Survey Readiness

Building A Culture of Quality & Compliance

Learning Objectives

1. Understanding Survey Focus Areas and Regulatory Expectations
2. Drivers of Condition-Level Deficiencies and Risk Indicators
3. Operationalizing Quality and Compliance Through QAPI
4. Building a Sustainable Culture of Survey Readiness

Revisions to SOM - Appendix M - *Hospice*

Guidance for Surveyors

- Released January 27, 2023
- Incorporates changes made in surveyor training and survey process in HOSPICE Act
- Incorporates 1135 waivers that were made permanent
- Increased pre-survey preparation
- Focus on quality of care with 4 Core Hospice Conditions of Participation
- Increased focus on reporting mistreatment and all types of abuse

NO change to Conditions of Participation

Revisions to SOM - Appendix M - *Hospice*

Training for Surveyors

- State Surveyors and Accrediting Organization (AO) Surveyors required to take the CMS Hospice Basic Training
- The trainings are available in the Quality, Safety and Education Portal (QSEP)
  - Training is also available to Providers

Surveyor Teams

- Minimum of one RN with Hospice Surveyor experience
- Team should be multi-disciplinary, "incorporating other areas of professional practice…"
- State agency will determine the size of the team, depending on size and characteristics of the hospice

CMS requires that **no conflicts of interest** are present between the Surveyor Team and the hospice being surveyed.

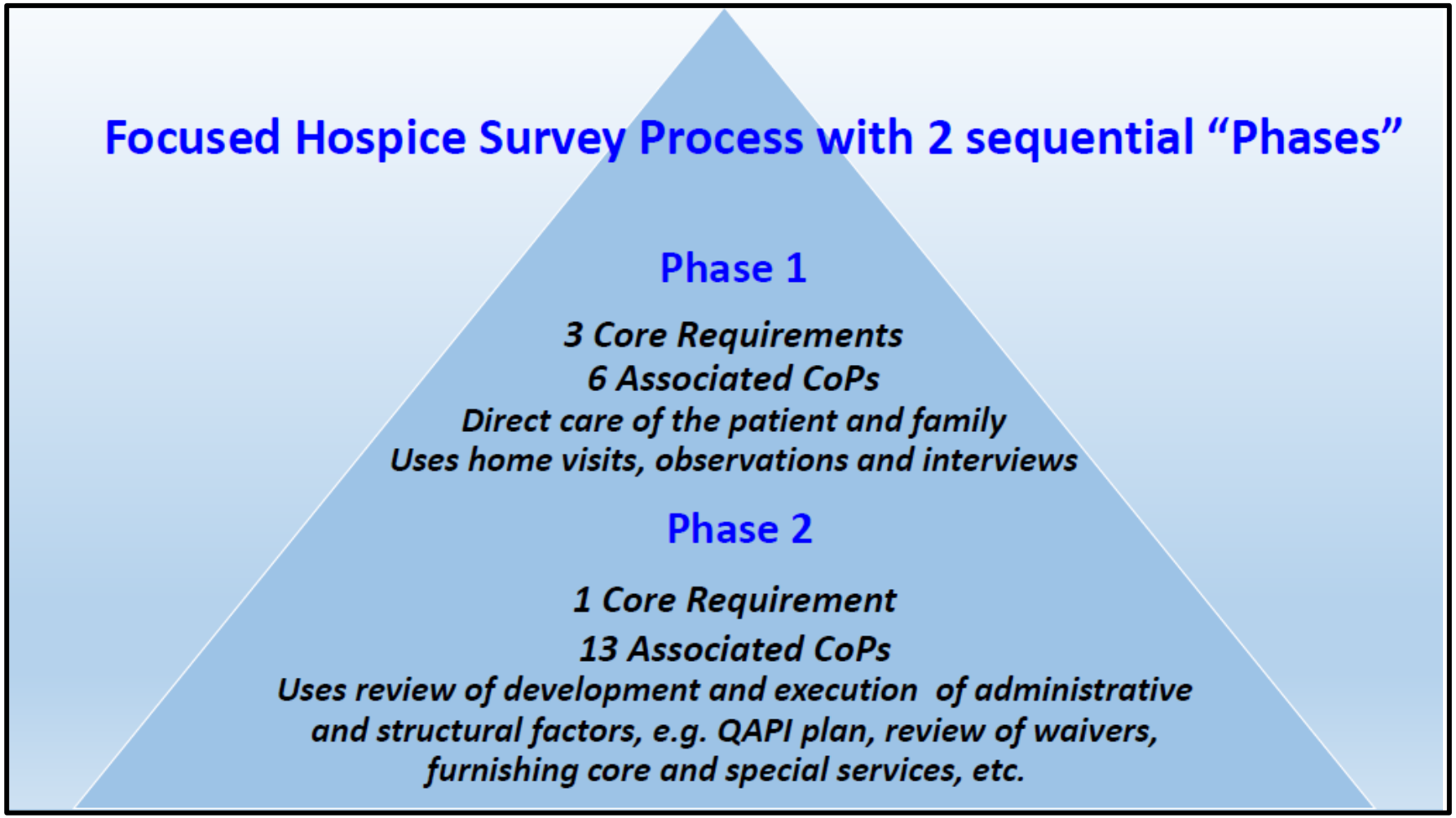
The Survey Process

CMS Survey Types

- Initial Surveys
- Standard Surveys
  - Every 36 months at minimum
- Post-Survey Re-Visit / Extended Survey
  - Condition Level Deficiency Corrected
  - Immediate Jeopardy Concerns
- Complaint Survey
- Direct Observation Validation (DOV) Survey / Revalidation Survey
  - CHOW

All CMS surveys are unannounced.

Hospice Survey Process



Phase 1: 3 Core CoPs

Phase 1

- Significant change in survey protocol
- Focus on investigating the **quality of care** provided to hospice patients
- Special attention directed to Phase 1 CoPs directly impacting patient care

Phase 1 includes three core Conditions of Participation and 6 associated CoPs:

- §418.52 Patient Rights
- §418.54 Initial and comprehensive assessment of the patient
- §418.56 Interdisciplinary Group, care planning, and coordination of services

Source: State Operations Manual, Appendix M – Hospice

Phase 1: Associated CoPs

Associated Quality of Care CoPs – Phase 1

- §418.60 Condition of participation: Infection control.
- §418.76 Condition of participation: Hospice aide and homemaker services.
- §418.102 Condition of participation: Medical director.
- §418.108 Condition of participation: Short-term inpatient care.
- §418.110 Condition of participation: Hospices that provide inpatient care directly.
- §418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.

Source: State Operations Manual, Appendix M – Hospice

Phase 2: 1 CoP

Phase 2 includes one core Condition of Participation, with 13 associated CoPs:

- §418.58 Condition of participation: Quality assessment and performance improvement.

Phase 2 determines if the hospice is "actively engaged in monitoring the effectiveness and safety of services and quality of care and includes the remaining 13 CoPs.

Protocol Phase 1 CoPs quality of care findings informs the Phase 2 CoPs investigation.

Source: State Operations Manual, Appendix M – Hospice

Phase 2: Associated CoPs

§418.62	Licensed professional services.
§418.64	Core services.
§418.66	Nursing services - Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.
§418.70	Furnishing of non-core services.
§418.72	Physical therapy, occupational therapy, and speech-language pathology.
§418.74	Physical therapy, occupational therapy, speech-language pathology, and dietary counseling.
§418.78	Volunteers.

§418.100	Organization and administration of services.
§418.104	Clinical records.
§418.106	Drugs and biologicals, medical supplies, and durable medical equipment.
§418.113	Emergency preparedness.
§418.114	Personnel qualifications.
§418.116	Compliance with Federal, State, and local laws and regulations related to the health and safety of patients.

Source: State Operations Manual, Appendix M – Hospice

The Survey Tasks

Survey Tasks

Task 1: Pre-Survey Preparation

Task 2: Entrance Conference

Task 3: Sample Selection

Task 4: Information Gathering - Phase 1 & Phase 2

Task 5: Preliminary Decision Making and Analysis of Findings

Task 6: Exit Conference

Task 7: Post-Survey Activities

Task 1 - Pre-Survey Preparation

External and internal resources to assess the current characteristics and services of the hospice.

- Background Information
- CMS Survey-Related Forms and Changes
- Publicly Available Information
- HQRP Data
- Complaint Investigations
- Agency website

Survey Prep Checklist

- ❑ Complete a Google search to see what people are saying about your hospice
- ❑ Complete a search on job posting sites (i.e.: Glassdoor and Indeed) to learn what employees and former employees share about your hospice
- ❑ Review and resolve negative comments or complaints if possible; Log actions
- ❑ Monitor Medicare.gov Care Compare data
- ❑ Take steps to improve Star Rating and areas below State and National averages
- ❑ Review Hospice CAHPS scores and comments
- ❑ Know how to explain the ratings found in Care Compare and on CAHPS

Task 2 – Entrance Conference

Surveyor will conduct a discussion (not interview) with the Hospice Administrator or Designee and other Hospice Leadership members at the start of the survey.

Discussion items including but are not limited to:

- Informing the Administrator or Designee of the survey's purpose.
- Explaining the survey process and the estimated duration.
- Requesting patient and agency information.
- Requesting assistance with a private space to work.
- Requesting access to an assigned staff person from the hospice who will assist with questions and obtaining information.

Survey Prep Checklist

- ❑ Outline communication plan to alert the Hospice Team upon the arrival of the Surveyor
- ❑ Determine a dedicated and quiet space for a Surveyor to utilize for independent tasks when on site for the duration of the survey
- ❑ Identify key personnel to interact with the Surveyor; Take notes with each interaction
- ❑ Know steps to add "Read Only" EMR access for Surveyor; Identify a "driver" for the EMR if Surveyor requests assistance
- ❑ Offer a brief building tour with instructions for parking, the bathroom, and copy machine access

Task 3 – Sample Selection

Sample size determined by:

- size of the hospice;
- closed record reviews of patients who revoked the hospice benefit;
- closed records for bereavement;
- current patient home visit with record review, and
- current patient record review only.

Surveyors can expand the sample, during the survey, to investigate findings as needed.

Task 3 – Sample Selection

Number of Admissions (Past 12 months)	Closed Records (Live Discharges)	Closed Records (Bereavement Records)	Record Review – No Home Visit (RR-NHV)	Record Review with Home Visit (RR-HV)	Total Minimum Sample	Inclusion of Records from Multiple Location(s)
< 150	2	2	7	3	14	The number of records from each location should be proportionate. Include at least one RR-NHV or RR-HV from each location
150 - 750	2	3	10	4	19	
751 - 1250	2	3	12	6	23	
1,251 or more	3	4	14	6	27	

Survey Prep Checklist

- ❑ Practice running key reports and staff schedules
  - ❑ Unduplicated Admissions past 12 months Report
  - ❑ Active Patient Report
  - ❑ Discharged/Transferred Patient Report
  - ❑ Active Bereavement Report
  - ❑ Schedule of Visits Report
- ❑ Know your Plan of Care week
- ❑ Once observation visits are identified, contact patient/MPOA for approval of visit; Assist with completion of authorization and confidentiality document

Task 4 – Information Gathering

The Survey Focus:

- Patient outcomes
- Implementation of requirements
- Provision of care/services

Surveyor considers the inter-relatedness of the regulations while evaluating compliance through:

Key Consideration for Field Observation Visits

Field visits are the only opportunity for the surveyor to observe the direct care provided by hospice personnel. The surveyor will use observation and interview skills to assess the hospice's adherence to the requirements.

- Patient / Family Rights and Communication
- Admission Paperwork / Emergency Plan
- Bag Technique / Medical Waste Disposal
- Infection Control / Hand Hygiene
- Clean and Dirty "Car Stock" Supplies
- Provision of Drugs, Treatments, Services and DME
- Volunteer Utilization
- Coordination of Care with Facility (if applicable)
- More

Key Consideration for IDT

IDT Meeting Observation:

- Are all relevant core services staff present (remote or in person)?
- Are other hospice staff members involved in the patient's care participating?
- Are family/caregivers encouraged to attend / provide input?
- Are the goals of care being reviewed and revised as needed?
- Are medication orders reviewed for effectiveness? New orders documented timely?
- Is the plan of care being reviewed and revised as needed? Individualized?
- How are documented missed visits being addressed?

The surveyor will also assess for evidence of coordination of care and communication with the IDT, Patient/Family, and with non-hospice providers (attending physicians, SNFs, etc.).

Survey Prep Checklist

- ❑ Workspace is clean and well organized; Required postings are current
- ❑ Routinely check medical supplies for expired supplies; Ensure proper storage
- ❑ Keep commonly asked for policies and procedures readily available
- ❑ Practice program interviews with hospice personnel
- ❑ Observe IDT and provide guidance on discussion
- ❑ Update manuals, logbooks, and bulletin boards regularly
  - ❑ QAPI
  - ❑ EPP
  - ❑ PIPs
  - ❑ Temp. Log
  - ❑ Complaints
  - ❑ On-Call
  - ❑ Volunteer Program
  - ❑ Bereavement Program
  - ❑ Contracts
  - ❑ Other
- ❑ Keep Governing Body engaged in activities of hospice
- ❑ Maintain current personnel credentials and education

Task 5 – Preliminary Decision / Findings

Preliminary Decision Making and Analysis of Findings:

Standard Level Deficiencies

- Noncompliance with any single requirement or several requirements within a particular standard.
- Doesn’t substantially limit a hospice’s capacity to furnish adequate care or doesn’t jeopardize the health or safety of patients if the deficient practice recurred.

Condition Level Deficiencies

- Noncompliance with requirements in a single standard or several standards within the condition.
- Representing an actual or potential severe or critical patient health or safety breach.

Survey Checklist

- ❑ Seek additional specific information related to finding
- ❑ Utilize key personnel to clarify findings at the time of survey (if possible)
- ❑ Offer evidence of compliance (if possible)
- ❑ Attempt to correct while Surveyor(s) is on-site
- ❑ Do not become argumentative with Surveyor(s)

Task 6 – Exit Conference

The Exit Conference serves as a forum for the Surveyor(s) to educate the Agency on regulations, provide the (preliminary) informal review of deficiencies, and advise on next steps/what to expect in regard to receiving their final statement of deficiencies and instructions for completing and submitting a plan of correction.

The Surveyor(s) may give specific regulatory citation references; however, final citations will be recorded on the official survey Statement of Deficiencies and Plan of Correction, Form CMS-2567, which is received after the survey has ended.

Survey Checklist

- ❑ Identify key personnel to be present for Exit Conference
- ❑ Take detailed notes
- ❑ Do not become argumentative with Surveyor(s)
- ❑ Thank Surveyor(s) for time and efforts

Task 7 – Post Survey Activities

After the exit conference and the Surveyor(s) depart the agency, the Agency should start to work on developing and implementing action plans immediately.

Immediate Post-Survey Checklist

- ❑ Debrief with key personnel the preliminary findings and deficiencies reviewed
- ❑ Maintain information and instructions from the Surveyor(s)
- ❑ Forecast potential deficiencies to begin a focused plan of correction can be initiated.
- ❑ Assign action items for follow-up and steps to begin developing an effective plan of correction.
- ❑ Do not wait until to receive the final statement of deficiencies to determine necessary corrective actions.

Analyze The Statement of Deficiencies

Analyze the Statement of Deficiencies – CMS-2567

- ❑ Thoroughly read every example cited.
- ❑ Multiple issues can be written under the citation for one tag.
- ❑ Each issue requires corrective action.
- ❑ Perform a Root Cause Analysis to determine why each deficiency occurred.
  - ❑ What systems were lacking or incomplete?
  - ❑ Was there something that staff should have been doing but were not?
  - ❑ Is the issue related to a knowledge deficit?
  - ❑ Is the problem isolated or discreet?
  - ❑ Is the problem system-wide or systemic?

Plan of Correction

Hospices have just **ten calendar** days upon receiving the written Statement of Deficiencies – Form CMS-2567 to complete and submit a Plan of Correction that effectively addresses the alleged deficiencies.

Core elements of a Plan of Correction:

- Directly and specifically describe the measures the hospice will put into place to take corrective action and ensure the alleged deficient practice does not recur.
- Identify the monitoring procedures the hospice will institute to ensure compliance is maintained into the future.
- Identify proposed completion dates and responsible parties for the corrective actions.

Plan of Correction

A general statement indicating compliance has been achieved or will be achieved will not be acceptable, as the plan of correction must state exactly how the deficiency has been or will be corrected, and how the Agency will measure effectiveness of the corrective actions and assure it will not recur.

Enforcement actions, such as termination, may not be delayed even if the Agency's plan of correction is late or needs revision prior to become acceptable.

Implementation of Plan of Correction

Supporting documentation is inclusive of:

- ❑ All staff educational offerings and special trainings designed to correct deficiencies, inclusive of copies of agendas, sign-in sheets and any handouts provided
- ❑ Agendas, sign-in sheets and minutes for all management and staff meetings that are related to plan of correction activities
- ❑ Any audit tools created and used for testing and monitoring activities, along with all the data aggregated and analyzed, and summaries of the findings
- ❑ All new and/or revised policies and procedures need to be effectively documented, along with evidence of communication and training of them to staff
- ❑ New or revised processes or established systems also need to be well documented and tested for the desired impact and outcomes the agency wished to achieve

Integrate Plan of Correction with QAPI

Your agency's Quality Assurance and Performance Improvement (QAPI) program should always include the plan of correction activities on some level.

Some deficiencies may easily be corrected and others may need extensive ongoing monitoring. Prioritize each one and align supporting documentation with performance improvement projects (PIPs) within your QAPI program.

- ❑ Encourage engagement from staff on all levels
- ❑ Update staff on progress toward goals
- ❑ Use visual displays in staff work areas for active PIPs
- ❑ Keep your Governing Body informed

Enforcement

Enforcement Remedies

Civil Monetary Penalties

Temporary Management

Directed Plan of Correction

Directed In-Service Education

Suspension of Payments (All or Partial)

Deficiencies and Risk Indicators

Most Commonly Cited Deficiencies

Plan of Care

Comprehensive Assessment

Hospice Aides

Infection Control - Prevention

Volunteers

Discharge or Transfer of Care (DC Summary)

Source: CHAP - HSP-Top-10-Deficiencies-2025_Final-Revised.pdf

Latest Data - SSVI

Services and Spending Variation Index (SSVI)

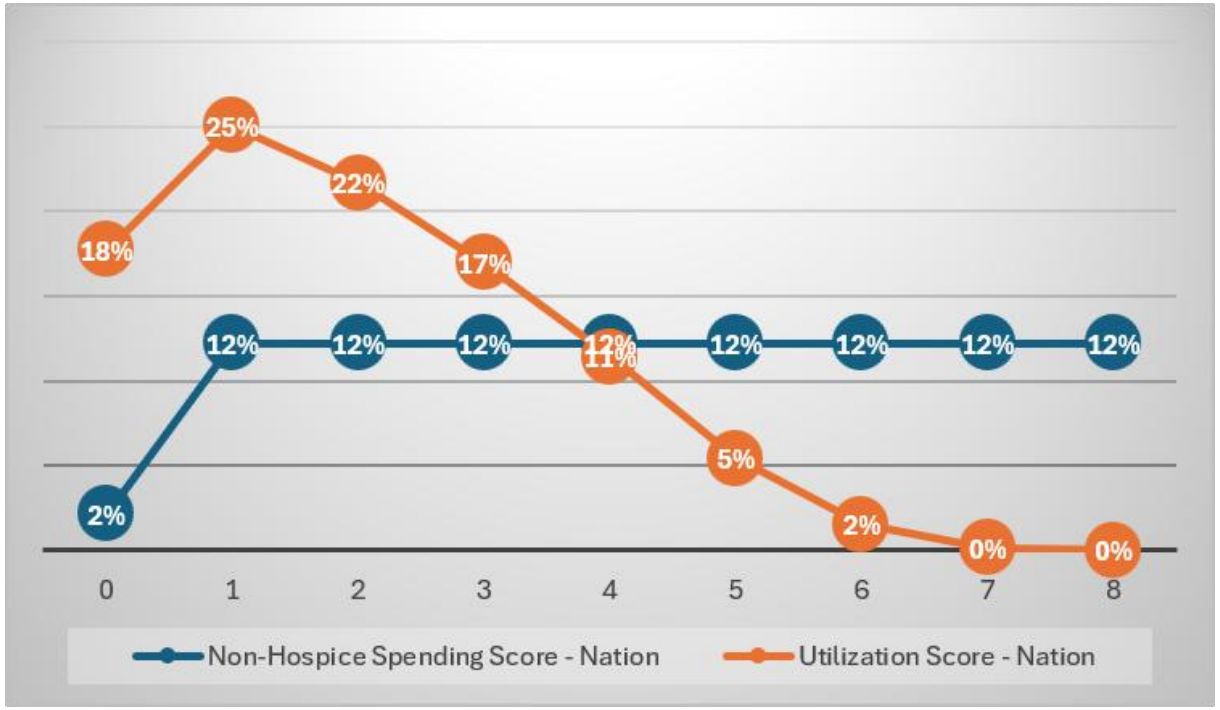
Composite index assessing hospice utilization and non-hospice spending using nine claims-based metrics.

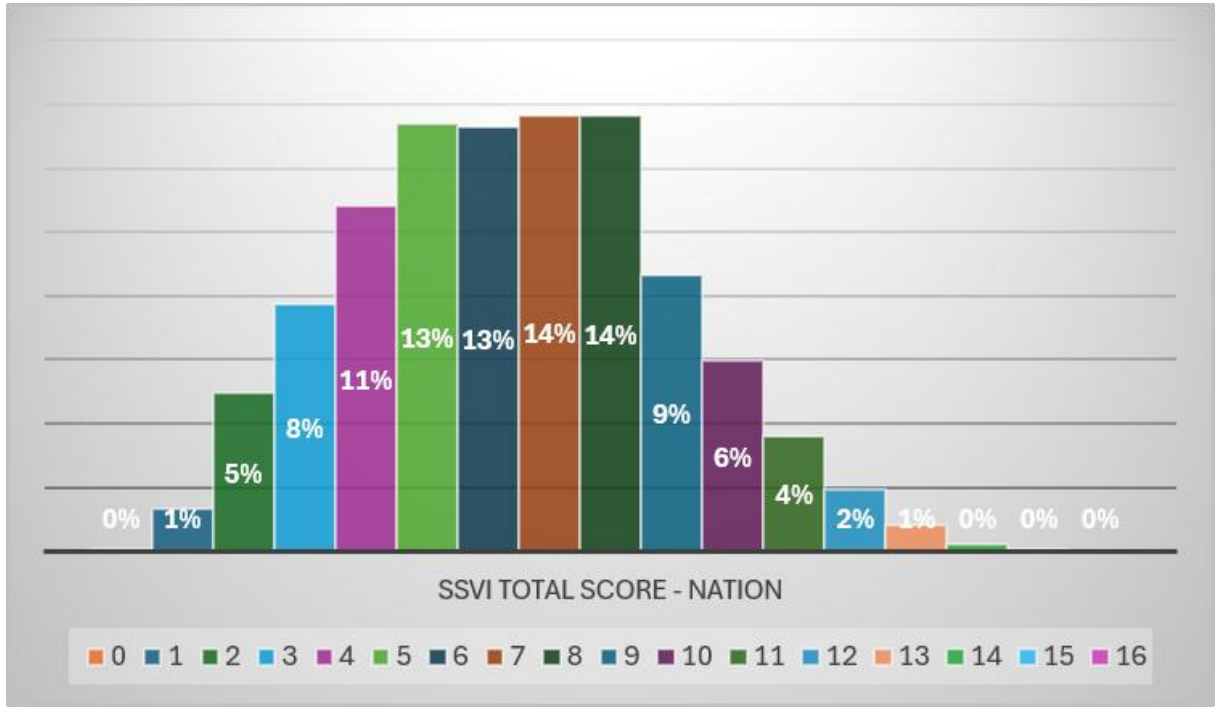
- Publicly available scoring system
- Non-hospice spending increases
- Not an indicator of fraud, waste, or abuse
- May signal potential program integrity risks or inappropriate utilization

Scores range from 0 to 16; higher scores indicate greater potential compliance risks and oversight focus.

Latest Data - SSVI

2025 National Scores – 6,673 Agencies





Source: [CMS 2027 hospice final Medicare payment rule]

Latest Data - SSVI

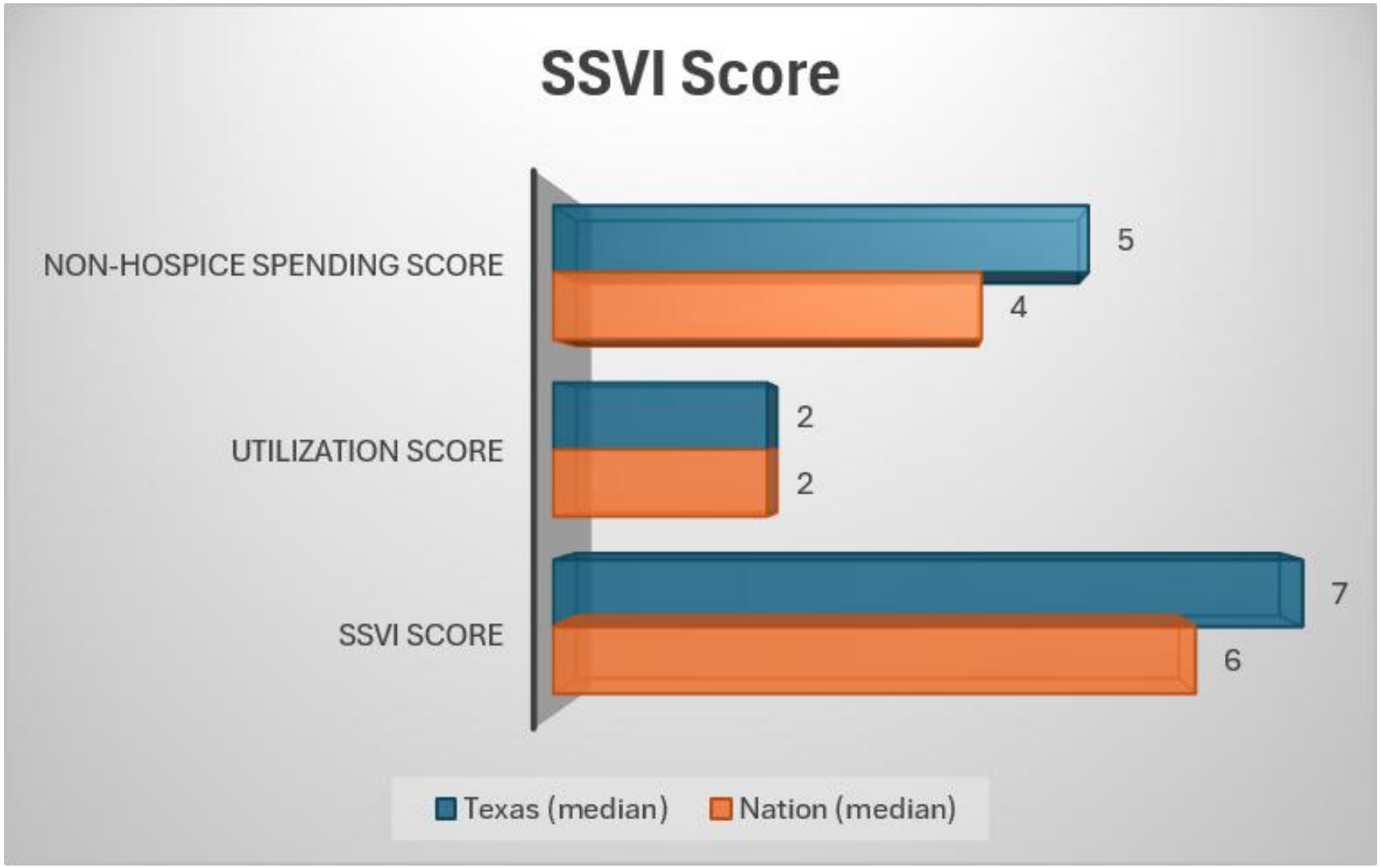
2025 Texas Scores – 1,005 hospices

Texas has 1,005 Medicare hospices with a FY2025 SSVI score.

The Texas median is 7 of 16, and 14% of the Texas hospices landed in the national worst grouping (SSVI 11+).

Source: CMS 2027 hospice final Medicare payment rule

Latest Data - SSVI



$10.10

Texas (median) non-hospice spending per day (all days in FY 2025)

$5.90

Nation (median) non-hospice spending per day (all days in FY 2025)

Source: CMS 2027 hospice final Medicare payment rule

Latest Data - SSVI

Percent of FY 2025 **RHC days** where site of service was a **NF or SNF**

3%
Texas (median)

6%
Nation (median)

Source: CMS 2027 hospice final Medicare payment rule

Latest Data - SSVI

Percent of beneficiaries who **died in hospice** in FY 2025, and:

- Last **two days** were **RHC**
- Last **two days** received at least **one SN visit**

97%
Texas (median)

97%
Nation (median)

Source: CMS 2027 hospice final Medicare payment rule

Latest Data - SSVI

Average LOS for beneficiaries discharged in FY 2025

- Includes lifetime hospice days
- Excludes transfers

154 days
Texas (average)

133 days
Nation (average)

Source: CMS 2027 hospice final Medicare payment rule

Latest Data - SSVI

Median LOS for beneficiaries discharged in FY 2025

- Includes lifetime hospice days
- Excludes transfers

46 days
Texas (median)

40 days
Nation (median)

Source: CMS 2027 hospice final Medicare payment rule

Latest Data - SSVI

Percent of beneficiaries discharged in FY 2025 whose **LOS** was **180 days or more**

- Includes lifetime hospice days
- Excludes transfers

25%
Texas (median)

22%
Nation (median)

Source: CMS 2027 hospice final Medicare payment rule

Latest Data - SSVI

Percent of FY 2025 discharges that were **live discharges**

- Includes live and dead discharges
- Excludes transfers

28%
Texas (median)

22%
Nation (median)

Source: CMS 2027 hospice final Medicare payment rule

Latest Data - SSVI

Percent of FY 2025 **live discharges** where beneficiaries **returned to same hospice in seven days**

0%
Texas (median)

0%
Nation (median)

Source: CMS 2027 hospice final Medicare payment rule

Latest Data - SSVI

Percent of FY 2025 **RHC** days on the **weekend** with **at least one skilled visit**

5%

Texas (median)

7%

Nation (median)

Source: CMS 2027 hospice final Medicare payment rule

Latest Data - PEPPER

- Hospice-specific Medicare statistics for discharges and services vulnerable to improper payment
- Data from 2025 federal fiscal year
- Released on 06.03.2026

Encourages hospices to review data about their billing practices to help ensure they submit accurate claims for payment.

Latest Data - PEPPER

Live discharges:

- **No longer terminally ill**
- **Revocations**

35%

25%

Texas 80th percentile

23%

36%

National 80th percentile

Source: FY 2025 hospice PEPPER reports

Latest Data - PEPPER

LOS

- **61-179 days**
- **180 days or greater (long)**

36%

32%

Texas 80th percentile

40%

28%

National 80th percentile

Source: FY 2025 hospice PEPPER reports

Latest Data - PEPPER

RHC provided in:

- **ALF**
- **NF**
- **SNF**

42%
34%
15%
Texas 80th percentile

44%
36%
21%
National 80th percentile

Source: FY 2025 hospice PEPPER reports

Latest Data - PEPPER

Claims billed with a **single diagnosis**

59%

Texas 80th percentile

88%

National 80th percentile

Source: FY 2025 hospice PEPPER reports

Latest Data - PEPPER

No GIP or CHC

100%

Texas 80th percentile

100%

National 80th percentile

Source: FY 2025 hospice PEPPER reports

Latest Data - PEPPER

Long GIP LOS (greater than 5 consecutive days)

30%

Texas 80th percentile

23%

National 80th percentile

Source: FY 2025 hospice PEPPER reports

Latest Data - PEPPER

Average number of **Medicare Part D** [*prescription drug*] claims for beneficiaries residing at (3-day minimum):

- **Home**
- **ALF**
- **NF**

7%
14%
17%
Texas 80th percentile

8%
14%
15%
National 80th percentile

Source: FY 2025 hospice PEPPER reports

Latest Data - PEPPER

Average number of **Medicare Part B** [*outpatient services*] claims for beneficiaries residing at (3-day minimum):

- **Home**
- **ALF, NF, or SNF**

5%

15%

Texas 80th percentile

4%

10%

National 80th percentile

Source: FY 2025 hospice PEPPER reports

Using QAPI To Enhance Survey Readiness

Survey Readiness Strategies and QAPI

Establish A Robust QAPI Program

- Leverage the power of your QAPI program as your early warning system for proactive compliance and operational excellence
- Develop a formal QAPI program tailored to your organization's operations and compliance requirements.
- Focus on data-driven improvement projects, including patient outcomes, staff performance, and operational efficiencies.
- Utilize an interdisciplinary team approach to lead, oversee, and drive QAPI initiatives.

Survey Readiness Strategies and QAPI

Conduct Regular Self-Surveys

- Perform routine mock surveys to simulate inspections.
- Utilize audit checklists and survey guidelines as essential benchmarks for evaluating performance.
- Design focused audits that align with your expectations.
- Evaluate key areas such as infection control, care planning, and emergency preparedness.
- Document findings and implement performance improvement plans.

Survey Readiness Strategies and QAPI

Implement Data Tracking Monitoring Systems

- Utilize technology to track and analyze key performance indicators (KPIs) for your Agency.
- Monitor trends to identify risk areas for improvement before they become deficiencies.
- Regularly review data with staff and adjust practices accordingly.

Survey Readiness Strategies and QAPI

Standardize Documentation Processes

- Establish clear documentation protocols to ensure records' accuracy, completeness, and timeliness.
- Design targeted audit tools to define and track essential Key Performance Indicators (KPIs), ensuring clear communication of expectations and measurable outcomes
- Conduct routine reviews of clinical documentation, human resource records, and incident reports to identify gaps.
- Provide ongoing training on effective documentation practices.

Survey Readiness Strategies and QAPI

Develop Focused Policies and Procedures

- Review and update your organization policies to align with current CMS regulations and standards.
- Ensure all staff are familiar with and adhere to updated expectations.
- Include protocols for high-risk areas like medication reconciliation, falls, pressure ulcers, and infection outbreaks.

Survey Readiness Strategies and QAPI

Train Staff on Quality Standards

- Incorporate quality assurance training into onboarding and ongoing education programs.
- Emphasize the importance of compliance with CMS regulations and organization policies.
- Use case studies and real-world examples to illustrate the impact of quality practices.

Survey Readiness Strategies and QAPI

Use Patient and Family Feedback

- Regularly request feedback from patients and their families to identify strengths and areas for improvement.
- Incorporate feedback into QAPI initiatives to enhance patient satisfaction and care quality.
- Demonstrate responsiveness to feedback during audits as evidence of continuous improvement.

Survey Readiness Strategies and QAPI

Maintain Comprehensive Training Records

- Keep detailed records of all training sessions, including dates, topics, and attendee lists.
- Demonstrate ongoing staff education efforts during audits.
- Review training records to identify knowledge gaps and prioritize future sessions.

Culture of Compliance

76% of Employees Believe Managers Establish Culture

Source: SHRM


NO
LEFT
TURN
Smith

BUILD A CULTURE OF COMPLIANCE

Culture of Compliance

Leading Voices

- Support From Leadership Is Essential
- Walk the Walk, Talk the Talk
  - Encourage and Affirm Quality

Culture of Compliance

Support Systems

- A Commitment To Resources
  - Proper Systems
  - Personnel
- Compliance Staff lead efforts to maintain compliance and evaluate risk

Culture of Compliance

Write On

- Written Policies and Procedures
  - Accessible For All
- Outline Regulatory requirements, expectations, and organizational strategies

Culture of Compliance

Learning Opportunities

- Provide Regularly Scheduled Training
- Grow Abilities and Skills of Team
  - Empowerment, Ownership, and Accountability

Culture of Compliance

Checks and Balances

- Independent Review and Audit
  - Celebrate Successes
  - Learn Weaknesses and Blind Spots

Culture of Compliance

Increasing Communication

- Internal Channels for Team to Receive and Send Information
  - Make Good Communication A Habit
- Focus on Compliance-Related Responsibilities
  - Fuel Momentum

Conclusion

Survey Readiness

UNDERSTAND YOUR ROLE IN SURVEY READINESS AND RESPONSE

ESTABLISH QUALITY ASSURANCE PRACTICES

USE AUDITS & DATA TO GATHER INSIGHTS

Survey Readiness

FOSTER A CULTURE OF COMPLIANCE THROUGH ACCOUNTABILITY

KEEP THE FOCUS ON QUALITY PATIENT CARE

Survey readiness should be an ongoing, team effort

Survey Readiness

References

Code of Federal Regulations 42 CFR Part 424-Conditions for Medicare Payment: https://www.ecfr.gov

State Operations Manual Appendix M - Guidance to Surveyors: Hospice

www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_m_hospice.pdf

General Compliance Program Guidance | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services

https://oig.hhs.gov/compliance/general-compliance-program-guidance/

CHAP: HSP-Top-10-Deficiencies-2025_Final-Revised.pdf