician's opinions on a terminal patient's prognosis does not

indicate falsity under the FCA, there have been other cases which have allowed a jury verdict. Consistent documentation is key to the defense.

### Barriers to Setting Expectations for EOL Care

Several barriers to setting clear expectations with residents and family members were identified and included:

- Lack of training of staff – to recognize the need for palliative/hospice care
- Lack of a standardized assessment of terminal status
- Communication gaps – among professional staff and with resident/family
- Lack of access to hospice services
- Issues created by joint management – including outside hospice providers
- Issues created by transitions across care settings
- Other delivery system issues

### Takeaways

These elements of an individualized plan developed by a team, including key caregivers/family members with a designated person for oversight, can facilitate establishing realistic expectations upon admission for all residents of an ALF/SNF, not only those on hospice. Facilities should have procedures regarding:

- Where documentation of the end-of-life discussion is found in the records (admission documents, care planning section)
- What is included in the documentation (e.g., EOL care options, patient wishes)
- Who is responsible for the EOL discussion (e.g., PCP, nursing, admission counselor, social services, case manager)

- Training for all staff on EOL issues and protocols

In the case study above, had these steps been initiated upon admission to the ALF, the resident's daughter would have been involved in the decision-making and planning, and would have known "what to expect" as her mother's condition progressed. As noted earlier, with many claims occurring in the first two weeks of residency, facilities need to emphasize early discussions with the resident and family rather than waiting until the resident's health prompts discussions. Setting expectations early improves quality of care/quality of life, family satisfaction, staff recruiting and retention, and reduces risk liability.

For more information on "Expectations Management Program for Long-Term Care Communities",

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Rebecca Adelman is an entrepreneur, influencer, thought leader and founder of Adelman Law Firm and Claims Management, a Women's Business Enterprise National Council (WBENC) certified Women Business Enterprise (WBE) established in 2001. In 2021. She founded the Adelman-Mettle Care Alliance with Dr. BJ Miller and Sonya Dolan, founders of Mettle Health, a palliative care consulting provider. AMCA provides certification for risk mitigation programs in the senior living industry. For nearly 30 years, Rebecca has concentrated her practice in insurance defense and business litigation. The firm's practice extends through the Tri-States of Arkansas, Mississippi and Tennessee. Rebecca's insurance defense practice includes representation of insurance companies and long-term care providers and their insurers, both regionally and nationally. She also provides consulting services and educational programming to healthcare professionals and business associates. She has active practices in the areas of general liability, professional liability, premises, and employment law. She is a listed mediator serving all areas of business and healthcare litigation.

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The staff at Excelas is driven by their mission to positively impact the way healthcare is delivered. By taking on the complex and laborious task of medical record organization and analysis, we help keep our clients' resources invested where they belong — in patient care.

We believe our biggest strength is our people. Led by Founder and President Jean Bourgeois, our staff is comprised of health information specialists, legal nurse consultants, quality assurance reviewers, client service professionals, and IT developers based in Cleveland, Ohio, and serving healthcare organizations nationwide.

Jean Bourgeois, MBA, RHIA, is the President and Founder of Excelas, LLC. Her career spans 35 years of leadership experience in healthcare and medical litigation consulting. She is the former director of medical records and health information at several Cleveland area hospitals, including the Cleveland Clinic Foundation. As a registered Health Information Administrator, Jean provides consulting assistance to healthcare organizations, law firms and insurance companies across the country. She speaks and publishes nationally on leadership, health information management and medical litigation support. Jean is a member of the American and Ohio Health Information Management Associations, the American Health Lawyers Association, the American Society for Healthcare Risk Management, The Defense Research Institute, and Women President's Organization. She serves as a member of the trustee committee for the American Cancer Society. Jean obtained her MBA from Baldwin Wallace College in Cleveland Ohio and a BA in Health Information Administration from the College of St. Scholastica in Duluth Minnesota.



# Mourning: A Basic Human Need

## PART 2



Welcome to part 2 of the theme of mourning where we'll explore ideas to weave mourning practices into the organizational culture to help support healing for everyone. In relation to the pandemic, there have been many articles and postings on posttraumatic growth and one in particular stands out

to me. From the Journal of the American Medical Association comes this quotation, *"Posttraumatic growth does not minimize the seriousness and severity of what has happened but can emerge from adversity through active management following the important process of grieving."* (Olsen) Simply put, growth cannot happen until we have grieved, and I would add, until we have mourned.

Being present with grief is not something we are taught to do or something that we typically see other people doing well. Being in the presence of grief may evoke feelings that we'd rather not experience like helplessness and nervousness. Colleague Carla Cheatham wrote a wonderful blog series called "BE-ing With Suffering" and in the first post, she addresses what it is that makes being with grief so hard: it reminds us of our own vulnerability to things that can happen in life, and it reminds us of our own pain/grief/fears that may be unresolved and that we'd rather not deal with. She goes on to name barriers to being with grief that include fear of not knowing what to say, fear saying the wrong

thing, feeling a need to fix the grief, and discomfort with silence.

How can we be present with grief and mourning, to step out of our socialized patterns and embrace these basic human needs? Appreciate that you might find this uncomfortable and consider stepping toward that discomfort. I like to use the "and" approach – I feel my discomfort and I am eager to expand my ability to have a different experience. No judgment, just acceptance of any feelings that might be present.

When you are with someone who is grieving, offer a calm and quiet presence with a relaxed posture.

Model taking deep breaths to support both you and the person in their grief. Nonviolent Communication (NVC) trainer, Kathy Simon, teaches attuned listening (some call this empathy) and the importance of sending the message verbally and non-verbally to the other person that you want to hear them – "I'm here, I care, I have the spaciousness, and I'm available." There is no agenda or problem-solving in this space, only listening.



Image from Pixabay

Acknowledge the pain and the struggle with something like, "This really hurts" or "I hear you" and allow for tears and other expressions of grief. You can express curiosity with a question that helps the person describe their experience of grief such as, "Is the grief like a wave?" These approaches are a gift of permission to ourselves and each other to grieve and to mourn. In essence, we are normalizing these basic human needs.

Let's talk about tears for a moment. Crying is a natural response, and it helps release hormones and toxins from the body. Crying may evoke feelings of discomfort because the person crying may feel vulnerable or the person witnessing the crying feels compelled to "do something" (Doheny). Years ago, when I was working on a palliative medicine team, I learned that simply being present and bearing witness to one's suffering is powerful. When someone says, "I'm sorry for crying" consider saying, "Thank you for allowing me to be present with your grief (sadness, hurt). Thank you for trusting me."

And here's something interesting to consider - while offering a tissue to someone who is crying may seem appropriate, be aware that it may be interpreted as a sign of nervousness that conveys a message "Please stop crying" (Cheatham). If possible, place multiple boxes of tissues in strategic places that allow a person to take one if they need to. This is not intended to say that we should never offer a person a tissue, just to be aware of how it may be perceived.

Let's switch now to mourning rituals. Understandably, we tend to associate rituals as activities that we engage in when someone dies. Perhaps there is a mourning ritual where you work, such as a memorial or celebration service or the placement of a rose on the bed to honor a resident who died. Other ritual ideas include opening a window and gathering staff for a 'prayer' or blessings and taking a moment of silence. A memory tree is a visible way to honor people who have died, their names written on leaves which are hung on the branches.

Rituals should be part of the organization's cultural fabric and it's important that they occur regularly. A memorial service that happens only a few times a year is likely insufficient as the need to mourn doesn't adhere to a schedule. Rituals are more structured and formal but there also needs to be an opportunity to grieve and to mourn informally.

Peer support is one way to support grieving and mourning. Peer support is a fundamental principle of trauma-informed care and while it can be more

structured, it can also occur organically as the need arises when people need time and space to gather after a loss, distressing news, or a death.

Debriefing is one example of a formal support where staff can discuss their experiences around an event: what went well, and what can be improved. Colleague Angela DeVanney teaches that debriefs are characterized as safe, constructive sharing of feelings that meet staff's needs. Debriefs are non-blaming, non-judgmental and non-critical opportunities to talk openly and to listen to each other while supporting expressions of grief and helping staff re-identify with their shared purpose. It's important to clarify that debriefs are not venting or complaining sessions or intended to 'fix' anyone's feelings. Debriefs are a safe space.

Another way to create a supportive environment for grieving and mourning is to provide psychoeducation, written materials or educational offerings on any number of topics. Making these opportunities available to staff, residents, families, and care partners supports wellbeing for everyone.

As we seek to find meaning, to heal, and to grow in the wake of the pandemic, our nursing homes and assisted living communities can be places where we can feel comfortable and supported in our recognition and expression of the grief and need to mourn that accompanies the loss of normalcy, people, and relationships we care about so deeply.

"BE-ing with Grief" blog series by Carla Cheatham, <http://carlacheatham.com/carlas-blog/page/4/>

Why We Cry: The Truth About Tearing Up by Kathleen Doheny

<https://www.webmd.com/balance/features/why-we-cry-the-truth-about-tearing-up#1>

Olsen et al. (2020). Pandemic-Driven Posttraumatic Growth for Organizations and Individuals. JAMA 324(18).

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