



Rural Health Clinic Survey Process

Bureau of Facility Standards

02/09/2012

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Objectives

- The RHC Survey Process:
 - Identify the 3 components of survey information gathering.
 - Identify the 4 types of RHC surveys.
 - Obtain an increased understanding of CMS direction to State Agencies.
 - Identify the 6 RHC survey tasks.
 - Demonstrate how to use surveyor tools including the regulations and the CMS-30 Form.

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This training is designed to provide an overview of the RHC survey process.



What is a survey?

- Process used to ensure compliance with Federal Regulatory requirements
- Applicable federal certification requirements are found in State Operations Manual (SOM), [Chapter 2](#), and § 2240, [Appendix G](#)

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The Rural Health Clinic program is a federal program under the direction of the Centers for Medicare and Medicaid (CMS). In order to participate in the RHC program, a clinic must achieve and maintain compliance with the Federal Regulatory requirements. RHC federal certification requirements are found in the CMS State Operations Manual (SOM), Chapter 2, and § 2240, Appendix G.

Survey is the process CMS uses to ensure clinics are in compliance with the Federal Regulatory requirements. CMS contracts with State Agencies (SA) to assist them in completing their survey work. In the Idaho, this is done by the Bureau of Facility Standards (BFS) staff, called state surveyors. State surveyors are responsible for conducting survey work for multiple provider types including RHCs.



When does survey happen?

- CMS Direction to State Agencies:
 - Mission & Priorities Document FFY2012

	Tier 1	Tier 2	Tier 3	Tier 4
Rural Health Clinics	Immediate Jeopardy (IJ) Complaints	Targeted Surveys, Non-IJ complaints, & Follow up	7.0 Year Interval & initials	6.0 Year Average

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Each federal fiscal year (FFY), CMS provides the State Agencies with a Mission and Priorities Document which directs how the workload is to be prioritized. The Mission and Priorities Document directs all work for all provider types under the CMS umbrella. For FFY 2012, Rural Health Clinic surveys have been given the priorities indicated on the slide.

Tier 1 includes complaint allegations with the potential for immediate jeopardy, which means the alleged deficient practice is placing the patients at risk for serious harm, impairment, or death.

Tier 2 includes targeted surveys. The direction from CMS regarding Rural Health Clinic targeted surveys states each year, the State surveys 5% of the providers in the State (or at least 1, whichever is greater). Also included in Tier 2 are complaints that do not include an immediate jeopardy component and follow-up surveys for Condition level non-compliance.

Tier 3 work states surveys are done to ensure that no more than 7.0 years elapse between surveys for any *one* provider. Initial surveys for new providers are also currently Tier 3 work. Tier 4 work states surveys are done (beyond tiers 2-3) such that all providers in the State are surveyed, on average, every 6 years.



Types of Surveys

- Initial
- Recertification
- Complaint
- Follow-up/Revisit

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As with all provider types, there are different types of surveys within the RHC program. Those are initial, recertification, complaint, and follow-ups/revisit. Initial surveys are conducted for facilities in order for them to become a Medicare certified Rural Health Clinic provider. Recertification surveys are conducted in order to recertify already established providers. During initial and recertification surveys, all regulatory requirements are reviewed.

Complaint surveys are conducted as the result of allegations of non-compliance with regulatory requirements. These allegations can arise from multiple sources, and all must be investigated when there is a regulatory basis relating to the allegation. Complaint surveys are focused and may not include a review of all regulatory requirements. Complaint surveys only investigate areas of alleged non-compliance with the regulatory requirements. However, surveyors may identify other areas of non-compliance during the course of the complaint survey, which may be unrelated to the original allegation. For example, if an allegation is made that the clinic is not keeping patient medical records, then a survey would be conducted focusing on Patient Records. However, if while conducting the survey, surveyors observed the clinic was not clean, then the Physical Plant and Environment would also be reviewed as it relates to the unsanitary conditions.

Follow-up/revisit surveys are conducted to ensure compliance with regulations which were determined out of compliance during a previous survey. Similar to complaint surveys, follow-up/revisit are focused, however surveyors are not precluded from addressing other deficiencies noted at the time of the follow up.



What happens during a survey?

- RHC survey tasks:
 - Task 1: Off-Site Survey Preparation
 - Task 2: Entrance Activities
 - Task 3: Information Gathering/Investigation
 - Task 4: Preliminary Decision Making and Analysis of Findings
 - Task 5: Exit Conference
 - Task 6: Post Survey Activities

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Basic survey tasks are completed for all surveys (initial, recertification, complaint and follow-up) as indicated on the slide. However, tasks may vary slightly depending on the type of survey being conducted. For example, initial and recertification surveys require a review of all regulatory requirements. However, follow up and complaint surveys are focused surveys and may not require a review of all requirements. As previously stated, for all types of surveys, surveyors conduct observations, record reviews and interviews. Typically, 2 surveyors will conduct the RHC survey, with one of the surveyors serving as a survey Team Leader for coordination purposes.



Task 1: Off-site survey preparation

- Pre-survey protocol
 - Assessment of basic requirements

 - Mandatory Forms:
 - CMS-29
 - CMS-30

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In accordance with SOM Chapter 2, Section 2242, basic requirements, including locations requirements, are to be assessed prior to an RHC initial or recertification survey. If basic requirements are met, then surveyors proceed in gathering all information they will need during the survey process, which includes two mandatory CMS forms. The CMS-29 is filled out by the provider and can be found at:

<http://www.cms.gov/cmsforms/downloads/CMS29.pdf>

The CMS-30 is filled out by surveyor staff. Surveyors record their findings on the CMS-30 form during the course of the survey. The CMS-30 form is also available on our website for your reference at:

<http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=jlz kfUYb00c=&tabid=427&mid=2745>

When looking at the CMS-30 form there is one thing to bear in mind. The CFR numbers are off by 10. So if you look at J0076, it includes a CFR number of 481.11. The actual CFR number for this regulation is CFR 491.11. So when using this form, please remember to add 10 to all CFR numbers.



Tasks 2: Entrance Activities

- Exchange of Information
- Clinic tour

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When surveyors enter the facility, they will introduce themselves and ask to meet with the clinic's Administrator. When meeting with the Administrator, survey staff will discuss the nature of the survey (e.g. recertification survey, complaint survey, etc.) and provide the Administrator with the CMS-29 form to complete (the CMS 29 form is only used for initial and recertification surveys). During the entrance conference, surveyors will also request information necessary to conduct the survey. Standard information requested during an initial or recertification entrance conference includes:

- An Organizational chart/Lines of Authority
- Hours of Operation and Physician and Mid-levels' hours/schedules
- A list of patients seen within the past 6 months
- Policies & Procedures
- Personnel Files
- Written Agreements or arrangements for all services provided outside the clinic
- Documentation from the clinic's most recent total annual program evaluation
- The clinic's CLIA certificate

Surveyors will then request to tour the clinic in order to orient to the physical

location and operations.



Tasks 3: Information Gathering/Investigation

- Observations
- Record review
- Interview

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In all surveys observations, record reviews, and interviews of facility staff and patients are conducted. The following are some examples of surveyor information gathering techniques:

- Observing patient and staff interactions
- Observing the physical environment for cleanliness, organization, privacy, and safety
- Reviewing patient records (typically a **minimum of 25 records selected from rosters of patients seen within the 6 months prior to the survey**)
- Reviewing policies and procedures, maintenance logs, etc.
- Interviewing patients regarding the care received at the clinic
- Interview staff regarding training staff have received, emergency procedures, etc.
- Interviewing staff to confirm what was observed or reviewed in records

Once all necessary information is gathered through these methods, surveyors review the information in light of the regulatory requirements. If the facility's practices are consistent with the regulation then the regulatory requirement is considered "met." If the facility practice is inconsistent with the regulation, then the regulatory requirement is considered "not met" and a citation is issued as a result of the deficient practice.



Tasks 4: Preliminary Decision Making & Analysis of Findings

- Individual findings
- Team Findings
- CMS-30 Form

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Each surveyor completes their individual findings. Individual findings document the concerns surveyors have relating to regulatory compliance. Team findings are then completed. During team findings, the team discusses the information gathered and makes determinations regarding whether the clinic's practices meet the regulatory requirements. Surveyors record their finding on the CMS-30 form.

If you have not already done so, please print a copy of the CMS-30 form to assess compliance with the following scenario. The form can be accessed at: <http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=jlz kfUYb00c=&tabid=427&mid=2745>



Determining Compliance

- Scenarios:
 - The office manager/administrator was interviewed on 6/1/08 at 10 AM. She stated the clinic had not completed an annual evaluation of its total program.
 - The policy titled "REGULAR MEETINGS AND MINUTES", last reviewed by the facility on 3/1/04, stated an annual review would be the subject of the February General Staff meeting. No documentation was found to indicate an annual review had been performed.

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During the recertification survey process, surveyors conducted their observations, record reviews, and interviews. While doing so they were given the information included on the slide. Please take a few minutes to review this information.

Please use the regulations and CMS 30 form to determine if this is a deficient practice. If this is a deficient practice which standard and element J-tag or tags would be cited? Please don't assess Conditional level compliance at this point, only focus on standard and element level tags.

Looking at the CMS 30 form, which Condition of the regulations would this information best apply?

(J-0076, Condition of Coverage for annual program evaluation being completed).

What is the first Standard under that Condition? (Standard J-0077). For additional regulatory information and interpretive guidance regarding this standard, refer to J-0077 in your ASPEN regulation set. After reading the information, determine whether the standard is met. (The standard is *not* met).

Now that it has been determined the Standard at J-0077 is not met, place a check in the "Not Met" box on the CMS 30 form. Then in the far right hand column of the form write a brief statement as to why the standard is not met.

Now please assess the remaining Standard and element level deficiencies under this Condition (J-0078 through J-0086).



Determining Compliance

- Standard J78 – Standard Elements J79, J80, & J81
- Standard J82 Elements J83, J84, & J85
- J86 - Standard

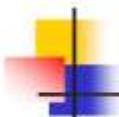
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Please determine whether each tag is met. Ensure to review the following J tags:

- | | | |
|------------------|------------------|------------------|
| J-0078: Standard | J-0082: Standard | J-0086: Standard |
| J-0079: Element | J-0083: Element | |
| J-0080: Element | J-0084: Element | |
| J-0081: Element | J-0085: Element | |

Review how one system break can result in several citations as none of the above requirements would be found met.

Based on the standard and elements which are not met, is the Condition at J-0076 met? It is not met.



Tasks 5: Exit Conference

- Presentation of preliminary findings

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Survey staff will schedule an exit conference with the clinic's Administrator, or their designated representative, to discuss *preliminary* findings of the survey. The clinic may invite other clinic staff to attend the exit as well. However, if the clinic chooses to have an attorney present, then a Department of Health and Welfare attorney must also be present. The survey Team Leader will ensure all final paperwork is received (i.e. CMS-29 form and any other documents that surveyors have requested) and lead the exit conference.

The Team Leader will inform the clinic that the survey team's findings are *preliminary* and subject to supervisory review. However, if there are any additions or deletions to the findings presented at the exit conference, the Team Leader will contact the Administrator and inform him/her.

The Team Leader will then discuss the survey findings for all regulator requirements which found to be not met. During this discussion, all survey team members may discuss the evidence (observations, record reviews, and interviews) that led to the determination of the regulatory requirement being found "not met."

After the presentation of findings, the Team Leader will give a brief summary of the process steps which will be taken following the survey.



Task 6: Post Survey Activities

- CMS 2567
- Patient Identifier List
- Cover letter

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After the survey exit conference, any deficient practice, regardless of the level of the tag - be it a condition, standard, or element, will be documented on the CMS form 2567 Statement of Deficiencies. The 2567 and a patient identifier list is then submitted for supervisory review. Once reviewed, changes to the 2567 are made, as needed, and a cover letter is generated. The 2567, patient identifier list, and cover letter are then sent to the clinic administrator. CMS requires this to be completed within 10 working days of the exit conference.



2567 Condition level example

Based on staff interview and review of clinic policies, it was determined the clinic failed to ensure an adequate program evaluation was completed. The clinic failed to carry out or arrange for an annual evaluation of its total program (J77). Also refer to J78-J86 as they related to the failure of the facility to conduct an annual total program evaluation. The cumulative effect of this systemic practice resulted in the clinic's inability to ensure its services met the needs of the community.

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An example of a Condition level citation is given on the slide. Please note how the Condition refers to other J-tags. While not always the case, when a Condition is not met, the Condition level citation on the 2567 will typically refer to the standards and elements under the Condition which are not met.



2567 Standard/Element level example

Based on staff interview and review of clinic policies, it was determined the clinic failed to perform an annual evaluation of all services, clinical records and policies. The findings include:

1. The office manager/administrator was interviewed on 6/1/08 at 10 AM. She stated the clinic had not completed an annual evaluation of its total program.
2. The policy titled "REGULAR MEETINGS AND MINUTES", last reviewed by the facility on 3/1/04, stated an annual review would be the subject of the February General Staff meeting. It further stated that items to be discussed included the utilization of clinic services, review of a sample of active and closed records, and the clinic's healthcare policies. No documentation was found to indicate an annual review had been performed.

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An example of a standard or elemental level citation is given. Standard level and element level citations typically include specific information related to the deficient practices. Although some Standard and element level citations may also be referred; frequently to demonstrate a cause-and-effect relationship.



Clinic's Response

■ Plans of Correction & Credible Allegations of Compliance

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When deficient practices are cited, the clinic is required to submit a response. Plans of Correction (PoC) and Credible Allegations of Compliance (Credible) identify how the facility plans to correct non-compliance as identified on the 2567. A PoC is submitted in response to standard or element level deficiencies and a Credible is submitted in response to Condition level deficiencies. Both PoCs and Credibles must be submitted to the State Agency within 10 calendar days of the date the 2567 was received and both PoCs and Credibles must include these elements for *each* citation:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- Procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the RHC into compliance, and that the RHC remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the plan of correction; and
- The administrator's signature and the date signed on page 1 of the 2567 form.

While general requirements and submission time lines are the same for both PoCs and Credibles, timeframes for the correction of the deficient practices vary. Within a PoC, the correction date may be a "future" date, normally less than 60 days. However, within a Credible the correction date must be a date prior to the date specified in the cover letter. That is, for a PoC the clinic is saying they will have a corrective plan in place by a certain date in the future, but for the credible the clinic is saying the issue has been resolved as of this date and we are ready to be resurveyed to determine compliance at the Condition-level. Timelines related to a specific survey are included in the cover letter which accompanies the 2567.



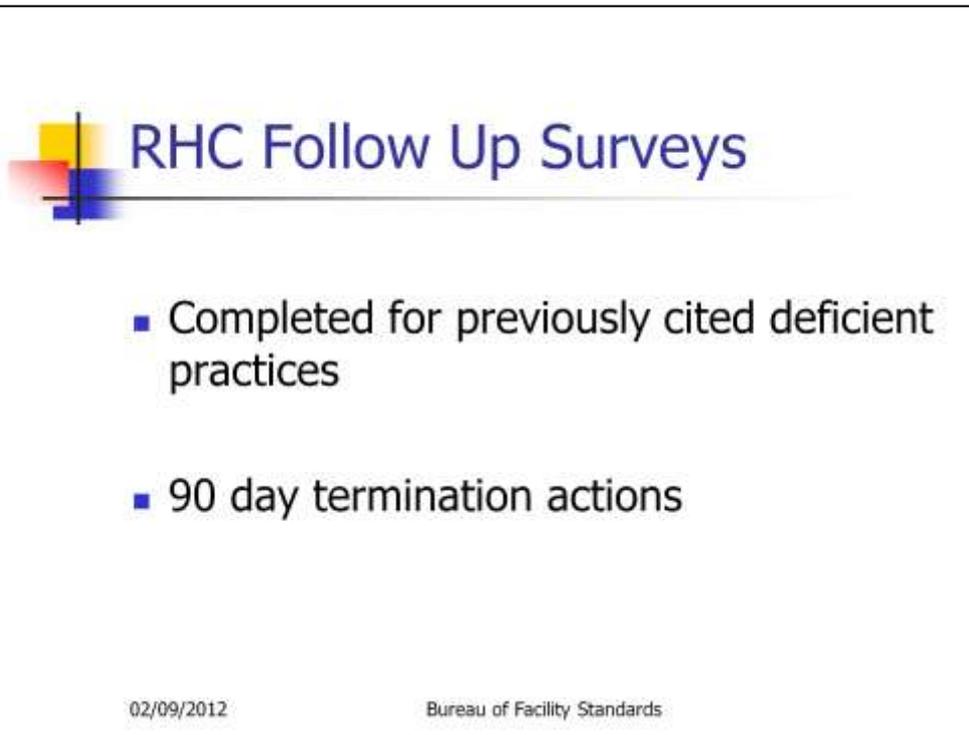
Reviewing the POC/Credible

- Action that will be taken to correct the deficiency
- Description of how the actions will improve the processes that led to the deficiency
- The procedure for implementing the acceptable plan of correction
- A completion date for correction
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the RHC into compliance, and that the RHC remains in compliance with the regulatory requirements
- The title of the person responsible for implementing the plan

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Once survey staff receive the PoC/Credible, they will ensure the administrator's signature and the date in on page 1 of the 2567 form are present. Surveyors then review the plan for each deficiency for adequacy and appropriateness. If additional information is needed, survey staff will contact the clinic Administrator, or designated representative.

It should also be noted that when complete, 2567s and PoCs/Credibles are posted to the BFS web site at www.facilitystandards.idaho.gov However, due to privacy and proprietary consideration, we are prohibited from releasing any information that may identify a patient or anyone else not employed by the entity. Nor will we publish to the internet any documentation regarding financial documents, such as vouchers, professional licenses, etc.

The graphic features a stylized logo on the left consisting of overlapping yellow, red, and blue squares with a black crosshair. To the right of the logo, the title "RHC Follow Up Surveys" is written in a blue, sans-serif font. Below the title is a horizontal line. Underneath the line, there are two bullet points, each preceded by a small blue square. The first bullet point reads "Completed for previously cited deficient practices" and the second reads "90 day termination actions". At the bottom left of the graphic, the date "02/09/2012" is displayed. At the bottom right, the text "Bureau of Facility Standards" is shown.

RHC Follow Up Surveys

- Completed for previously cited deficient practices
- 90 day termination actions

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Follow-up surveys are focused surveys, conducted to ensure compliance has been achieved with previously cited deficient practices, in accordance with the PoC/Credible submitted by the clinic. If a Conditional level citation was issued, the clinic is placed on a 90 termination track. This means the clinic has 90 days from the date of the exit to come back into compliance with the Condition. Additionally, any referenced standard or element level deficiency would need to be found met before the Condition level citation could also be found met. If the clinic can not achieve compliance, then its participation in the RHC program is terminated by CMS. Typically, the 90-day timeframe is divided into two 45-day periods, allowing the clinic two opportunities to achieve compliance. Again, timelines related to a specific survey are included in the cover letter which accompanies the 2567. Please note, when a Condition-level citation is due to a determination based upon immediate jeopardy, the termination track changes from 90-days to 23-days. Please refer to the “Appendix Q: Guideline for Determining Immediate Jeopardy” training on the BFS website for additional information related to Immediate Jeopardy.



The RHC Survey Process

- ***Please send your comments or questions to fsb@dhw.idaho.gov***

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Thank you for your time and participation. Please feel free to email any comments or questions you may have.