

## **A GUIDE TO SURVEY PREPARATION FOR CRITICAL ACCESS HOSPITALS**

A facility that participates in the Medicare program as a Critical Access Hospital (CAH) must meet the Medicare Conditions of Participation (CoPs) specifically for CAHs. All CAHs will receive an initial survey by the Nebraska Health and Human Services System/Regulation and Licensure prior to HCFA certification and will be re-surveyed somewhere between nine to fifteen months after receiving their CAH status.

The intent of the CAH survey process is to evaluate facility compliance with each of the CoPs in the most efficient manner possible. State surveyors will assess each CoP concurrently through observation, interviews with staff and patients, policy and procedure reviews and record reviews of open and closed patient records.

During the initial survey, the state survey team will be focusing on the “process” that are in place or being established by the CAH to comply with the CoPs. The follow-up survey will be more “outcome” oriented, including chart reviews and other types of assessments for compliance.

### **Notes:**

It is highly recommended that a hospital establish a survey preparation team within your facility to accomplish the work that will need to be completed prior to the survey. This team should consist of, at a minimum, the administrator, director of nursing, CFO/business office staff, medical records and the quality assurance coordinator. It is also highly recommended that hospitals have a department head meeting and pass out the CoP-interpretive guidelines for CAHs. This should serve as a valuable guide for each department head to review the requirements for each of their departments.

Your facility will also be surveyed by the State Fire Marshall’s Office for life-safety codes around the time of your initial survey. This will happen no matter when your last inspection occurred, even if it was only two months prior to your initial CAH survey.

Although the MDS assessment for swing beds is not required to be started until a CAH has been certified, it is recommended that hospitals waiting for their survey begin applying the MDS to swing bed patients within their facility two weeks prior to their initial survey. This will allow the state survey team to evaluate your procedures and assist you in making sure you are complying with the specific CoPs for swing beds. This proactive action will prevent finding out that you are non-compliant, or do not have the appropriate procedures in place, during your re-survey almost twelve months later.

All policy and procedures must be changed to reflect CAH status. (Don’t forget that approval for these changes should be reflected in the minutes of board meetings, medical staff meetings, etc.)

## **STEP 1 – PRE-SURVEY PREPARATION**

All CAH surveys are announced in advance. The state surveyors will call the hospital administrator to arrange for a survey time that is mutually convenient. During this initial telephone contact with the CAH, state surveyors may inquire about such things as the expansion of services, current patient load and staff size, and physical renovations at the facility. They will also ask about significant changes in operations such as: revisions to the rural health network agreement, new services provided by arrangements or agreements and new transfer agreements with receiving hospitals.

During this initial telephone contact, the state surveyors will request that the individual who administers or directs the CAH quality assurance program must be available to meet with the survey team at the CAH during the time the survey is conducted.

## **STEP 2 – THE CAH SURVEY ENTRANCE CONFERENCE**

The purpose of the CAH survey entrance conference is to verify such things as: changes to applicant information, changes in current roster of personnel, changes in ownership and/or legal responsibility for day-to-day operations in the facility, changes in hours of operation and to obtain the name of and verify the availability of key staff during the survey.

### **Notes:**

It is an excellent idea to have all of your department heads at the CAH survey entrance conference to introduce them to the state survey team and for the department heads to learn what will be occurring during the course of the three-day survey.

Also, please have a list of names and titles of all department heads for the survey team at the entrance conference and make sure they have a reasonably sized room to work from.

The following documents should be available for review within the room the state survey team is working from:

Facility policies and procedures covering all CAH requirements (i.e., infection control, pharmacy, emergency department, dietary, nursing, medical records, and outpatient/clinics);

List of services the facility provides directly and a list of services provided through arrangements or agreements.

Copy of all service agreements and any network agreements, including participation in a communications system, physician coverage (if applicable), and referral, admission, and transportation of patients;

Organizational chart and position descriptions for levels of personnel;

Staffing schedules for emergency department, outpatient/clinic department, nursing unit, etc., for the past three months;

On-call schedules for physicians, other staff (e.g. mid-level practitioners, laboratory, imaging, etc.), for the past three months;

Personnel files with evidence of appropriate licensure, certification, or registration, when applicable (surveyors will request specific files during the survey);

Credential files for physicians and midlevel practitioners (surveyors will request specific files during the survey);

Committee meeting minutes for the past six months (i.e., infection control, pharmacy and therapeutics, CAH policy development, quality assurance);

Governing body-meeting minutes for the past six months;

Quality assurance plan;

Annual program evaluation;

Infection control log;

Menus for one month for all diets offered;

Incident reports for the past six months;

List of authenticated signatures; and

Current and closed medical records (surveyors will request specific records during the survey).

### **STEP 3 – FACILITY TOUR**

A brief facility tour by the survey team will be conducted, especially on initial certification surveys at hospitals that are converting to CAH providers, to help the survey team become familiar with the physical layout of the facility as well as the locations of key personnel. The purpose of the facility tour is to give the state surveyor the opportunity to make initial assessments relative to the cleanliness and infection control practices of the facility, the safety and emergency preparedness of the facility and staff, the appropriateness of patient treatment areas, and the ambiance of patient/staff interactions.

## **STEP 4 – REVIEW OF POLICIES, PROCEDURES AND AGREEMENTS**

A CAH must have policies, procedures, agreements or arrangements to comply with several of the CoPs for CAHs. In some instances, policies, procedures, agreements or arrangements must be in writing. In other instances the regulation requires the CAH to provide some evidence that a policy, procedure, agreement or arrangement is in effect. The following requirements will be reviewed:

An agreement to participate in a network communications system if the CAH is in a network that participates in such a system;

A policy or procedure, and if provided, contractually, an agreement or arrangement, for services for the procurement, safekeeping and transfusion of blood, including the availability of blood products needed for emergency patients 24-hours-per-day;

A procedure which demonstrates how the CAH, in coordination with local response systems, has a doctor of medicine or osteopathy immediately available by telephone or radio on a 24-hour-a-day basis to receive emergency calls, provide treatment information and refer patients to the CAH or to other appropriate locations for treatment;

Evidence (e.g., minutes of board meetings of the governing body) which establishes that the CAH governing body or responsible, individual assumes full responsibility for determining, implementing and monitoring all CAH policies governing CAH operations;

Disclosure information showing the principal owners of the CAH, the person principally responsible for CAH operations, and the person responsible for medical direction in the CAH;

Written policies and procedures that cover all health care services provided at the CAH, including the following:

A description of the services furnished directly by the CAH and those services furnished through agreement and arrangement;

Emergency medical services;

Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, maintenance of health care records, and the periodic review and evaluation of the services furnished by the CAH;

Rules for the storage, handling, dispensing, and administration of drugs and biologicals;

Procedures for reporting adverse drug reactions and errors in the administration of drugs;

A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel;

Procedures that ensure that the nutritional needs of inpatients are met;

A procedure for the annual review of policies by the professional staff

Emergency medical procedures as a first response to common life-threatening injuries and acute illness;

Agreements or arrangements with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including the following:

Inpatient hospital care;

Services of doctors of medicine or osteopathy;

Additional or specialized diagnostic and clinical laboratory services not available at the CAH;

Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH; and

If agreements are not in writing, the CAH must be able to present evidence that patients referred by the CAH are being accepted and treated.

A list of all services furnished under arrangements or agreements;

Written policies and procedures for the maintenance of a clinical records system;

Written policies and procedures governing the use and removal of records from the CAH and the conditions for release of information;

Policies and procedures regarding who is allowed to perform surgery for CAH patients;

Policies and procedures regarding who is allowed to administer anesthetics to CAH patients;

Policies, procedures and/or other documentation that demonstrate that the CAH carries out the periodic evaluation of its total program;

A quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished at the CAH, which requires:

Evaluation of all patient care services and other services affecting patient health and safety;

Evaluation of nosocomial infections and medication therapy;

Evaluation of the quality and appropriateness of the diagnosis and treatment furnished by mid-level practitioners at the CAH by a doctor of medicine or osteopathy who is a member of the CAH staff or under consult with the CAH;

An agreement for the evaluation of the quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH with at least one hospital that is a member of the network, the Peer Review Organization (PRO) for the State in which the CAH is located, or equivalent entity, or with another appropriate and qualified entity defined in the State rural health care plan;

Evaluation of the reviewing entity's findings and recommendations along with corrective action by the CAH;

Procedures to take remedial action to address deficiencies found through the quality assurance program; and

Documentation of the outcomes of any remedial actions taken.

There are other sections in the CAH CoPs that do not specifically require written policies and procedures. However, the facility may choose to develop written policies and/or procedures for some or all of these requirements, including the following:

Ensuring that supplies, drugs and biologicals are periodically ordered and monitored;

Written policies and/or procedures requiring the discharge or transfer of patients within 96 hours of admission;

Written policies and procedures ensuring that sufficient staff are available to provide essential services for CAH operation;

Delineating specific CAH responsibilities for the doctor of medicine or osteopathy, and for mid-level practitioners;

Ensuring that all written policies pertaining to healthcare services furnished in the CAH are developed with the advice of one or more doctors of medicine or osteopathy and one or more mid-level practitioners; if they are on staff, at least one of whom is not a member of the CAH staff;

Ensuring that the person responsible for CAH operations is also responsible for contracted services and that those contracted services, including contracts for shared services and joint ventures, are provided in a manner that allows the CAH to comply with the CoPs for CAHs;

Ensuring that a registered nurse (RN) provides or assigns to other personnel the nursing care for each patient, and that an RN, or if applicable, a physician assistant, supervises and evaluates the nursing care for each patient; and

Ensuring that the confidentiality of medical records is maintained and that records are protected against loss, destruction or unauthorized use, and are retained for at least six years.

## **STEP 5 – FACILITY INSPECTION/INTERVIEWS WITH STAFF**

At a minimum, the state surveyors will inspect the following areas:

Emergency services—Through inspections and interviews with emergency services staff, ascertain the following: the methodology used by the CAH to make emergency services available 24-hours-a-day; the availability and condition of equipment, supplies, drugs and biologicals; the availability of blood and blood products; the methodology used to meet the 24-hour availability and 30 minute on-call requirements; and the methodology used to link the CAH with local emergency response systems;

Physical plant and environment—Reviewed as part of the Life Safety Code inspection;

Drug storage area—Through inspections and interviews with staff, ascertain how drug storage is managed, how records are kept, and how all outdated, mislabeled, or otherwise unusable drugs are made unavailable for patient use;

Direct care services—Through inspections and staff interviews ascertain how the CAH is providing diagnostic and therapeutic services for patients;

Laboratory services—Through inspection and interviews with staff, ascertain that the CAH has an appropriate CLIA certificate and that the CAH has the capability (i.e., proper equipment and records) to perform all required laboratory tests;

Radiology services—Through inspections and interviews with staff, ascertain that the CAH radiology staff are properly qualified and that radiology services are provided in a manner that is safe for patients and staff;

Inpatient treatment areas—Through inspections and interviews with staff; ascertain that the CAH has in inpatient treatment area with no more than 15 beds or no more than 25 beds (if it has a swing-bed agreement), the CAH has adequate numbers of qualified professional and ancillary staff to care for its inpatients, there is a methodology to assure that nursing care for each patient is supervised and evaluated by a registered nurse, and there is a current nursing care plan for each inpatient;

Clinical records—Through inspections and interviews with staff, ascertain that the CAH has an effective clinical records system maintained in accordance with its written policies and procedures, records are systematically organized, and a designated member of the professional staff is responsible for the records area; and

Swing-beds—Through inspections and interviews with staff, determine if the CAH is in compliance with all of the SNF requirements.

## **STEP 6 – MEDICAL RECORDS REVIEW**

For a first-time CAH survey, the records review will consist only of the review of medical records policies and procedures described in Step 2, and the inspection of the medical records area in Step 3. During the re-survey, surveyors will be looking in the medical record for identification and social data, properly executed informed consent forms, medical history, health care status and needs assessment, and a summary of the episode, disposition and instructions the patient, reports of physical examinations, diagnostic and laboratory test results and consultative findings, orders of physicians and/or mid-level practitioners, reports of treatment or medications, nursing notes, documentation of complications, and other pertinent information necessary to monitor patients progress, dated signatures of the doctor of medicine or osteopathy or other health care professional and patient consent forms, if applicable, for the release of any records information not required by law.

## **STEP 7 – ANALYSIS AND EVALUATION OF FINDINGS**

The state survey team will consolidate the findings from each step of the survey and decide whether further information and/or documentation are needed. They will review

any conditions in which they consider an immediate and serious threat to patients and will compile their information and observations into a verbal format, which will be shared with the CAH facility during the exit conference.

## **STEP 8 – EXIT CONFERENCE**

The purpose of the exit conference is to inform the CAH staff of the surveyor's observations and findings and to provide an opportunity for the CAH to present additional information in response to the surveyor's findings. The exit conference will be conducted with the CAH administrator, director, supervisor, and other invited staff, and will address the following:

The CAH requirements that are not in compliance and the findings that substantiate these deficiencies;

Discuss and provide additional information in an attempt to resolve differences regarding deficiencies, and review the CAH's responsibility to determine the corrective action(s) necessary to remedy the problem(s);

The surveyor's recommendation to the HCFA Regional Office to certify, recertify or deny certification of the CAH; subject to review by the State agency supervisor; and

If necessary, instructions and the time frame necessary for submitting a plan of correction.

### **Notes:**

Hospitals will receive a copy any deficiencies in writing within 10 days of the survey. A plan for corrective action by the facility must be returned the Department within 10 days. Depending on the type of deficiency, it will be either handled by mail or a member of the state survey team will return for a follow-up on the corrective action needed.

During the exit conference, potential CAHs should consider submitting a formal letter to the state survey team to be forwarded to: Nancy Brown, Facilities License and Inspection, Nebraska Health and Human Services System requesting a delayed certification date for designation as a CAH. In most cases, this certification date would be the first day of the second month subsequent to the successful completion of the CAH survey or approved plan of correction. (This will assist your making sure there are minimal delays in your ability to bill for CAH services. For a sample letter, contact John Roberts 458-4909 or Brenda Kresten at 676-0978)