The Surveyors Are Coming – Finally!

Subscriber Webinar
April 2015

HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Today's Plan

- Review regulatory survey trends
- Describe a process to prepare your hospice for a Medicare survey

What's the Difference?

Conditions of Participation

Subparts C & D
Care Delivery / All Patients

Conditions of Coverage

Subparts B & F
Payment / Medicare Patients

Impact Act

- The IMPACT Act mandates that all Medicare certified hospices be surveyed every three years for at least the next ten years
- Law effective April 6, 2015
- History behind the change
  - Surveys had typically been conducted every 6-7 years due to a lack of funding staff
  - Provider community has been requesting more frequent surveys
  - OIG and others have had concerns about this frequency

Purposes of Surveys

- Determine effectiveness of program's practices in implementing the hospice regulations (Medicare, state and/or accreditation) and providing hospice services
- Assure that required education, training and competency testing has been completed and documented
- Determine if staff demonstrate knowledge of & application of policies and procedures in relation to job title & function
- Evaluate consistency in application and implementation of policies

Bottom Line

1. Does your hospice program demonstrate an understanding and execution of the appropriate regulations?
2. Is this demonstrated in the quality of care and patient safety?

Types of Surveys

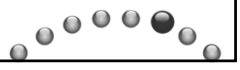
Medicare (State Agency or Accreditation Organization)	• Certification/Recertification • Complaint • Follow Up
Accreditation	• Accreditation • Deemed Status • Complaint • Follow Up
State	• Licensure/Licensure Renewal • Complaint • Follow Up

Components of Survey Success

1. Know What to Expect in a Survey
2. Know How Well You Measure Up
3. Manage the Survey Process

General Survey Information

- By law unannounced
- Frequency
  - Effective 2015, every 3 years for Medicare
  - Accreditation every 3 years
  - State dependent on state licensure regulations
  - Complaints depending on severity
- Expect 1 or more surveyors for 1 or more days



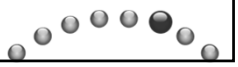
State Operations Manual
Appendix M Guidance to Surveyors: Hospice

Part I Investigative Procedures

What It Is: The basic instructions to surveyors on how to conduct a survey and post survey actions

The Sections

- Pre-Survey Preparation
- Entrance Interview
- Information Gathering
- Information Analysis
- Exit Conference
- Formation of the Statement of Deficiencies



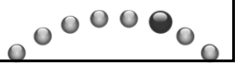
State Operations Manual
Appendix M Guidance to Surveyors: Hospice

Part II Interpretive Guidelines

What It Is: Guidance that tells surveyors what to look for to see if a hospice has met the regulation

- Overview of condition or standard
- Procedures and Probes
  - Guidance and questions for surveyors address
  - Directions for what surveyor might look for or do
  - Interview questions for staff
- Organized by L Tags

Why It Is Important to Read: Hospices should know this section as well as a surveyor does



Top 10 Medicare Deficiencies (2013)

	L Tag	Description	Examples of findings
1	L543	Plan of care	• Plan of care not individualized • Missing or incomplete documentation • Inadequate of lack of IDG collaboration • Patient/ representative not documented collaboration of plan of care goals
2	L545	Content of plan of care	• Missing or inaccurate documentation. • Physician orders missing
3	L530	Content of comprehensive assessment (drug profile)	• Incomplete medication profiles • Patient taking medications not on medication profile
4	L555	Coordination of service	Overarching-not following the plan of care • Services provided not on the plan of care • Interventions on patient's plan of care were not provided by IDG
5	L547	Content of plan of care-scope and frequency	Missing frequencies

Top 10 Medicare Deficiencies (2013)

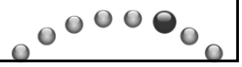
	L Tag	Description	Examples of Findings
6	L591	Nursing services	RN not meeting patient needs On-call issues
7	L629	Supervision of hospice aides	Missing every 14 day RN supervisory visits
8	L557	Coordination of services-between all disciplines providing care and services in all settings	Lack of communication among IDG and with other non-hospice service providers Patient/family requests for services of other IDG members not communicated to IDG
9	L533	Update of comprehensive assessment	Progress or lack of progress towards goals not documented by IDG Changes in assessment status not communicated to other members of IDG
10	L671	Clinical Records	Clinical records missing timely visit documentation Missing signatures

Quality of Care

After hours calls are mostly about care provided during regular working hours

Pick records from on-call

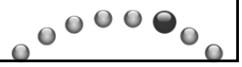
- How did the care look prior to the call?
- Did the plan of care address the issue appropriately?
- What could have been done differently?
- Is there a quality of care issue?
- What would surveyor see if this record were picked for review?



Quality of Care

What do the complaints and/or grievances tell you?

- Look at your complaint reports/log
- Review a record with a documented complaint
- Does the POC address the need? Has the POC been revised?
- Does the complaint report address the corrective action?



Quality of Care

What about live discharges: revocations and discharges for entering non contracted facility?

- Review records
- Service delivery failure? Complaint? Documented?
- Proactive care planning and care delivery?
- What would surveyor see if this record was picked for review?

Quality of Care

What about incident reports?

- Review incident reports/logs
- Review records
- Proactive care planning and delivery?
- Was issue addressed proactively that was related to incident?
- Did the POC address issues related to the incident? Has the POC been revised?
- QAPI address trends?
- What would surveyor see if this record was picked for review?

Clinical Record Reviews

Focus on high risk, problem prone areas

- Plan of care
- Comprehensive assessments
- Coordination of services
- Clinical records
- Patient rights
- Nursing services

Plan of Care

Top Tags L543, L545, L547, L555, L557

- One of the most important processes/documents (per CMS)
- Read the regulations and interpretive guidelines for these tags. Be able to answer the probes.
- Do you know your current policies and procedures? Are you following them?
- What documents (paper and/or electronic) make up your plan of care? Is this supported by policy?
- Can you explain how the IDG is involved in the development and revisions of the POC?
- What clinical record reviews are in process that address POC? What do the results show?
- Does staff understand the care planning process?

Using the Interpretative Guidelines L545

§418.56(c) Standard: Content of the plan of care

- Determine through interview/observation &record review if the plan of care identifies all the services needed to address problems identified in the initial, comprehensive and updated assessments.
- Is there evidence of patients receiving the medication/treatments ordered?
- Are plans of care individualized and patient-specific?
- Does the plan of care integrate changes based on assessment findings?
- Is there documentation to support that the development of the POC was a collaborative effort involving all members of the IDG & the attending physician, if any? The attending physician & IDG members do not have to sign the plan of care but there must be documentation of their involvement.

Comprehensive Assessments

Top Tags L524, L530, L533

- Read the regulations and interpretive guidelines for these tags. Be able to answer the probes.
- Do you know your current policies and procedures? Are you following them?
- What documents and processes make up the comprehensive assessment?
- How are the findings communicated within the IDG and used to update plan of care?
- Does the documentation show progress or lack of progress towards the goals?

Using the Interpretative Guidelines L530

§418.54(c)(6) Content of comprehensive assessment (drug profile)

Ask clinical staff to describe their process of medication review

- How potential adverse effects and drug reactions are identified?
- What process is followed when a pt/family is found to be noncompliant?
- What non-pharmacological methods are considered to relieve pain & other sx?
- How pts/families are educated about pain & symptom management.
- What process hospice utilizes to assess & measure pain & other sx.
- What procedures the hospice uses to reassess pain & sx management.
- How the hospice monitors a patient when they begin a new medication, change dosage or discontinue a medication.

During the home visit, ask the patient/caregiver:

- What medications the patient is currently taking and compare this information with the medications documented within the plan of care.
- Are the patient's preferences/goals for pain management and symptom control followed and achieved?

Coordination of Services

Top Tags L555 and L557

- Read the regulations and interpretive guidelines for these tags. Be able to answer the probes.
- Do you know your current policies and procedures? Are you following them?
- How does your documentation system tie to plan of care?
- How does the IDG know the current status and needs of the patient?
- What is your method of communication and documentation with contracted providers?

Clinical Records
L671

- Read the regulations and interpretive guidelines for these tags. Be able to answer the probes.
- Do you know your current policies and procedures? Are you following them?
- Do you have real time documentation?
- Is every visit documented? How do you know?
- Is every note signed? If using electronic signatures, are proper controls in place

Supervision of Hospice Aides
L629

- Read the regulations and interpretive guidelines for these tags.
- Do you know your current policies and procedures? Are you following them?
- How do you know when a supervisory visit has been completed? How can your EMR help track?
- What are the consequences when an every 14-day supervisory visit is not completed?

Nursing Services
L591

- Read the regulations and interpretive guidelines for these tags. Be able to answer the probes.
- Do you know your current policies and procedures? Are you following them?
- Review complaints, on-call, revocations and live discharges for entering a non-contracted facility for and incidents.

Staff Interviews

- Answer only what the surveyor asks
- Review State Operations Manual on Patient Care and Organizational Environment
- Common Topics
  - Patient safety
  - Quality of care
  - Staff competency
  - Patient rights
  - IDG communication

IDG Meetings

Refer to State Operations Manual on Patient Care

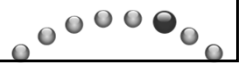
- Patient safety
- Quality of care
- Staff competency
- IDG communication
- Plans of care
- Coordination of care

Home Visits (All Locations)

- Refer to SOM section on Home Visits
- Car check
- Protect PHI
- Know the plan of care and deliver care accordingly
- Confirm patient identifier if not in personal residence
- Hand washing policy / Infection control practices
- Ensure education is provided
- Determine if unmet needs before ending the visit
- Complete documentation
- Answer only what the surveyor asks

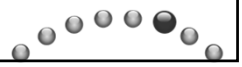
Nursing Home Visit

- Are all required documents in the nursing home record?
- Check in process followed?
- Do you review NF record for changes?
- NF/ALF coordination and communication process
- Report off by communicating any changes in the plan of care and education which occurred
- Contact family per plan of care



Managing the Survey Process

- Entrance
- Surveyor preference and suggestions
- When differences arise
  - "Help me understand…"
  - Reaching out for assistance
- Behind the scenes
- Copies of everything they take copies of
- Daily debriefings
- Exit



After the Survey

- Debrief & compare notes
- Celebrate
- Communicate results to staff
- Start correcting any deficiencies
  - Don't wait until deficiency statement is received
- Prepare for writing and implementing a plan of correction

Actions of the Prudent Hospice

1. Familiarize yourself with the State Operations Manual and use the probes
2. Ensure you can your produce all the documents completely and timely
3. Use your clinical record audits results and QAPI program to improve comprehensive assessments and care planning
4. Conduct a review of personnel files for competency and licensure
5. Implement (and practice) a plan for when the surveyors arrive

To Contact Us

Susan Balfour
919-491-0699
Susan@HospiceFundamentals.com

Roseanne Berry
480-650-5604
Roseanne@HospiceFundamentals.com

Charlene Ross
602-740-0783
Charlene@HospiceFundamentals.com

The information enclosed was current at the time it was presented. This presentation is intended to serve as a tool to assist providers and is not intended to grant rights or impose obligations.

Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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Sample Work Plan: Care Planning

	Task	When	Who	Comments
20% of Admissions	**Plan of care identified the patient/ family 's immediate needs during the initial assessment**	January & July	Compliance	Review records from each admission nurse.
	The initial plan of care was developed before services were provided			
20% of Current Patients	**Plan of care is reviewed/revised as frequently as the patient's condition requires but no less frequently than every 15 calendar days** **Care is provided according to the plan of care** **Visit frequencies for each discipline correspond to frequencies on the plan of care**	February & August	Compliance/Clinical Ops	Review records from each team.
	Supervisory visits of hospice aides documented at least every 14 days.	March & September	Compliance	Review records from each team.

Clinical Audit Tool-Example

Date: _____ Review Dates: _____ DX: _____

Patient: _____ MR# _____ Election Date: _____ ❒Home ❒ALF ❒NF ❒GIP

Component		*Comments*	
	Initial and Comprehensive Assessment		
1.	The hospice identified the patient/ family's immediate needs during the initial assessment	❒Yes ❒ No	
2.	During the hospice admission patient was screened for pain	❒Yes ❒ No	
3.	If pain is identified, the plan of care addresses the management of pain	❒Yes ❒ No ❒NA	
4.	If the POC addresses pain, there is desired level for pain in the goal	❒Yes ❒ No ❒NA	
5.	On admission, was patient screened for dyspnea	❒Yes ❒ No	
6.	If patient screened positive for dyspnea on admission, the plan of care addresses the management of dyspnea	❒Yes ❒ No ❒NA	
7.	If the POC addresses dyspnea, there is desired level for pain in the goal	❒Yes ❒ No ❒NA	
8.	RN comprehensive assessment is completed as frequently as the condition of the patient requires but no less than q 15 day	❒Yes ❒ No	
9.	Evidence that SW participates in comprehensive assessment updates as frequently as the condition of the patient requires but no less frequently than every 15 days.	❒Yes ❒ No ❒NA	
10.	Evidence that chaplain participates in comprehensive assessment updates as frequently as the condition of the patient requires but no less frequently than every 15 days.	❒Yes ❒ No ❒NA	

	IDG, care planning and coordination of services		
11.	Plan of care established by IDG on day of admission	❒Yes ❒ No ❒NA	
12.	Plan of care is reviewed/revised as frequently as the patient's condition requires but no < q 15 calendar days	❒Yes ❒ No ❒NA	
13.	Each visit to a patient in a facility includes documentation of coordination with facility	❒Yes ❒ No ❒NA	
14.	HA supervisory visits every 14 days	❒Yes ❒ No ❒NA	
15.	Drug Profile contains all current medications	❒Yes ❒ No	
16.	Visit frequencies of nurse correspond to those found on the Plan of Care	❒Yes ❒ No	
17.	Visit frequencies of the Social Worker correspond to those found on Plan of Care	❒Yes ❒ No ❒NA	
18.	Visit frequencies of the chaplain correspond to those found on Plan of Care	❒Yes ❒ No ❒NA	
19.	Visit frequencies of the HA correspond to those found on HA Assignment /Plan of Care.	❒Yes ❒ No ❒NA	
20.	Visit frequencies of the Volunteer correspond to those found on the Plan of Care.	❒Yes ❒ No ❒NA	

This is a sample and does not constitute what may be best for your hospice program or your documentation system. It is simply intended to provide an idea of what a tool might include.