



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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November 24, 2015

Justin Cheney, Administrator
Solace Healthcare
197 Stockham Blvd, Suite 2
Rigby, ID 83442-1275

Provider #131566

Dear Mr. Cheney:

An unannounced on-site complaint investigation was conducted from September 28, 2015 to September 29, 2015 at Solace Healthcare. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006187

Allegation: Patients without terminal diagnoses were inappropriately solicited or recruited and placed on hospice services.

Findings: An unannounced investigation was conducted at the hospice agency on 9/28/15 to 9/29/15. During the complaint investigation, nine patient records, hospice policies, and job descriptions were reviewed. Additionally, hospice staff and one former hospice patient who revoked hospice benefits were interviewed.

One former hospice patient was interviewed by telephone on the morning of 9/29/15. She stated she had called the hospice inquiring about a non-hospice service and the nursing director asked to come out and talk to her about hospice benefits. She stated she thought she was being recruited and he was quite persistent. She allowed him to come out and sign her up for hospice but she later revoked her benefit.

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The hospice staff provided a job description of an employee position, referred to as a "Community Representative," whose role, in part, was to procure hospice referrals for Solace Health Care and to meet weekly and monthly goals. During an interview on 9/25/15 at 9:00 AM, hospice staff described these individuals as "marketers" and said it was their job to look for patients who might qualify for hospice. There is no regulatory requirement prohibiting the hospice from soliciting referrals.

According to a hospice policy, titled "MEDICARE HOSPICE BENEFIT," patients were to meet the following criteria to be eligible for the hospice benefit:

- Patients "are eligible for Medicare part A, and"
- Patients "are certified as terminally ill by their personal physician, if they have one, and by the hospice medical director and have six (6) months or less to live if the terminal illness runs its normal course, and"
- Patients "sign a statement choosing hospice care instead of other Medicare-covered benefits to treat the terminal illness (Medicare will continue to pay for covered benefits for any health problems that are not related to the terminal illness), and"
- Patients "receive care from a Medicare-approved hospice."

After receiving a referral for hospice and prior to admission to hospice, the agency was required to determine and verify that patients were appropriate for hospice based on Medicare requirements and agency policy.

The hospice's undated policy "Admission Criteria and Process," was reviewed. It described the following procedure for admitting a patient to hospice:

- "Referral information provided by family, caregiver, healthcare clinicians from other facilities, other agencies and physicians {sic} offices may help in the determination of eligibility for admission. If the patient's physician does not make the request for service, Hospice will consult with the physician before the assessment visit."
- "Hospice staff shall make the initial home visit within the time requested by the referral source or as ordered by the physician or at least by 72 hours after the referral. The purpose of the initial visit:
 - a. To explain hospice and its philosophy and services to the patient, family member or caregiver

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- b. To assess the patient, the availability of a support system, the physical facilities and equipment
- Pc. To decide if the patient meets the criteria for admission, is appropriate for Hospice and has a safe environment for effective care
- d. To allow the patient, family or caregivers to ask questions and decide about Hospice services especially those provided under the Medicare/Medicaid Hospice Benefit
- e. To review appropriate forms and subsequently sign forms if the patient, family member or caregiver agrees that the patient is appropriate for Hospice services."

All 9 patient records reviewed included documentation of appropriateness for hospice based on the regulatory requirements and hospice policies. For example, one medical record documented a 61 year old female who was admitted to hospice on 6/12/13. The initial manner of referral to the hospice was not documented. However, the medical record included documentation of "Physician's certification of Terminal Illness," dated 6/13/13, based on a diagnosis of Parkinson's Disease. The certification of terminal illness was signed by the attending physician and the hospice medical director.

It could not be determined that patients without terminal diagnoses were inappropriately solicited or recruited and placed on hospice services. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TH/pmt



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Provider #131566

Dear Mr. Cheney:

An unannounced on-site complaint investigation was conducted from September 28, 2015 to September 29, 2015 at Solace Healthcare. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006999

Allegation #1: Patients without accurate terminal diagnoses were inappropriately solicited or recruited and placed on hospice services without being fully informed.

Findings #1: An unannounced investigation was conducted at the hospice agency on 9/28/15 to 9/29/15. During the complaint investigation, nine patient records, hospice policies, and job descriptions were reviewed. Additionally, hospice staff and one former hospice patient who revoked hospice benefits were interviewed.

One former hospice patient was interviewed by telephone on the morning of 9/29/15. She stated she had called the hospice inquiring about a non-hospice service and the nursing director asked to come out and talk to her about hospice benefits. She stated she thought she was being recruited and he was quite persistent. She allowed him to come out and sign her up for hospice but she later revoked her benefit.

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The hospice staff provided a job description of an employee position, referred to as a "Community Representative," whose role, in part, was to procure hospice referrals for Solace Health Care and to meet weekly and monthly goals.

During an interview on 9/25/15 at 9:00 AM, hospice staff described these individuals as "marketers" and said it was their job to look for patients who might qualify for hospice. There is no regulatory requirement prohibiting the hospice from soliciting referrals:

According to a hospice policy, titled "MEDICARE HOSPICE BENEFIT," patients were to meet the following criteria to be eligible for the hospice benefit:

- Patients "are eligible for Medicare part A, and"
- Patients "are certified as terminally ill by their personal physician, if they have one, and by the hospice medical director and have six (6) months or less to live if the terminal illness runs its normal course, and"
- Patients "sign a statement choosing hospice care instead of other Medicare-covered benefits to treat the terminal illness (Medicare will continue to pay for covered benefits for any health problems that are not related to the terminal illness), and"
- Patients "receive care from a Medicare-approved hospice."

After receiving a referral for hospice and prior to admission to hospice, the agency was required to determine and verify that patients were appropriate for hospice based on Medicare requirements and agency policy.

The hospice's undated policy "Admission Criteria and Process," was reviewed. It described the following procedure for admitting a patient to hospice:

- "Referral information provided by family, caregiver, healthcare clinicians from other facilities, other agencies and physicians {sic} offices may help in the determination of eligibility for admission. If the patient's physician does not make the request for service, Hospice will consult with the physician before the assessment visit."
- "Hospice staff shall make the initial home visit within the time requested by the referral source or as ordered by the physician or at least by 72 hours after the referral. The purpose of the initial visit:
 - a. To explain hospice and its philosophy and services to the patient, family member or caregiver

- b. To assess the patient, the availability of a support system, the physical facilities and equipment
- c. To decide if the patient meets the criteria for admission, is appropriate for Hospice and has a safe environment for effective care
- d. To allow the patient, family or caregivers to ask questions and decide about Hospice services especially those provided under the Medicare/Medicaid Hospice Benefit
- e. To review appropriate forms and subsequently sign forms if the patient, family member or caregiver agrees that the patient is appropriate for Hospice services."

All 9 patient records reviewed included documentation of appropriateness for hospice based on the regulatory requirements and hospice policies. For example, one medical record documented a 69 year old female who was admitted to hospice on 3/10/15 and revoked the benefit on 4/14/15. The initial manner of referral was not documented in the record. However, during an interview on 9/29/15 at 9:00 AM, hospice staff stated the patient had called the hospice inquiring about different benefits that were not available at the time of the request, and staff suggested she might qualify for hospice benefits. The patient's physician signed an order to "evaluate for hospice and admit if criteria is met." An evaluation was documented and it was determined criteria was met. The medical record included documentation of "Physician's certification of Terminal Illness," dated 3/10/15, which was signed by the attending physician and the hospice medical director.

The patient's terminal diagnosis was chronic obstructive pulmonary disease (COPD). She revoked the benefit on 4/14/15. History information provided to the hospice by the patient's physician included diagnoses, such as diabetes, hypertension, hyperlipidemia, hypothyroidism, chronic kidney disease, depression, anxiety, Post Traumatic Stress Disorder and COPD.

There was no reference in the patient's hospice medical records indicating the patient had a diagnosis of dementia. However, the medical record included a form "Pain Assessment in Advanced Dementia." It was completed on 3/10/15. When asked why the form was used for a patient who did not have documented dementia, hospice staff stated it was a tool that was used to assess non-verbal expression of pain. The information was compared to the pain rating provided by patients on a scale of 1-10. Hospice staff said the form was routinely completed on patients, whether or not they had known dementia.

It could not be determined that diagnosis information was not accurate.

Further, agency's admission packet included written information which was provided to patients and/or their caregivers upon admission to hospice. One form included in the initial packet was titled "Medicare Benefit Informed Consent." The form included, but was not limited to, the following information:

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"I elect/agree to have Solace Health Care provide me with hospice services, which is of a palliative nature, in providing care for me and my family in relation to my terminal illness. I acknowledge that I have been fully informed that my care is of a palliative nature, in that it is not focused on curative treatment, but comfort measures (pain and symptom management) associated with my physical, emotional, social, and spiritual needs as it relates to my terminal illness. I acknowledge that Medicare will cover my hospice care as set forth by this section:

- (1) My care will be provided by the elected hospice I designate to care for me, and no other hospice unless provided under arrangements made by the designated hospice.
- (2) Any Medicare services that are related to the treatment of my current terminal condition, or equivalent to services provided by hospice for which I elected designated hospice to care for. I understand that I may offer input as to the care I will be receiving from the hospice team.
- (3) My attending physician will continue to receive compensation from Medicare as long as he/she is not receiving compensation from Solace Health Care (hospice).
- (4) If I seek care outside of my designated hospice, I am financially responsible for the cost of that care/service and I agree to communicate that with my designated hospice.
- (5) Room and Board are not covered under the Medicare hospice benefit unless I meet the qualifications for inpatient or respite levels of care set forth by the hospice benefit.
- (6) I may be held responsible for no more than \$5 for each prescription drug or similar products. In addition I may also be responsible for 5% of the Medicare payment amount for inpatient respite.
- (7) I will receive hospice care as long as my physician and or hospice medical director certifies and continues to re-certify that I have a terminal illness.
- (8) The hospice will designate a registered nurse to coordinate the implementation of my plan of care.

I acknowledge that I have the right to discontinue hospice services at any time by notifying my designated hospice and completing a revocation statement. I acknowledge that if I seek curative treatment, admittance to a hospital, or call 911 without notifying my designated hospice first, the agency may assume that I wish to revoke my Medicare hospice benefit. The duration of this election will continue through the initial election period (initial certification) and through the subsequent election periods (recertification) without a break in care as long as I remain in the care of the hospice and do not revoke this benefit.

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I acknowledge that the physician I designated as my attending physician, the hospice medical director and the hospice team will coordinate my care. The hospice team will not take the place of my caregivers or support network, but will supplement and support the caregivers in place. I authorize Solace Health Care to obtain any medical record/history pertaining to my care from any Hospital, Nursing Facility, Physicians, hospice, or appropriate location to assure continuity of care. Solace Health Care will not release any patient information without written consent of patient or legal guardian in accordance with HIPAA."

All 9 patient records reviewed included documentation that patients had elected the hospice benefit and received the "Medicare Benefit Informed Consent" information.

It could not be determined that patients without accurate terminal diagnoses were inappropriately solicited or recruited and placed on hospice services without being fully informed. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The agency did not allow patients to choose their physician.

Findings #2: The agency's admission packet included information on a form titled "Notice of Hospice Patient Rights and Responsibilities." The form documented multiple rights which included the right to "choose your attending physician." On the informed consent document, there was a place for the patient to state the name of the physician being selected as the attending physician.

On 9/29/15 at 9:00 AM hospice nursing and administrative staff were interviewed. They stated patients were allowed to keep their personal physician as the attending. However, if the attending physician became unavailable, then the patient could select another doctor or the hospice medical director would assume responsibility for caring for the patient.

All 9 patient records reviewed included a signed document which stated "I have chosen {physician's name} as my attending physician." For example one medical record documented a 69 year old female who was admitted to hospice with a diagnosis of chronic obstructive pulmonary disease on 3/10/15. She revoked the benefit on 4/14/15. An "An Admission Assessment Worksheet," dated 3/10/15, indicated the patient was able to answer questions and was alert and oriented to person, place, and time.

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Her record included an informed consent document, dated 3/10/15, stating the patient had selected a specific physician to be her attending physician. No other documentation regarding her physician's status (e.g. being asked to change physician's, the patient requesting to change physician's, documentation of her physician becoming unavailable, etc.) was present in the record.

It could not be determined that patients were not allowed to choose their physician. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Patients were not fully informed of hospice suppliers and costs, and medications and tests are ordered inappropriately.

Findings #3: The agency's admission packet included written information which was provided to patients and/or their caregivers, upon admission to hospice. One form included in the initial packet was titled "Medicare Benefit Informed Consent." The form included, but was not limited to, the following statements:

"Any Medicare services that are related to the treatment of my current terminal condition, or equivalent to services provided by hospice for which I elected designated hospice to care for. I understand that I may offer input as to the care I will be receiving from the hospice team."

"If I seek care outside of my designated hospice, I am financially responsible for the cost of that care/service and I agree to communicate that with my designated hospice."

"Room and Board are not covered under the Medicare hospice benefit unless I meet the qualifications for inpatient or respite levels of care set forth by the hospice benefit."

"I may be held responsible for no more than \$5 for each prescription drug or similar products. In addition I may also be responsible for 5% of the Medicare payment amount for inpatient respite."

Further, the agency's "Notice of Hospice Patient Rights and Responsibilities" also included the right to "be informed in advance of the extent to which payment may be expected from Medicare, Medicaid or other third party payer and any costs for which you may be responsible."

All 9 patient records reviewed included documentation that patients had received the "Medicare Benefit Informed Consent" information. Further, patient records included additional documentation of patient consent based on their individualized needs.

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For example, one medical record documented a 69 year old female who was admitted to hospice with a diagnosis of chronic obstructive pulmonary disease on 3/10/15. She revoked the benefit on 4/14/15. Her record included a "Pharmacy Services Provider Agreement," dated 3/10/15, which was signed by the patient to authorize "assignment of benefits" to the pharmacy that contracted with the hospice. Supplies, including an oxygen concentrator, nebulizer, portable oxygen, walker, and shower chair, were authorized to be provided by "Hospice Supply" per the patient's 3/10/15 physician's verbal orders.

The hospice agency assumed financial responsibility for all medication and supplies provided by the pharmacy and durable medical equipment suppliers the agency contracted with.

The patient's record also documented that at the time of her admission, the patient had informed the agency that she did not use pain medications. However, a physician order for a "Comfort Kit" was ordered on 3/10/15 and signed by a physician. There was an indication to send the kit to the patient's home, followed by a note to "hold" it. The reason for the hold was not stated. However, the record did not document specific contraindication to the medications, such as patient allergy or sensitivity. A second physician order, dated 3/13/15 at 9:30 AM, documented Tramadol was ordered to be used "as needed" for pain.

A staff RN who was interviewed on 9/29/15 at 9:00 AM, stated the hold may have been based on the patient's preference to not use pain medication. However, hospice staff said the pharmacy did not get the message in time to hold the medication and had already delivered the medication to the patient's home. She stated the patient was under no obligation to use the Tramadol or any of the "Comfort Kit" medication, as the "Comfort Kit" was intended for emergencies. The RN stated the medications were being paid for by the hospice.

Additionally, the patient's record documented a verbal physician's order for an echocardiogram, dated 3/17/15. The reason for the test was not documented.

Hospice staff were interviewed on 9/29/15 and asked why the test was ordered. They stated the nurse that obtained the order, and the physician who ordered the test, were no longer associated with the hospice and unavailable for interview. They speculated the test was ordered to evaluate the patient's condition and her prognosis. They stated the cost of the test would have been covered under the hospice benefit, and if the patient received a bill in error, it would be corrected if and when the hospice was alerted to the error.

The patient was interviewed by telephone on 9/29/15. She stated she did not understand why the test was ordered. When asked if she was sent a bill for the test, she stated she did not receive a bill.

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While there was not clear documentation as to the purpose of the test or communication that occurred with the patient about the test, it could not be determined the test was unnecessary or the patient was inappropriately billed.

It could not be determined patients were not fully informed of hospice supplies and costs, or that medications and tests had been ordered inappropriately.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
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