FYI:

Live Discharges: Where Are You Now?

HOSPICE FUNDAMENTALS SUBSCRIBER EMAILS -- April 5 , 2012

The Least You Need to Know: *This FYI is a follow-up to Be Aware of 4.4 (February 20, 2012) Starting July 1, 2012, hospices will be required to use more specific coding on Medicare claims for beneficiaries whose hospice services are terminated (or interrupted) due to a revocation or discharge. The change clearly signals the government's intent to more closely scrutinize these claims and that begs the question – how well is your hospice handling live discharges now? This FYI provides a guide to self-assessment.*

Each opens with The Least You Need to Know. Read it in a minute or less.

Additional Information

Additional Information gives a more thourough rundown of the core content. We use graphs, charts, and tables to ease information processing.

The more precise coding required on all live discharge claims should result in more scrutiny by any Medicare or governmental entity with interest in the topic. Where are we now and what do we need to get in order over the next few months? Three areas bear examination.

1 *The Quality of Documentation*

How well does documentation capture the circumstances of the live discharge? Can a reviewer with no knowledge of the patient and the sequence of events gain a clear understanding from reviewing the medical record? Use the attached Live Discharge Chart Audit tools to see where you are now.

2 *The Level of Staff Knowledge*

Assess staff knowledge in two areas – general understanding of live discharges and specific understanding on agency policies and procedures. The chart audit process will give you a good idea of both areas.

3 *The Monitor*

Every hospice needs to have an on-going monitor in place that captures all live discharges; data should automatically be reviewed by the QAPI and/or compliance committee on a monthly or quarterly basis (frequency may vary based on agency size). Analysis of this data provides an early warning system that can alert hospices to potential internal process issues, quality of care and compliance problems, and staff knowledge deficits.

To fully analyze, categorize total live discharges for the period and drill down to see what is happening if there are variations between teams or RN case managers or if trending demonstrates changes.

1. Type of discharge (by team and/or RN case manager)

- **Revocation – Seeking Care Outside Plan Of Care**
- **Revocation – Displeased With Hospice Services**
- **Revocation – Reason Unknown**
- **Discharge – No Longer Terminal**
- **Discharge – Out Of Service Area**
- **Discharge – For Cause**
- **Transfer – Hospice Out Of Service Area**
- **Transfer – Hospice Within Service Area**

2. Trending against past performance and any available external benchmarking. The NHPCO national data set uses non-death discharges as a percentage of total discharges with further breakdown to hospice initiated versus patient initiated.

FOR MORE INFORMATION: visit **www.hospicefundamentals.com** or call us at **919-491-0699**

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Actions of The Prudent Hospice™

ONE. If your hospice does not already have the monitor in place, get it started now. You want to have some idea of where you are before the new discharge claim codes go into effect on July 1.

TWO. Use the audit tools to collect data from your clinical records (consider training a volunteer for this task – in addition to the areas on the tools you will get helpful feedback about the consistency of documentation). What do the results tell you? Does the staff need additional training and monitoring?

And the most helpful of all: ***Actions of the Prudent Hospice™****. Practical guidance in evaluating current systems and policies, adding new ones, and preparing for what's to come.*

THREE. Review your policies and procedures on live discharges. Are they current? Do they make sense? Who makes the final decision on the discharge? Are there any notification requirements? For instance, some hospices require that every revocation, completed or pending, be reviewed by a clinical manager. Same with discharges.

FOUR. Poll randomly chosen IDG members and ask them what the policy says and what the procedure for any time of live discharge is. If they don't know and also don't know how to access it there's a problem.

FIVE. Let us know if you have questions. We're here to help.

Other Materials:

Live Discharges
Audit Tools

When the topic calls for it, ***tools*** *to guide subscribers in their audit and monitoring efforts are included.*

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FYI:

Registered Nurses Did Not Always Visit Medicare Beneficiaries Homes at Least Once Every 14 days To Assess Quality of Care and Services Provided by Hospice Aides

HOSPICE FUNDAMENTALS SUBSCRIBER EMAILS -- December 2019

The Least You Need to Know:

This report is the fourth released from the OIG this year regarding concerns with the quality of hospice care. The OIG found that registered nurses (RNs) did not always visit the patient's home every 14 days to assess the quality of care provided by the hospice aide (HHA), or document the visits in the medical record. The deficiencies occurred because of lack of oversight by the hospice, scheduling errors, employee turnover and ignorance of the regulation by the RN. This suggests to the OIG that there was no assurance that hospice patients received appropriate care from hospices.

The Findings

The OIG found that RNs did not always:

1. visit the patient's homes every 14 days to assess the quality of care provided by the hospice aide (HHA) or
2. document the visits in accordance with Federal requirements.

The findings are based on 186,000 "date pairs" that occurred between January 1 and December 31, 2016. A date pair is comprised of two care visits made by an RN to a patient's home, 14 days apart. The sample was limited to patients that also had an HHA assigned to them.

Of the 189.000 date pairs, the OIG identified 99,000 cases in which the RN did not visit the patient at least every 14 days to perform HHA supervision, and 5,000 cases in which the RN's supervisory visit was not documented.

Recommendations

The OIG recommends that CMS work with State survey agencies and accreditation organizations to increase emphasis on this requirement, educate hospices about this requirement, and make this standard a quality measure. They also recommend action to ensure that all RN supervisory visits meet CMS regulations and interpretive guidelines. CMS concurs with these recommendations.

The Standard

§418.76(h)(1)(i) Standard: Supervision of hospice aides states that a registered nurse must make an on-site visit to the patient's home no less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit. If an area of concern is noted by the supervising nurse, then the hospice must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.

The Interpretive Guidelines advise that if the RN makes a supervisory visit on a Tuesday, the next supervisory visit is due by the Tuesday, which occurs 14 days later. In addition to ensuring that hospice aides furnish the care identified in the plan of care, RN supervisors must assess the adequacy of the aide services in relationship to the needs of the patient and family. In-person visits by the supervising nurse to the patient's home allow the nurse to directly observe the patient and the results of the aide's care. The supervisory visits must be documented in the patient's clinical record.

At its most simple level, while the RN is in the home, he or she would ask questions and make observations to ensure that the aide is performing their duties as ordered and competently. They are to document in the record that this supervisory assessment occurred.

FOR MORE INFORMATION: visit **www.hospicefundamentals.com** or email **heretohelp@hospicefundamentals.com**

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Actions of a Prudent Hospice™

ONE. Conduct an internal audit of compliance with §418.76(h).

TWO. Ensure oversight of compliance is a routine part of hospice operations.

THREE. Educate RNs and HHAs twice annually on the requirement to control for turnover and reinforce the important aspect of interdisciplinary team function, quality of care and regulatory compliance.

FOUR. When preparing for surveys, attend to this area as it will likely be a focus of the surveyor.

FIVE. Consider standardizing HHA supervision as part of every RN visit. Documentation should reflect that follows the **P's** below:

PLAN of care was reviewed with the patient and family.

Patient and family are **PLEASED** with the quality of the services and can confirm they are being **PERFORMED** as ordered.

PATIENT CONDITION reflects appropriate care is being provided.

HHAs are **PROVIDED** feedback from the supervising RN on their performance.

Links to More Information

The Full Report - https://oig.hhs.gov/oas/reports/region9/91803022.asp.

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