Will YOU be ready when the surveyors come knocking?

Cheryl Pacella DNP(c), HHCNS-BC, CPHQ
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At the end of this session, the learner will:
1. Describe the survey process and the specific tasks that encompass a survey
2. Describe how to review patient charts to assure compliance with the CoPs
3. Verbalize the penalties for non-compliance
Why is this important?

- You never know when the surveyor will show up
- Several agencies reporting that surveyors are arriving ~3 months ahead of the anniversary of their last triennial visit
- Preparation takes planning
- Quality must become routine
- Will your agency be ready?
Where do you start?

- Chart audits
- Joint visits
- Review policies and procedures
- Review admission process all the way from referral through to final claim
- CASPER reports
- Personnel records
Audit Tools

- Chart review
- Supervisory visit
- Potentially avoidable events

* Mock survey tool
* G Tags Master
* Exhibit 285
* Form CMS-2567

Benefits of this presentation

- Understand the survey process and any recent updates
- Describe possible sanctions
- Learn how to identify any medical record documentation deficiencies
- Effectively prepare charts and staff for survey
- Develop a suitable corrective action plan
Agenda

- Conditions of Participation (CoPs)
  - Top survey issues in the CoPs
- The survey process
  - Level 1 and Level 2 deficiencies
- Sanctions
- Agency preparedness
- Corrective Action Plan
Most current guidance


* Updates were posted on March 14, 2014
* Effective July 2014
So what’s changed?

- State Operations Manual (SOM) Chapter 2
  - Detailed informations about branches
  - Policies related to OASIS data transmission
  - Change of ownership
  - Deactivation of billing privileges
- Addition of Chapter 9
  - Imposing sanctions
  - Informal dispute resolution
- Appendix B: Guidance to Surveyors
Review of the Basics

* Enacted in 1965 as an addition to Social Security
  * Lyndon Baines Johnson was President
  * Former President, Harry Truman, was the recipient of the first Medicare card
* Part A covers hospitals, skilled nursing facilities and home health
* Part B covers physician visits and out-patient services
Conditions of Participation

- Commonly referred to as the “CoPs”
- § 42 CFR Part 484
- Originally developed in 1965 to offer guidance to home health agencies
- Proposed Rule in 1997 & Revisions to incorporate comprehensive assessment and OASIS in 1999
- SOM Updated in 2011 and 2014
More about the CoPs

- Subpart A: General Provisions
  - Basis & scope
  - Definitions
  - Personnel qualifications
More about the CoPs

- **Subpart B: Administration**
  - Patient rights
  - Release of patient identifiable OASIS information
  - Compliance with Federal, State & Local laws
  - Organization, services and administration
  - Group of professional personnel
  - Acceptance of patients, plan of care, and medical supervision
  - Reporting OASIS information
More about the CoPs

* Subpart C: Furnishing of Services
  * Skilled nursing services
  * Therapy services
  * Medical social services
  * Home health aide services
  * Clinical records
  * Evaluation of the agency’s program
  * Comprehensive assessment of patients

* Subpart D: Currently “Reserved”
More about the CoPs

- Subpart E: Prospective Payment System for Home Health Agencies
  - Basis and scope
  - Definitions
  - Basis of payment
  - Data used for the calculation of the national prospective 60-day episode payment
  - Initial establishment of the calculation of the national 60-day episode payment
Subpart E continued

- Calculation of the adjusted national prospective 60-day episode payment rate for case-mix and are wage levels
- Annual update of the unadjusted national prospective 60-day episode payment rate
- Methodology used for the calculation of the low-utilization payment adjustment
- Methodology used for the calculation of the partial episode payment adjustment
Subpart E continued

- Methodology used for the calculation of the outlier payment
- Accelerated payments for home health Agencies
- Patient assessment data
- Limitation on review
- Additional payment
Top 10 Home Health Survey Deficiencies in 2012

* G158 – Written Plan of Care established & periodically reviewed
* G159 – Plan of Care covers diagnosis, required services, visits, etc.
* G236 – Record with past/current findings maintained for all patients
* G337 – Assessment includes review of all medications
* G121 – Compliance with accepted professional standards/principles
Top 10 Home Health Survey Deficiencies in 2012

* G229 – Supervisory visits if skilled care no less than once every 2 weeks
* G143 – Coordination of Patient Services
* G170 – Skilled Nursing Services furnished in accordance with Plan of Care
* G176 – RN prepares notes, coordinates, informs MD, other staff of changes
* G165 – Drugs and treatment administered only as ordered by physician
History of the Survey Process

* Process revised in 2011 (announced in February and became effective in May)
  * Data-driven
  * Patient outcome-oriented
  * Less structure & process oriented
* Appendix B of the State Operations Manual
  * Part I includes information on the process
* Most agencies have now experienced the new survey process
Purpose

Survey and certification process:

* Provides a method for CMS to evaluate agencies’ compliance with the CoPs
* Ensure that provided patient services meet health and safety standards and a basic level of quality

Surveyors utilize Interpretive Guidelines to guide them in the process
Role of Surveyor

* Gather information during
  * Entrance interview
  * Patient and staff interviews
  * Home visit observations
  * Clinical Record reviews
* Utilize information available from reports (e.g. OASIS outcome data)
* One member of the survey team should be an RN with home health experience
Types of Surveys

* Initial Certification
  * Survey specific to new providers
  * Guidance available in Appendix B

* Standard Survey
  * Assess the quality of care and services provided
  * Assess compliance with the highest priority standards
  * Level 1 Standards that address 9 of 15 CoPs
Type of Surveys

- **Partial Extended Survey**
  - Conducted when there is a non-compliant finding found at Level 1
  - Utilizing Level 2 Standards

- **Extended Survey**
  - A review of ALL CoPs
  - At the discretion of CMS or the surveyor

- **Recertification Survey**
  - No later than 36 months from prior survey
  - Conducted similar to a Standard Survey
Level 1 Standards

* Highest priority
* Address 9 of the 15 CoPs
  * Patient rights
  * Compliance with laws
  * Organization, service and administration
  * Acceptance of patients, etc.
  * Skilled nursing, therapy and home health aide services
  * Clinical records
  * Comprehensive assessment of patients
Level 2 Standards

* Refer to G-Tag Master handout
* Same conditions as Level 1
* Level 1 are “highest” priority and Level 2 are “next highest” priority
* Different G-tags
* Refer to State Operations Manual for greater detail
Clinical Records

- **Level 1 G236**
  - A clinical record containing pertinent... findings... is maintained for every patient receiving home health services... a current, organized and clearly written synopsis of the patient’s course of tx...

- **Level 2 G239**
  - Clinical record information is safeguarded against loss or unauthorized use.
Patient Rights

- Level 1 G107
  - Participate in planning of care and treatment
- Level 2 G108
  - Advance notice of care & changes to plan of care
- Level 2 114
  - Oral & written notice
Survey Tasks

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

- Compliance with OASIS CoPs
- Reference Exhibit 285
- Tier 1 Potentially Avoidable Events
  - Emergent care for injury caused by fall
  - Emergent care for deterioration in wound
- Review patient outcomes in comparison to the national reference
- Error summary report
  - Inconsistent MO 90 (date assessment completed)
  - Inconsistent sequencing
Entrance Interview

Surveyor(s)

* Shows ID, establishes rapport and authority
* Requests overview of HHA structure, will ask for an organizational chart
* Will request a list of unduplicated patients, a list of current employees, and the names of key staff
* Ask for access to patients for home visits
Additional Questions

- Surveyor(s) will ask:
  - How complaints are handled
  - To review admission packet
  - How the agency monitors professional skills
  - Questions pertinent to staffing, including home health aide supervision
  - How referrals are handled, maintenance of records, process for OASIS submission
Information Gathering

* An organized, systematic and consistent process to assure agency’s compliance with CoPs
* Focus on chart reviews, home visits and staff interviews
* Concerns raised may lead to additional chart reviews and/or home visits
### What to Expect

<table>
<thead>
<tr>
<th>Number of Unduplicated Skilled Admissions During Recent 12 Months</th>
<th>Minimum Number of Record Reviews With Home Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 150</td>
<td>5</td>
</tr>
<tr>
<td>150 – 750</td>
<td>6</td>
</tr>
<tr>
<td>751 – 1250</td>
<td>8</td>
</tr>
<tr>
<td>1,251 or more</td>
<td>10</td>
</tr>
</tbody>
</table>
Information Analysis

* Surveyors review all the information gathered and make judgments related to compliance
* Analyze findings specific to:
  * Effect on patient care outcomes
  * Degree of severity
  * Frequency of occurrence
  * Impact on delivery of service
Exit Conference

* Purpose is to inform agency staff of observations and preliminary findings
* Should be no surprises due to on-going dialogue between the surveyors and staff
* Typically attended by the administrator, clinical managers and other invited staff
* Provides an opportunity for the surveyors to thank the staff and answer questions
Formation of the Statement of Deficiencies

- Deficiencies cited on Form CMS-2567
- Data tags are assigned to HHA conditions and standards in the interpretive guidelines
- Condition-level and standard-level tags
- “The HHA is out of compliance with...”
- “Expected outcomes are not met for...”
- Written in language that a reasonably knowledgeable person can understand
Level I Deficiencies

- Level 1 highest priority standards are those most related to the delivery of high-quality patient care.
- Non-compliance with a standard tag will lead to a deficiency (could result from one chart review or one home visit)
- Will prompt the surveyor to conduct a review of the Level 2 standards
Level II Deficiencies

- Survey moves to a partial extended survey
- At a minimum, the surveyor will examine the Level 2 standards under the same condition cited as being deficient at Level 1
- Deficiencies cited at this level will prompt an Extended Survey to review all CoPs
- Immediate jeopardy is a crisis situation jeopardizing patient safety
- CMS or the State may request an extended survey, based on findings of the surveyor
Chapter 9

* Sanctions apply to *Condition-level* deficiencies
* Imposition of civil money penalties (CMP)
* Directed in-service training
* Directed plan of correction
* Suspension of payment
* Temporary management
* Informal dispute resolution (IDR)
Informal Dispute Resolution

- Opportunity to refute one or more condition level deficiencies
- May settle disagreements prior to formal hearing
- An informal administrative process
- IDR process must be in writing
- Request for IDR must be submitted in writing
- May be a face-to-face meeting
  - Counsel may accompany the agency
informal dispute resolution

- Request for IDR will not delay enforcement actions
- CMS will verbally advise the agency of CMS’s decision followed by written confirmation
- Agencies can not challenge findings of previous surveys
- If the agency is successful during the process, the agency can request a new (clean) Form CMS-2567
“A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a patient(s).”

- CMS would immediately terminate provider agreement
- Alternative sanctions may also be imposed
Considerations R/T Sanctions

- Extent that deficiencies pose immediate jeopardy to patients
- Nature, degree, duration of non-compliance
- Agency’s compliance history, repeat deficiencies
- Failure to provide quality patient care
- Extent to which agency is part of a larger organization with performance problems
- Indication of system-wide failure to provide quality care
Civil Monetary Penalties

- 63% to the federal government and 37% to the state
- Imposed *regardless* of Immediate Jeopardy for failure to comply with one or more CoPs
- Lower range: $500 - $3,000 / day for first time deficiency
- Mid-range: $2,500 - $8,500 / day
- Upper range: $8,500 - $10,000 / day for IJ
Civil Monetary Penalties

* **Per instance**
  * Assessed for one or more singular events
  * $500 to $10,000 per instance

* **Per “day”**
  * Begin to accrue on the last day of the survey that identified non-compliance.
  * Continue to accrue until the agency achieves substantial compliance with all compliance or the date of termination
What you should do NOW

* Conduct and review the results of quarterly chart audits
* Review policies and procedures
  * OASIS transmission
  * OASIS correction
* Review CASPER reports
  * Conduct audits of potentially avoidable events
* Construct/revise organizational chart
The “Binder”

* Performance Improvement Initiatives
  * Plans of action
* Copies of most recent CASPER reports
* Information on infections
* Summary of patient complaints
* Summary of incident reports
* Summary of satisfaction surveys
Preparedness: Medical Records

- Prepare a record review tool that encompasses the critical elements examined during survey
- Refer to Appendix B for specific elements
- Conduct chart audits to assess compliance
  - Need to incorporate paper and electronic
  - Peer-review
  - Modify tool to address specific elements
Chart audits

Surveyors will look at

* The most recent plan of care, admitting diagnosis and goals
* Timeliness of initial visit ≤ 48 hours
* Complete comprehensive assessment
* Medications
* Case conferences
* Supervision of HHAs, LPNs, PTAs, COTAs
Potentially Avoidable Events

* Formerly known as “Adverse Events”
* Examples include:
  * Acute care hospitalization
  * Injury related to fall
  * Deterioration in wound
  * Hypo/Hyperglycemia
  * Development of UTI
* Keep record of chart audits
Preparedness: Staff

* Educate staff about policies and procedures
* Make sure that practice matches P & P’s
* Surveyor should be able to go out with any clinical staff member
* Conduct a “mock” survey well in advance of anticipated survey
* Utilize modules, newsletters
* Make education fun and interactive
Planning Joint Visits

* Strongly recommend accompanying surveyor on home visits with clinical staff
* Make sure patients know DPH hot line !!!
* Bag Technique
* Hand sanitization
* Storage of equipment
* Maintenance of equipment
Plan of Correction

* How the agency will correct each deficiency
* How the agency will protect patients in similar situations
* How the agency will assure that the deficiency will not re-occur
* How the agency will monitor performance
* Timeframe
* Who, what, when, where, why and how?
An acceptable Plan of Correction must include:

* Month, day and year each deficiency will be corrected
* Specific action to address deficient practice
* Process by which the agency will identify other patients at risk
* Specific measures to prevent re-occurrence
* Plan for monitoring and tracking
Other accrediting bodies

* Joint Commission (commonly referred to as “JCAHO”) [www.jointcommission.org](http://www.jointcommission.org)
* Community Health Accreditation Program (CHAP) [www.chapinc.org](http://www.chapinc.org)
* Accreditation Commission for Healthcare (ACHC) [www.achc.org](http://www.achc.org)
Joint Commission

* 25 year history of surveying home care agencies
* Requirements for Accreditation
  * Emergency Management
  * Human Resources
  * Infection Prevention
  * Information Management
* Requirements for accreditation continued
  * Leadership
  * Medication Management
  * Provision of Care
  * Performance Improvement
  * Record of Care
  * Rights and Responsibilities
National Patient Safety Goals

Specific to home health

* Identify patients correctly
* Use medicines safely
* Prevent infection
* Prevent patients from falling
* Identify patient safety risks (e.g., oxygen)

www.jointcommission.org
Deemed Status

- Accreditation by a CMS-approved accreditation program (e.g. Joint Commission or CHAP)
- Benefit: reduce the number of site visits from different agencies
- Increase in Home Health Participation
- May still have a visit by state surveyor (look back)
Deemed Status

“The number of Medicare-certified home health agencies increased by 23% from 2008-2011. Of these agencies, the number of those with deemed status increased from 1,161 to 4,117, a 255% increase! That's an increase from 12% to 34% of all Medicare-certified home health agencies.”

Fazzi & Associates May 2013
References

* www.thinkhomecare.org
* www.cms.gov
* Home Health Agency (HHA) Center - Centers for Medicare & Medicaid Services
References


* www.nahc.org

* www.jointcommission.org
“We are what we repeatedly do. Excellence, then, is not an act but a habit.”

Aristotle

“Quality is free. It’s not a gift, but it is free. What costs money are the unquality things— all the actions that involve not doing jobs right the first time...”

Philip B. Crosby, Quality is Free
Questions
Contact Information

* cpacella27@gmail.com
* 617-756-1442