FYI:

OIG Report Part 2: Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm

HOSPICE FUNDAMENTALS SUBSCRIBER EMAILS -- August 2019

The Least You Need to Know: *This report describes 12 specific instances of harm to hospice beneficiaries, which the OIG says reveal vulnerabilities in CMS's efforts to prevent and address harm to hospice patients. The OIG makes five recommendations to strengthen safeguards that would better protect patients and families. This is the second part of a two-part series released this month by the OIG. See Hospice Fundamentals FYI 19.11 for a summary of Part 1, which focuses on quality of care and widespread survey deficiencies.*

Additional Information:

The findings in the OIG Report are based on a 2016 sample of 12 cases of harm to hospice patients, from 12 different hospices. These cases were selected because of their severity. The survey reports for these 12 were reviewed in order to identify vulnerabilities in CMS's efforts to prevent and address harm – vulnerabilities that may have implications for the wider hospice population. The OIG also determined whether or not the surveyor cited the hospice for immediate jeopardy, and whether the harm was identified through a standard survey, or through a complaint.

The 12 Cases

The twelve cases reflect poor care that caused unnecessary suffering and sometimes prompted the patient to revoke in an effort to get proper care:

1. A patient with Alzheimer's disease developed pressure ulcers, which became gangrenous and later required amputation.

2. A patient was transferred to the hospital for treatment of maggots which were found at the site of his feeding tube.

3. The initial plan of care for one patient specified respiratory therapy one to three times a month. He received no respiratory therapy and his respiratory symptoms increased.

4. The hospice failed to recognize signs of possible sexual assault. Hospital staff later notified police.

5. A hospice social worker identified caregiver burnout, but the plan of care for the patient was not changed, and respite care was not provided. The caregiver had been abusing and neglecting the patient, and there was no intervention for harm to this patient by his caregiver.

CMS and Nursing Homes

In contrast to limitations in holding hospices accountable, CMS has precedent with strong safeguards to protect patients in skilled nursing facilities (SNFs):

- SNFs must report all alleged violations—not just those that are verified-- involving abuse, neglect, exploitation or mistreatment immediately to officials, including CMS.

- SNF surveyors are required to report to law enforcement all substantiated findings of abuse.

- CMS has a range of enforcement tools available for SNFs that do not comply with Medicare guidelines, including civil monetary penalties, denial of new payments or temporary management.

- SNFs are required to have policies and procedures for investigating and reporting suspicions of abuse or neglect.

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6. A hospice social worker did not visit a patient for several weeks after being notified of signs of abuse, and the hospice did not intervene with the abuse of the patient by her daughter.

7. A hospice did not address theft of a patient's medications by an impaired neighbor, despite being aware of the situation.

8. A hospice did not properly record, investigate or address a grievance from a family over poor pain control.

9. A hospice failed to provide essential pain management to an ALF patient, resulting in her being sent to the hospital emergency department for relief .

10. A hospice did not provide care to a patient who was vomiting blood; he was told he could revoke and go to the emergency room.

11. A hospice did not provide wound care for a Stage IV wound for two years.

12. A patient suffered a broken femur after being dropped by an improperly trained hospice aide.

Check the archives for July 2019 webinar *"Involving the While Team for Excellence"* for information on social worker and chaplain accountability in care planning and interdisciplinary communication.

Vulnerabilities

Apart from the distressing nature of these incidents, the OIG is concerned with the following larger issues that limit the protection of hospice patients:

• **CMS requires hospices to report abuse, neglect and other harm only when it involves someone furnishing services on behalf of the hospice, and the hospice has investigated and verified the allegation is true.** Only one of the 12 cases cited in the report was reported to CMS by the hospice.

• **Surveyors are not required to report crimes to law enforcement.** The only guidance has been that in cases of immediate jeopardy, the surveyor must notify local law enforcement only if the hospice does not do so. In March 2019, even this guidance was removed, though CMS states that it was removed in error.

• **Patients and families have just two avenues for complaints: complain to the hospice or complain to the State.** Hospices are not required to provide information to families about how to file a grievance. The guidance for consumers on Hospice Compare about how to file a complaint directs consumers back the hospice's "patient advocate" (a position hospices are not even required to have), and is otherwise difficult to follow.

Link to the Hospice Compare Complaint guidance here: https://www.medicare.gov/hospicecompare/#about/contacts.

Further, hospices do not always handle grievances properly, and families often don't understand how to make complaints. In the 12 cases, only 7 were discovered as a result of a complaint. The rest were uncovered

Immediate Jeopardy

As explained in FYI 19.11 Part 1, surveyors can cite a hospice that fails to meet a requirement with either a standard or condition-level deficiency. The hospice must respond with a plan of correction explaining how each will be addressed, and how the problems will remain corrected.

Immediate Jeopardy is where noncompliance with one or more Conditions of Participation (CoPs) has placed the health and safety of patients at risk for serious injury, harm, impairment or death. Once this is identified by a surveyor, the hospice must take immediate action to prevent the situation from recurring.

CMS considers immediate jeopardy the most severe and egregious threat, and it carries the most serious sanctions for many providers. It carries no sanctions for hospice providers.

Vulnerabilities, *cont'd*

• **Hospices responsible for harming beneficiaries are not always held accountable in a meaningful way.** None of the 12 cases in the OIG report resulted in serious consequences for the hospice.

• **Surveyors do not always cite immediate jeopardy;** in the 12 cases in the report, immediate jeopardy was cited only 5 times.

• **Plans of correction are limited, in that they address the specific circumstance, but not the broader concerns of structural or administrative issues.** The plans of correction did not include disciplinary action for the employees responsible.

• **Other than termination from the Medicare program, CMS has no intermediate fines or other penalties available to hold hospices accountable for harm.** Termination from Medicare can only occur when the hospice fails to comply with the survey or plan of correction process.

OIG Recommendations to CMS:

The OIG has previously recommended that CMS seek authority to establish additional, intermediate remedies for poor hospice performance, and they reiterate that in this report. The OIG makes five additional recommendations to CMS:

1. **Strengthen the hospice Condition of Participation related to the reporting of abuse, neglect and other harm.** This would include a requirement for written policies and procedures for investigating and reporting suspected abuse and neglect, and require training for employees regarding identifying and reporting signs of abuse, neglect and other harm.

2. **CMS should provide hospices with educational materials and other information** about recognizing abuse, neglect and other harm, to help hospices train their employees.

3. **Strengthen guidance to surveyors** to ensure that surveyors and State agencies are required to always contact local law enforcement if they suspect a crime has been committed.

4. **Monitor surveyors use of immediate jeopardy and ensure it is being used appropriately.** If it is not being used appropriately, CMS should consider adding a hospice-specific subpart to its guidance to clarify what constitutes immediate jeopardy.

5. **Improve the process for making complaints, and make it more accessible to beneficiaries and caregivers.** This could include an online, centralized complaint form. Also, make the State agency's phone number more easily available than it is now, and work with hospices to provide information to consumers about making complaints. The OIG also recommends that CMS include information about making complaints in its own education materials about hospice.

CMS concurred with the first four of these recommendations, and partially concurred with the fifth, citing regulatory and resource constraints.

Actions of a Prudent Hospice™

ONE. Interview or survey your employees to evaluate their competence and comfort with escalating concerns about the care of your patients or conditions in the home that might indicate risk of abuse, neglect or other harm.

TWO. Review your agency's policies, procedures and staff training regarding abuse and neglect. Remedy deficits that could compromise appropriate identification, communication and action to prevent harm to patients and families.

THREE. Train staff, audit charts and observe IDT meetings to evaluate the integrity of the assessment and care planning process, and interdisciplinary team communication.

FOUR. Review the information your hospice provides to patients and families regarding filing grievances and voicing concerns. Revise as necessary to ensure that it is user-friendly and easily understood.

FIVE. Ensure that you have a definition of what constitutes a complaint in your hospice and that your staff understand their responsibility to report.

SIX. Review your hospice's process for receiving, responding to, addressing and resolving complaints. Is the process easy for staff to follow? Remedy any deficits that could result in delays in correcting care deficits or other service issues that cause harm, prolong suffering or otherwise adversely affect the patient and family experience.

Link to Other Material:

The Complete Report
https://oig.hhs.gov/oei/reports/oei-02-17-00021.asp?utm_source=homepage&utm_medium=web&utm_campaign=OEI-02-17-00021

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