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Hospice

CMS: Hospice Compare's search by location is returning many incorrect results

CMS has recently announced that the location search field on Hospice Compare hasn't worked since the website launched in August.

The federal Medicare agency posted a message on Hospice Compare letting users know that when they search by location, many of the hospices that appear in the search result may not serve the correct ZIP code, city or even state.

*(see **Hospice**, p. 7)*

Prepare for new CoPs

Expert answers agencies' questions about how to prepare for the revised CoPs

Surveyors in 2018 are likely to pay close attention to how agencies comply with the QAPI and patient rights requirements within the revised Home Health Conditions of Participation (CoPs), attorney Robert Markette said during a recent DecisionHealth webinar on the draft interpretive guidelines.

Q: *If you made a list of the standards that surveyors are most likely to cite agencies on once the new CoPs take effect, what would be on it?*

A: The standards that involve patient rights and QAPI are going to be very big. In the patient rights portion of the CoPs,

*(see **CoP Q&As**, p. 6)*

Prepare for changes coming due to the 2018 PPS final rule

To ready your agency for changes outlined in the 2018 PPS final rule, attend a webinar 1 p.m. to 2:30 p.m. EST Dec. 14. The webinar will be presented by industry experts Sue Payne and Barbara McCann. Sign up at *https://store.decisionhealth.com/2018-pps-final-rule*.

Prepare for new CoPs

Understand CMS' expectations for working on emergency prep within a system

If your agency is part of a health care system, there are many benefits to choosing to work with the umbrella organization as you attempt to comply with CMS' new emergency preparedness requirements.

Even if your agency has a separate Medicare certification number than the overall health system, you can benefit from combining resources on everything from planning and exercises to increased communication and manpower in the event you need help providing care for patients.

But if your agency chooses to work with that umbrella organization, understand that CMS' requirements make clear you must participate in overall emergency prep planning, conduct your own risk assessment and comply with Conditions of Participation (CoPs) relevant to your provider type.

"Each separately certified facility must be capable of demonstrating during a survey that it can effectively implement the emergency preparedness program and demonstrate compliance with all emergency preparedness requirements at the individual facility level," CMS states within the interpretive guidelines in the new Appendix Z of CMS' State Operations Manual. "Compliance with the emergency preparedness requirements is the individual responsibility of each separately certified facility."

This is the case as well with revisions to The Joint Commission's Emergency Management chapters of accreditation standards for home health agencies, hospitals, critical access hospitals and ambulatory health care providers.

CMS' emergency prep requirements took effect Nov. 15. Agencies in noncompliance could be cited on a survey.

Follow these prep requirements

There are several requirements agencies must meet if they're part of a health care system and choose to participate in the system's emergency prep program, notes Jennifer Cowel, president of Patton Healthcare Consulting in Naperville, Ill., and a former executive with The Joint Commission.

Among those requirements:

1. Prove your agency actively participated in the development of the integrated emergency operations plan.

2. Show that the integrated plan reflects your agency's unique patient population, services and circumstances.

3. Demonstrate that your agency complies with the preparedness program.

4. Document an individual facility-based risk assessment for the agency using an all-hazards approach. (This can reside within the integrated emergency operations plan risk assessment, Cowel says.)

5. Ensure that your agency is represented within the integrated policies and procedures, communications, and training and testing plans for the emergency operations plan.

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Understand how often to have exercises

The Joint Commission's standards require the emergency operations plan to be activated and evaluated once a year. But under the commission's new standards to align with the CoPs, agencies must have two exercises a year.

However, The Joint Commission's revised standards for agencies note that one exercise may be tabletop, as allowed by the CoPs.

John Maurer, The Joint Commission's interim director of engineering, said surveyors will want to see how well each provider participated in the community planning.

According to The Joint Commission's recent annual Executive Briefing session, providers in an integrated emergency operations plan are expected to:

- Have emergency plans that coordinate sites along with the system-wide plan.
- Be part of training on site and jointly as part of the system.
- Be part of joint exercises including sites as well as the health system.

Note that CMS' interpretive guidelines state that agencies choosing to participate as part of a system's integrated and unified emergency preparedness program and exercises "will still be responsible for documenting and demonstrating their individual facility's compliance with the exercise and training requirements."

One positive outcome of the new emergency preparedness CoPs is the requirement for all providers to sit at the table, notes disaster planning expert Barbara Citarella, president of RBC Limited Healthcare & Management Consultants in Staatsburg, N.Y.

Outpatient providers within a system, she says, don't often "get to sit at the table and be a partner." — *A.J. Plunkett (aplunkett@h3.group)*

Private duty

Improve your turnover rate by taking steps to help home care aides with grief

Prepare aides for the possibility that their clients might die, and ensure your agency uses compassion and empathy when communicating with aides after those clients pass away.

Since private duty home care aides spend so much time with clients, they may handle the grief process similarly to a client's family member, says Hayley Gleason, assistant director of the Home Care Aide Council in Watertown, Mass. Yet often agencies don't consider this after the client has died.

The grief aides experience and a perceived lack of support from the agency can lead those aides to quit. Grief is one reason why the home care industry's turnover is so high, yet it's not a reason many agencies consider or address, Gleason says.

The median turnover rate for private duty caregivers was a mindboggling 65.7% in 2016, a 6% increase from 2015, according to the 2017 Home Care Benchmarking Study by Home Care Pulse in Rexburg, Idaho. The study included 646 respondents.

"It's a more significant factor than we understand," Gleason says of grief leading to turnover. "There are physical demands of the job, and there are emotional demands. We often think about the physical demands but don't often think about the emotional ones — the grief, the burnout."

This issue is not only an issue for private duty caregivers. Clinicians at Medicare-certified agencies also may grieve when a patient has died, and it's something your agency must pay close attention to, says Katherine Vanderhorst, president of C&V Senior Care Specialists in Buffalo, N.Y.

"Grief is a normal human experience and human emotion," she says.

While the overall turnover rate at Medicare-certified home health agencies is about 19%, the turnover rate for home care aides at those agencies is about 23%. That's according to the newly released 2017-2018 Home Care Salary & Benefits Report from the Hospital & Healthcare Compensation Service in Oakland, N.J. (*See benchmark, p. 4.*)

Prepare your aides from the beginning

Many new home care aides come in unprepared for the possibility that clients they care for will die, Gleason says.

Agencies assume aides know when the client is close to the end of life, she says. But a large percentage of home care aides feel "extremely" unprepared by their clients' death and are shocked by it.

"That's something we're missing the boat on," she says.

Consider having aides attend a webinar or receive video training about the grieving process, says Amy Craven, vice president of C&V Senior Care Specialists.

"Help them understand it as part of their onboarding," she says.

Gleason also recommends working to improve the communication chain from supervisors to staff. Sometimes a supervisor might be informed the client's cancer has progressed, for example, but the supervisor might not tell the aide.

Being informed empowers aides, Gleason says.

She says a call from supervisor to aide might sound like this: "The client is declining. We're seeing these changes. It's possible that the client may pass away in the coming months. Can we talk about this?"

Do this to help aides better handle grief

- **Have agency leadership alert the aide that the client has died.** In a study Gleason is conducting about the notification process following client deaths, she learned about 16% of 80 aides were not notified at all by their agency. Instead the aides later learned of the death — from coworkers or the client's family, for example — after the agency had reassigned them to a different client.

"The notification piece is really important," she says. "And most agencies don't strategically think about it."

BENCHMARK of the Week

Turnover rates in 2017 for Medicare skilled home care aides, other employees

Medicare skilled home care aides nationwide have a turnover rate of about 23%, according to the Hospital & Healthcare Compensation Service's 2017-2018 Home Care Salary & Benefits Report.

By comparison, the turnover rate for RNs is about 19%. (*See story, p. 3.*)

More than 1,800 agencies participated in the study, which is published annually in cooperation with the National Association for Home Care & Hospice.

Turnover rate	National percentage
All employees	19.01%
RNs	19.03%
LPNs	16.90%
Home care aides	22.99%
Therapists	11.19%

Source: *Hospital & Healthcare Compensation Service, Oakland, N.J.*

An aide might be very upset after learning about the death later from a different source, Gleason says.

When Craven was administrator for an agency in western New York, she actually had the aide come in to the office so she could break the news about the death.

"We felt that we could give them more support in person," Craven says.

- **Take the right tone when alerting the aide.** Be straightforward, empathetic and compassionate, Gleason says. Ask the aide if there's anything your agency can do to support her.

Craven offered aides time off if they needed it, and encouraged the aide to attend the funeral.

- **Understand that not all aides need the same amount of time to grieve.** After learning of a client's death, some aides want to be immediately reassigned while others might need some time to process the death, Gleason says.

Regardless, it's important to acknowledge the role the aide had with the client and that you understand the bond she might have had, she says.

- **Ensure aides and supervisors develop strong relationships.** This will help with retention, Gleason says.

Many aides would appreciate it if the supervisor called to check in on them after a client died. During a conversation with an aide about a client's death, the supervisor should use the same kind of language she would use with the client's family, Gleason says.

There should be enhanced supervisory support for new aides, she adds.

- **Consider offering outside help.** Jeff Salter, founder/CEO of San Antonio-based Caring Senior Service, says he would utilize bereavement services of hospice when they were involved. And over the years he formed relationships with chaplains and would often refer caregivers to them — even when no hospice was involved in the care.

"Though I was always available to speak to any caregiver that was dealing with grief, these chaplains have the skills and the expertise to provide the appropriate services to our caregivers," he says. "I often advise our owners today to make sure they have good relationships in their community for when the time comes to help grieving caregivers in their office." — *Josh Poltilove (jpoltilove@decisionhealth.com)*

5-star ratings

CMS decides to drop influenza measure from quality of care star ratings system

CMS is holding a webinar Dec. 14 to announce it is finalizing its plan to eliminate "Influenza immunization received for current flu season" from the list of measures used to calculate home health quality of care star ratings.

"During this call, CMS will present the rationale, comments received, timing and impact of this change," CMS says on its website.

The change will be implemented for the April refresh of Home Health Compare. That refresh will include data from June 1, 2016, through July 31, 2017.

Stakeholders and a technical expert panel previously said they were considering dropping the influenza measure from the ratings because it is largely influenced by factors outside agencies' control — and those factors might vary by state (*HHL 10/16/17*).

The influenza measure will remain important, however, because it is part of a value-based purchasing demonstration ongoing in nine states (*HHL 8/7/17*). — *Josh Poltilove (jpoltilove@decisionhealth.com)*

Related link: *Sign up for the webinar, which will be held 2 p.m. to 3 p.m. EST Dec. 14, at http://bit.ly/2nkWmWz.*

Trump administration

GOP tax overhaul plan takes big step forward by getting Senate approval

Before sending a final bill for President Donald Trump to sign, the U.S. House and Senate must work to reconcile versions of tax overhaul bills they recently passed.

The Senate passed its version Dec. 2 with a 51-49 vote.

The House passed its version Nov. 16 with a 227-205 vote. Two House Democrats didn't vote.

As written, the Senate version would increase the federal deficit by about $1 trillion over 10 years.

A federal anti-deficit law already in effect could trigger about $25 billion in cuts from Medicare, according to the New York Times, though GOP leaders have said those cuts won't occur.

The tax overhaul bills have key similarities, though they also have significant differences.

Both versions slash the corporate tax rate to 20% from 35%, and they also double the standard deduction most taxpayers use, according to CBS News.

But only the Senate bill repeals the individual health insurance mandate created by the Affordable Care Act (ACA). The Congressional Budget Office estimates 13 million more people would be uninsured in 2027.

For those who continue to have insurance through the ACA, media reports state, insurance premiums would rise.

The two versions of the bill now head to a conference committee, which will draft a final version in the coming weeks. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

Marketing

CJR localities halved; hip fracture episode payment model eliminated

CMS has finalized its plan to cancel four mandatory episode payment models for common cardiac and orthopedic conditions, according to a rule posted Nov. 30. The models had been due to begin in January.

Within the same rule, CMS also finalized its plan to dial back the comprehensive care of joint replacement (CJR) program that has been in effect since April 2016. For CJR, CMS is reducing the number of geographic areas where hospitals are required to participate from 67 to 34.

The change takes effect Jan. 1.

CMS believes "developing different bundled payment models and engaging more providers is the best way to drive health system change while minimizing burden and maintaining access to care," CMS Administrator Seema Verma says in a release.

In the future, CMS plans to create more opportunities for providers to participate in voluntary initiatives as opposed to large, mandatory bundled payment models, a CMS release states.

Low-volume and rural hospitals would no longer be required to participate in CJR in all of the geographic areas.

And participation in CJR would be voluntary in the 33 geographic areas where it is no longer required. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

Related link: *Read the final rule at http://bit.ly/2zCWdiO. Read a CMS fact sheet about the changes to the models at http://go.cms.gov/2B08D8y.*

CoP Q&As

(continued from p. 1)

surveyors will pay close attention to whether you have provided patients their rights and communicated the rights in a language patients understand.

Surveyors also will pay attention to the governing body's involvement in QAPI projects. The quality performance standard is important.

In addition, surveyors will examine significant changes in condition and how that impacts the patient's plan of care.

The performance improvement project standard for QAPI is off the table for the first six months. Unlike the other new CoPs, it doesn't go into effect until July 13. But I think that's going to be one down the road that surveyors are going to look at a lot.

More key insights from the webinar

Q: *The draft guidelines say nothing about what documentation surveyors should expect to find when it comes to a QAPI program or what questions surveyors should ask about the QAPI process. Based on your interpretation of the CoPs, what do you think surveyors will expect to see and what things do you expect surveyors to ask?*

A: Expect surveyors to look for all your governing body documentation. Show that your governing body is doing its part and has approved the information gathering and approved the performance improvement projects.

Agencies also should expect surveyors to want to see your process for identifying potential performance improvement projects, how you settled on a particular project and that you followed through on data gathering.

Surveyors will want to see that you identified a performance improvement project where you're below some objective, measurable standard and that you want to get to that standard. Surveyors will want to see those objective measures on the schedule outlined on the performance improvement plan. And surveyors will want to see that when you hit that measure, you're moving on to your next performance improvement project.

Agencies should go back and check to make sure that they stay on that target.

Surveyors also will want to see that agencies get feedback from patient complaints and infection control to draw in that information for potential performance improvement projects.

During surveys, agencies should expect surveyors to ask, "How did you settle on this project? Why this project and not that project? Why this measure? Why did you decide on this frequency?"

Be able to articulate to the surveyor your process and why you've done it — and articulate this in terms of patient outcomes and patient care. This should be spelled out in your documentation as well.

Q: *With about a month to go before the CoPs take effect, can you walk us through a last-minute timeline that agencies should use to ensure preparedness?*

A: Get your board up to speed on what's coming. Educate the board about its roles and responsibilities as well as OASIS, QAPI and related information members will need to understand QAPI.

Get documents prepared so the board has the tools to document its involvement.

Train staff on the patient rights issues, the changes in how we're going to deal with orders and patient communication.

Explain to staff what we're going to give to patients at intake and throughout the episode due to the ongoing consent process.

Explain the additional forms, such as new intake forms for documenting patient communication needs, forms for documenting legal representative/patient-selected representative, forms for field staff to identify languages utilized by non-English speakers, plan of care summary forms and other revised or new forms that will be utilized at intake.

Train staff on using telephone or web-based interpreters and make sure they understand why you're doing this.

Update patient rights forms.

Explain to intake that when your agency gets a referral, you will need to get additional information if possible including whether the patient has a representative, if the patient is competent, does the patient speak English or need assistive devices for communication.

Look at your compliance with Section 1557 of the Affordable Care Act — including whether you have identified the most common languages in your community.

Train employees on what to do if they get to the home and become aware the patient doesn't speak English. Ensure there's a process for making a call and getting an interpreter on the line, and ensure there's a process for documenting this.

Train nurses that when you take an order, you'll need your signature to include name, date and time. The new CoPs require nurses to include the time when they are signing verbal orders. This is one more potential compliance problem.

Start training them now — have them start including the date and time when they sign orders now. Audit their documentation to ensure they are doing it properly. Start building the habit now so it will be ingrained in January.

Go to your physicians and say, "You're probably going to hear from us more than you used to because of some of these changes in the new CoPs." And explain some of the changes related to plans of care and the need for orders and that this kind of information will need to be documented.

Q: *Can you tell us where we can find more information regarding patient rights and requests you must refuse?*

A: Although patients have rights, home health employers are subject to other federal laws, including civil rights laws. These laws, which protect your employees from discrimination, impact patient choice.

For example, a patient might request a caregiver based upon the caregiver's skin color. This request must be declined.

The U.S. Equal Employment Opportunity Commission (EEOC) has brought a number of lawsuits in the last five years against home health agencies for responding to inappropriate requests from patients related to staffing.

Despite this fact, agencies continue to believe that "patient choice" always wins. It is important to understand that the CoPs, while emphasizing patient choice, do not eliminate the agency's other obligations under federal civil rights laws, for example.

Editor's note: *For more on the draft interpretive guidelines and how to prepare for the CoPs, purchase the on-demand recording of this 90-minute webinar, "Walk Through New CoP Interpretive Guidelines, Ensure Compliance and Survey Readiness." Order your copy at https://store.decisionhealth.com/new-cop-interpretive-guidelines.*

Hospice

(continued from p. 1)

The inaccuracy of the website's location search might lead fewer people to use Hospice Compare to determine the quality of their areas' hospices, says Joy Cameron, vice president for policy and innovation for ElevatingHOME. It could potentially lead patients and families to grow frustrated with the website in their time of need — and discourage them from recommending the website for others to use.

CMS recommends that people using Hospice Compare call the hospice they select to confirm that it serves their desired areas.

Hospice Compare's issues involve underlying data that populate the website, CMS officials tell *HHL*. Officials aren't sure exactly how many hospices are affected but believe the information is "much more accurate than inaccurate."

CMS officials tell *HHL* that one major fix will occur in early 2018. CMS on April 1, 2017, added a data item to the Hospice Item Set (HIS) that asks hospices to record the ZIP code where services are being provided. This new information will replace the data that currently inform Hospice Compare's location search.

Hospices, meanwhile, can work to fix a second Hospice Compare issue themselves by ensuring their demographic information is accurate within the Automated Survey Processing Environment (ASPEN) system, CMS officials add.

Quarterly refresh is coming soon

CMS decided to postpone its quarterly refresh of data on Hospice Compare from Nov. 21 to sometime in December as a direct result of the location search issue, officials tell HHL.

CMS officials believe some improvements to the website will be in place for that December refresh.

The National Association for Home Care & Hospice (NAHC) alerted CMS almost immediately after the website's Aug. 16 launch about the location search problem on Hospice Compare, says Theresa Forster, NAHC's vice president for hospice policy & programs.

One example of the problem: In New York, there are about 50 hospices but about 250 appear when you type "New York" into the "Location" search field.

Despite the issue, Hospice Compare remains useful and is something beneficiaries have asked about for a long time, CMS officials say.

Compare website still has use

Although that search field's functionality doesn't work properly, if people know the name of a hospice, they still can type it into a separate search field and get an accurate result, Forster notes.

After typing the hospice's name into that field and clicking "Search," members of the public will be able to view how that hospice compares with the national average on seven measures on the HIS.

Those measures are: treatment preferences; beliefs/values addressed (if desired by the patient); pain screening; pain assessment; dyspnea screening; dyspnea treatment; and patients treated with an opioid who are given a bowel regimen.

CMS previously indicated that Hospice Compare also will include Hospice CAHPS data beginning with the Feb. 20 refresh, Forster says.

Ensure your info is accurate

CMS recommends hospices check whether their address, phone number and type of ownership are correctly listed within the ASPEN system.

In a post last month, CMS recommended hospices do the following to ensure their information is accurate and get it corrected if it isn't:

Step 1: Verify your data. Review your preview reports to verify the accuracy of your demographic data.

The preview reports, CMS says, reflect quality measure data and hospice demographic information that will be posted to Hospice Compare in the upcoming quarter.

Check Hospice Compare's website at *www.medicare.gov/hospicecompare*.

Check your preview reports in CASPER during the 30-day preview windows prior to each quarterly Hospice Compare refresh, CMS says.

Step 2: Contact your state ASPEN coordinator. If you identify that your demographic data isn't correct, alert your state ASPEN coordinator. View coordinators' names at *http://bit.ly/2hZjK6h*.

Call the QTSO Help Desk at (800) 339-9313 or email *help@qtso.com* if you're unable to reach your ASPEN coordinator or are unable to access your preview reports.

Step 3: Use the right language to get your information updated properly. Ask for updates to data within ASPEN, not updates to your Hospice Compare data, CMS says.

The coordinator will change the demographic data and upload it to the national database, CMS says. CMS doesn't have the access or authority to change this data within ASPEN.

Step 4: Be patient. Updates take months to appear on Hospice Compare, CMS notes.

The cutoff date to get your information updated on Hospice Compare in time for the May 2018 refresh passed as of the first business day of December.

But if you alert your state's ASPEN coordinator to the issue by the first business day of March, that information will be updated on Hospice Compare in August. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

Related link: *Visit the Hospice Quality Public Reporting webpage at http://go.cms.gov/2oSKc3d for updates on when Hospice Compare will be fixed.*

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