

Getting Back in Gear for Hospice Surveys!

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GLAD YOU'RE HERE!

HOSPICE FUNDAMENTALS

Objectives

	At the conclusion of this session, learners will be able to:
Identify	Identify the rules used for hospice surveys
Discuss	Discuss the survey process, including what should be included in a self assessment
Develop	Develop a Survey Readiness Binder, based on the tools provided

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CMS Oversight

State Surveyors and Accrediting Organizations

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Who Holds the Rules: Survey

- Center for Medicare and Medicaid Services (CMS)
- **Conditions of Participation (COPs) with interpretive guidelines for surveyors**
- Focus on Quality of Care- applicable to ALL patients for ALL payers

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf



COMING SOON: Updated Survey Process

- CMS has announced they are updating the survey process
- COPs are not changing, but focus of survey is being redefined
 - 418.52- Patient Rights
 - 418.54- Initial and Comprehensive Assessment
 - 418.56- IDG, Care Planning and Coordination of Services
 - 418.58- QAPI



PHE and Survey...

- Like many things in our lives during this PHE- surveys were put on hold
 - Resumed in August 2020
 - Some states still holding
 - Accrediting organizations also resumed
 - Emphasis on agencies who had infection control citations in last three years



Routine Survey Preparation

- We have the test questions!
- Surveyors use the Interpretive Guidelines for the Conditions of Participation and standards of care
- Surveys include: Initial, Recertification (3 years), Revisit (if a Condition is cited upon initial or recertification), Complaint survey
 - Rules are all the same

Survey Strategy

- All surveys have a similar structure to expect:
 - Task 1 Pre-Survey Preparation;
 - Task 2 Entrance Interview;
 - Task 3 Information Gathering;
 - Task 4 Information Analysis;
 - Task 5 Exit Conference, and
 - Task 6 Formation of the Statement of Deficiencies.

Entrance Interview

- Request a meeting with appropriate staff based on the organizational characteristics of the hospice. Request a copy of the organizational chart;
- Inform the administrator or designee of the purpose of the survey;
- Ask the administrator or designee to explain the organization, services provided (directly and under arrangement) and the relationship to any corporate structure;
- Explain the survey process, and estimate the number of days onsite;
- Be aware that the unannounced survey may be disruptive to the normal daily activities of the hospice;
- Discuss the extent to which hospice staff may be involved during the survey;
- Set up the schedule for any necessary interviews with key staff (e.g., medical director, spiritual or pastoral counselor, bereavement counselor, volunteer supervisor, social worker, RN coordinator, etc.);
- Request that the hospice complete the Form CMS-417, Hospice Request for Certification in the Medicare Program (Exhibit 72) and return it to you as soon as possible, but no later than within 24 hours of the entrance conference.

Entrance Interview (part 2)

- Verification of addresses of all locations and/or short term inpatient facilities used by the hospice (either directly or under arrangements);
- Access to clinical records and the equipment necessary to read any clinical records maintained electronically. The hospice must also produce a paper copy of the record, if requested by the surveyor;
- Information given to the patient on admission to hospice;
- Documentation of hospice aide training and/or competency evaluations and in-service training;
- Information concerning services not provided directly;
- Names of key staff (e.g., RN coordinator(s) for IDG(s), and persons most knowledgeable about the hospice aides, homemakers, volunteers, infection control, quality assessment and performance improvement (QAPI), in-service training, clinical supervision, bereavement);
- Clinical staff person who will be the primary resource responding to the surveyor's questions;
- Documentation of grievances/complaints that the hospice received during the past 12 months;

Entrance Reports to Run

- Number of unduplicated admissions for the entire hospice during the recent 12 month period, including Medicare/Medicaid and private pay patients;
- Number of current patients who are receiving hospice care at home, in an inpatient facility, SNF/NF, ICF/IID or other facility;
- List or access to names of patients scheduled for a home visit during the survey;
- Access to all active patient names (Medicare/Medicaid/private pay) receiving hospice services that identifies the election date, diagnosis, and date the initial and comprehensive assessment was completed. This will aid in selecting the sample for home visits and record reviews;
- Access to bereavement records for expired patients who received services during the last 12 months;
- List of current employees and volunteers, including name and title;
- List of contracts as applicable (e.g., SNF/NF, DME, Pharmacy, Inpatient facilities);

Patient Care

- Is there evidence during the survey that:
- The hospice promotes and protects the rights of its patients.
 - The hospice interdisciplinary group (IDG) gathers the appropriate patient/family information needed to perform accurate comprehensive assessments and necessary updates to the assessment.
 - The IDG works together to develop and update the individualized plan of care for each patient, based on the assessments, to meet the identified patient/family needs and goals. (During the survey, it is helpful to attend at least a part of the scheduled IDG reviews of the patients' plans of care, if possible.)
 - The hospice involves the patient and/or family in developing the plan of care. (Interviews with staff, patients and family can be helpful in determining how the hospice involves patient/families in developing the plan of care.)
 - All members of the IDG and all relevant patient care providers (e.g., hospice aide, volunteer etc.,) share current relevant information regarding each patient/family's status.

Patient Care

- The hospice provides education to the patient/family about the patient's disease process, the palliation and management of the patient's symptoms, the safe and effective use of medication and medical equipment used by the patient, and the physical, psychosocial and spiritual aspects of the dying process.
- All personnel are qualified and furnish services to the patient in accordance with accepted professional standards of practice.
- The hospice assures that hospice aides are competent to provide care to their patients and supervised by a registered nurse.
- The hospice's infection control program protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.
- The hospice develops, implements, and maintains an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement (QAPI) program.



Organizational Environment

Is there evidence during the survey that:

- The governing body ensures the hospice has an ongoing program to promote quality assessment and performance improvement;
- The hospice administrator assumes full responsibility for the day-to-day operations of the hospice;
- The hospice understands the principles surrounding quality assessment and implements effective ongoing performance improvement projects utilizing data collected;
- When the hospice identifies trends that indicate potential or actual problems, it takes follow up actions to resolve the issue(s);
- The hospice provides care that optimizes the patient's comfort and dignity and is consistent with the patient and family needs and goals;



Organizational Environment

- The hospice assumes overall professional management responsibility for all services provided directly and under arrangement;
- Nursing services, physician services, drugs and biologicals are routinely available on a 24-hour basis, 7 days a week. Other covered services are available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family;
- The on call system is operational on a 24 hour basis so that patients can contact the hospice as necessary;
- Drugs, treatments and medical supplies are provided as needed for the palliation and management of the terminal illness and related conditions, and
- The hospice makes arrangements for any necessary inpatient care according to §418.108, and retains professional management responsibility for services furnished by inpatient facility staff.



Clinical Record Review

- Based on the 12-month unduplicated census (admissions)

Unduplicated Admissions	Min # Of Record Reviews Without Home Visit	Min # Of Record Reviews With Home Visit	Total Record Reviews
< 150	8	3	11
150-750	10	3	13
751-1250	12	4	16
1251 or more	15	5	20

How to Choose

- Choose a variety of length of stay, diagnoses and reasons for discharge
- Review the bereavement for deceased

Does the Clinical Record Show...

- Determine if the patient's **comprehensive assessment** and updates to the assessment were **timely and accurately** reflect the patient/family's status.
- Review the **plan of care** to identify whether the **IDG used** the comprehensive **assessment** and assessment updates to make sound **care planning decisions** appropriate to the patient/family needs.
- Determine if the plan of care is current and **reflects the participation of all members of the IDG**.
- Evaluate the hospice's ability to **coordinate care** and services that optimize patient comfort and dignity.
- Review a sample of clinical notations by all personnel providing services. Determine if the plan of care and **frequency of visits** by hospice personnel **support the findings of the comprehensive assessment** and updates to the assessment. **Did the agency's interventions follow the plan of care?** Was the documentation specific to changes in the patient/family's status?
- Determine how the hospice ensures **coordination of services among and between the IDG members and other personnel providing services**. What evidence is found in the clinical record(s) that this is occurring?
- Determine if hospice aide clinical notes document the status of the patient. **Do the hospice aides report changes in the patient's condition to a registered nurse?**

Home Visits- Surveyor Questions

- Who comes to see you from the hospice?
- How frequently do you receive care and services?
- Has the nurse talked with you about treating your pain and/or other uncomfortable symptoms?
- Have there been any instances where the hospice failed to respond to the patient's request for pain medication or symptom management?
- Have you ever had to wait long to get medication for discomfort? If yes, how long was the wait?

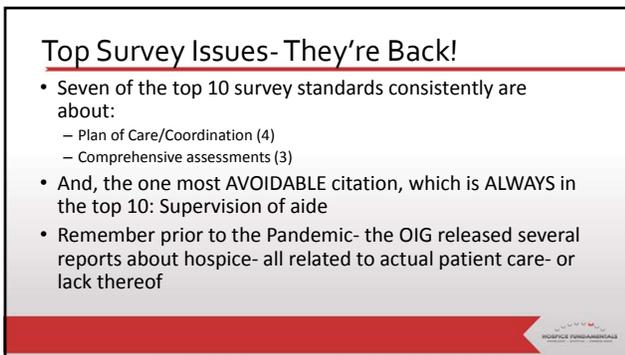
Home Visits

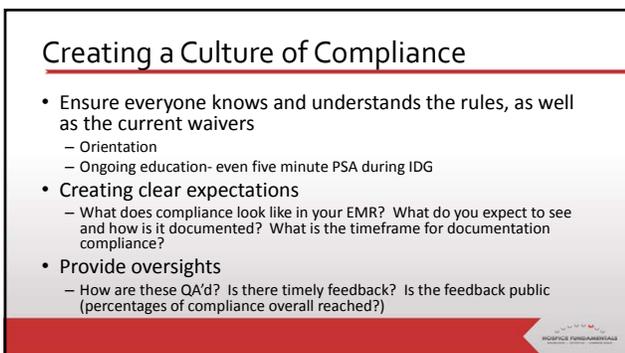
- Has someone from the hospice given you a chance to talk about your religious or spiritual beliefs or concerns?
- Have you ever needed to call the hospice on weekends, evenings, nights, or holidays? What was your experience with this?
- Have you received care in any other setting while under hospice care? If so, what was your experience?
- Since you have been receiving care from the hospice, have you had any out-of-pocket expenses for your health care? If yes, what kind?
- How satisfied are you with the services provided? Do you have any suggestions for improvement?
- Would you recommend this hospice?

Creating a Mock Survey

- Use the Entrance Interview questions to practice how a survey will be performed
- Ensure all documents and reports can be provided
- Gather known information in the Survey Manual, using the Table of Contents provided
- Know during the PHE a strong emphasis will be on the infection control and surveillance strategies







Why are we talking about this?

2019

- Plan of Care -- L543
- Drug Profile—L530
- Supervision of Hospice Aides—L629
- Timeframe for Completion of Comprehensive Assessment—L523
- Content of Plan of Care— L545, L547
- Level of Volunteer Activity—L547
- Coordination of Services—L555
- Infection Prevention—L579
- Bereavement—L531



What's the Problem?

- Not delivering care according to the plan of care
- Not having orders for items on the plan of care
- Not including the required individuals in development of the plan of care
- Not incorporating updated comprehensive assessment information into the plan of care/not individualizing this information



The 2019 OIG Report

- The OIG has concluded that the way hospices operate poses a risk to hospice patients, and they want CMS to take steps to protect patients and families from harm
 - Patient assessment does not include key information
 - Not following the Plan of Care
 - Poor coordination of care
 - Not delivering services on the Plan of Care
 - Not responding appropriately to issues identified on the Plan of Care



418.54 Comprehensive Assessment

- Completion no later than 5 calendar days
- All members participate to provide a 360 view
- E mail, faxing, and phone calls are fine
- Consider the information gathered and decide on a plan, and who should visit



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418.54 Comprehensive Assessment

- Screen for: pain, dyspnea, nausea, vomiting, anxiety, constipation etc. Also emotional distress, spiritual needs, family counseling and education, support/concrete needs
- Consider: "Why hospice, Why now?", Risk factors, imminence of death, symptom severity, bereavement and referrals

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Drug Regimen Review- with All Comp Assessments

- Does your EMR support each of these findings?
- §418.54(c)(6) - Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:
 - (i) Effectiveness of drug therapy
 - (ii) Drug side effects
 - (iii) Actual or potential drug interactions
 - (iv) Duplicate drug therapy
 - (v) Drug therapy currently associated with laboratory monitoring.

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Take it to the IDG!

- §418.56(a)(1) - The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:
- (i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).
- (ii) A registered nurse.
- (iii) A social worker.
- (iv) A pastoral or other counselor.

418.56 Through the Lens of IDG

- The IDG members have unique experiences with the patient/family
- Bring different focus
- Have different skills
- Complete the 360 degree view of the patient/family

418.56 Survey Instructions

- Interpretive Guidelines §418.56(a)(1)(i)-(iv) The number of individuals on the IDG is not as important as their qualifications and abilities. For example, if a group member meets the hospice criteria and is licensed as a registered nurse and also meets the Medicare criteria to be considered a social worker under the hospice benefit, he/she would be qualified to serve on the IDG as both a nurse and a social worker.
- Determine through interview, observation and record review that all disciplines comprising the IDG contribute to the patient's comprehensive and ongoing assessments and care planning process.

COPs During a PHE

How Does this Change a Survey?

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Hospice FTF Flexibilities

- o Amending the regulations at § 418.22(a)(4) on an interim basis to allow the use of telecommunications technology by the hospice physician or NP for the face-to-face visit when such visit is solely for the purpose of recertifying a patient for hospice services during the PHE for the COVID-19 pandemic.
- o If FTF is only for administrative need for certification, this is not billable (no change here!)
- o If the FTF (or any additional physician visits) are medically necessary, the hospice can bill for these visits on their hospice claim, as long as the visits were with both audio and video.

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Updated §418.22- Certification of Terminal Illness

During a Public Health Emergency, as defined in § 400.200 of this chapter, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, **such encounter may occur via a telecommunications technology** and is considered an administrative expense.

Telecommunications technology means the use of interactive multimedia communications equipment that includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner.

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Comprehensive Assessment Timeframes

The timeframes for updating the assessment may be extended from 15 to 21 days (\$418.54)
Best case scenario- the hospice RN can see the patient at least every 21 days to do a full comprehensive assessment

- o If not? In this emergency- again- do the best you can.



Telehealth Use Expanded

CMS expanded use of Telehealth for hospice team member visits

Temporary and retroactive (March 1, 2020) use of Telehealth for the hospice routine level of care as virtual visits. This can be audio and audio-video; if it is feasible and appropriate to do so.

Only in-person visits will be submitted on the hospice claim (with exception of MSW as allowed previously)



CMS Example

A terminally ill 85-year-old male with heart failure has been receiving hospice services and recently developed a fever, sore throat and cough. The patient has been diagnosed with suspected COVID-19 and his hospice plan of care now includes medications for symptom management. He is mildly short of breath but does not require supportive oxygen therapy. The patient's wife is concerned about potential for worsening cardiac and respiratory symptoms as a result of the patient's risk for increased complications due to COVID-19. **The hospice plan of care has been updated to include remote patient monitoring with a telecommunications system to assess the patient's daily weight and oxygen saturation levels.** The plan of care identifies the **measurable goal** that the patient will maintain an oxygen level above 92 percent and the patient will not gain more than 2 pounds in a 24-hour period. The plan of care identifies interventions if either of these goals are not met. **The remote patient monitoring allows for more expedited modifications** to the plan of care in response to the patient's changing needs.



How Are You Applying This?

At IDG, review care and determine the need to alter the POC to include telehealth and/or remote monitoring

- o Patients who are refusing visits at this time, or the facility in which they live is refusing access to patients
 - o Patients whose symptoms are controlled and some or all of their currently planned visits may be feasibly completed remotely
 - Update the plan to distinguish in-person visits and remote encounters in POC
 - Update goals to include goals for the remote encounters
- Identify where you will document these remote encounters so they are not identified on the claim
- o Could use "visit notes" if you have a way to make them "non-billable"
 - o Could use coordination of care note, etc



Other Flexibilities



Non-Core Services and Volunteers

Waive Non-Core Services: CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements at 42 CFR §418.72 for physical therapy, occupational therapy, and speech-language pathology.

Volunteers: CMS is waiving the requirement at §418.78(e) that hospices are required to use volunteers (including at least 5% of patient care hours). It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and potential quarantine.



Supervisory Visits May Be Remote

CMS is waiving the requirement for in-person/on-site supervision of hospice aides (42 CFR §418.76(h))

Supervision should be done remotely by phone and/or video

Document how supervision occurred and ensure the components of the supervisory visit standard are still answered

In accordance with section 1135(b)(5) of the CARES Act, postponed onsite supervisory visits are required to be completed by the RN no later than **60 days after the expiration of the public health emergency.**



Annual Training

42 CFR §418.100(g)(3) which requires hospice agencies to annually assess skills and competency of all individuals furnishing care and provide in-service training and education programs.

This requirement has been postponed until the **end of the first full quarter after** the declaration of the public health emergency ends



Aide Competency Training

Temporary modification to §418.76(c)(1) which requires the aide to be observed performing certain tasks on an actual patient.

The hospice aide may now be observed using a pseudo patient using role-play situations or on a computer-based device.



QAPI (Quality Assurance and Performance Improvement)

42 CFR §418.58 was modified to more align with the current state of emergency.

QAPI activities are still required of hospice agencies BUT instead of focusing on the overall hospice wide approach, CMS wants agencies to focus more on infection control issues and adverse events. This refers specifically to sections of the CoP §418.58(a)-(d)

This allows the hospice to have more of a focused effort on care delivery with COVID-19.



2022 Proposed Rule COP Change

- Permit use of pseudo-patient for aide training and evaluation
 - – Define **“Pseudo-patient”**: a person trained to participate in a role-play situation or a computer-based mannequin device. A pseudo-patient must be capable of responding to and interacting with the hospice aide trainee, and must demonstrate the general characteristics of the primary patient population served by the hospice in key areas such as age, frailty, functional status, cognitive status and care goals.



2022 Proposed Rule COP Change

- Permit use of pseudo-patient for aide training and evaluation
 - – Define **“Simulation”**: a training and assessment technique that mimics the reality of the homecare environment, including environmental distractions and constraints that evoke or replicate substantial aspects of the real world in a fully interactive fashion, in order to teach and assess proficiency in performing skills, and to promote decision making and critical thinking.



2022 Proposed Rule COP Change

- Hospice Aide Training and Evaluation – Targeting Correction of Deficiencies
 - – If area of concern verified during on-site RN supervisory visit, the required competency evaluation may focus on specific deficiencies of aide rather than requiring a full competency evaluation



Infection Control Survey Issues



Pandemic's NOT Over- & Neither Are the Surveys

- CMS issued updated Survey guidance for Infection Control at beginning of 2021
- <https://www.cms.gov/files/document/gso-21-08-nltc.pdf>
- Checklist provides step by step self-check!



Use of PPE is appropriate	
• Gloves are worn if potential contact with potentially contaminated skin or equipment	Y N
• Gloves are removed following contact with potentially contaminated skin or equipment	Y N
• Gloves are changed & hand hygiene performed in moving from contaminated to clean site	Y N
• Isolation gown is worn for direct patient contact if the patient has uncontained secretions	Y N
• Appropriate mouth, nose and eye protection along with gowns are worn for patient care activities likely to involve splashes or sprays of bodily fluids/secretions	Y N
• Unless additional source control is needed, facemasks are worn by all staff	Y N
• Extended/reuse of PPE is according to national/local guidelines	Y N
• Reused PPE is appropriately cleaned/stored/maintained after and/or between uses	Y N
Aerosol-Generating Procedures	
• Appropriate mask (N95 or higher) is worn, as well as gloves, clothing, eye protection	Y N
• Procedures likely to induce coughing - N95 or higher respirator, eye protection, gloves, and a gown are worn	Y N
• Limit number of people in the room	Y N
• Conduct in private room with door closed	Y N
• Procedure surfaces are disinfected promptly with EPA-registered disinfectant	Y N
Education	
• Have patients/family been educated on mitigating transmission of COVID-19	Y N
• Agency has educated staff on SARS-CoV-2 and COVID-19 (symptoms, transmission, screening criteria, work exclusions)	Y N

Intentional Focus for Staff and Patient Safety	
1. Hand hygiene	
2. Use of PPE per current CDC guidelines- and plans if lack of PPE	
3. Transmission-Based Precautions	
4. Patient care (including patient placement);	
5. Infection prevention and control standards, policies and procedures (hand hygiene, PPE, cleaning and disinfection, surveillance);	
6. Visitor entry (i.e., screening, restriction, and education);	
7. Education, monitoring, and screening of staff; and	
8. Emergency preparedness – staffing in emergencies	

So... Let's Talk.	
How are you monitoring your team for s/s of COVID each day?	
What options do we have when our team gets ill and we have very few nurses to begin with?	
How are you documenting your patient screen for COVID?	
What options do we have for IDT?	
How are you reducing the risk of exposure for the patient, and the team?	
<ul style="list-style-type: none"> o Reduce frequencies? Reduce the number of team disciplines? For all, or case by case? 	
What are we doing in the instances where the patient or facility are turning our visits away?	

Actions of the Prudent Hospice™

- Know the "Hot-Topics"- What is survey looking at what and why?
Infection Control
POCs
Assessments
- Know your own risks by performing routine reviews using tools provided
- Know the COPS and the Interpretive Guidelines
Hospice IGs



To Contact Us



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