

Supporting Clinical Excellence and Co-Location Compliance

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HOW WE BECAME CHILDREN'S HOSPITAL OF CHICAGO MEDICAL CENTER ('CHCMC') . . .

- 1882 - Maurice Porter Memorial Hospital in a four bed cottage.
- 1904 - became Children's Memorial Hospital, a Chicago institution.
- Over decades – evolved into the Children's Hospital of Chicago Medical Center, which includes the Ann & Robert H. Lurie Children's Hospital of Chicago and the Stanley Manne Children's Research Institute.
- Now partners with Northwestern University Feinberg School of Medicine as primary pediatric teaching hospital.
- The Stanley Manne Children's Research Institute focuses on improving child health, transforming pediatric medicine, and ensuring healthier futures.

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IN PURSUIT OF CLINICAL EXCELLENCE

- At CHCMC, a top-ranked children's hospital, we put children and their families at the center of all we do.
- Many highly talented pediatric experts and specially trained people care for children - from before birth, through childhood and adolescence, and beyond.
- Giving the best patient family experience is the core of our mission.
- Co-Location of our physicians and hospital services is a part of how we do that.

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A New Part of the Regulatory Landscape We Must Navigate – Anne's Analogy

CMS Draft Only: Guidance for Hospital Co-Location with Other Hospitals or Healthcare Facilities

- Available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/OSO-19-13-Hospital.pdf>.

What is Co- Location?

- "Co-location occurs where two hospitals or a hospital and another healthcare entity are located on the same campus or in the same building and share spaces, staff, or services."

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Examples of Co-Location Arrangements

One hospital is entirely located on another hospital's campus, or in the same building as another hospital.

Consider – which of these do you support or operate?

Which would your Providers like to be?

Part of one hospital's inpatient services (e.g., at a remote location or satellite) is in another hospital's building, or on another hospital's campus.

The outpatient department of one hospital is located on the same campus of, or in the same building as, another hospital or a separate Medicare-certified provider/supplier, such as an ambulatory surgical center, rural health clinic, federally qualified healthcare center, imaging center, etc.

How can we apply the Guidance to Physicians and Non-Physician Practitioners ("Providers") as "another healthcare entity"?

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Why is Co-Location Important to Both Regulators and Clinicians?

- CMS cites "protection of patients, including but not limited to their right to personal privacy and to receive care in a safe [consider security, privacy, infection control] environment".
- Co-locating services can drive clinical excellence:
 - Putting patients at the center of the services
 - Enabling physicians and non-physician practitioners ("Providers") to coordinate hospital and physician services

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What's the Nexus Between Clinical Excellence and Co-Location?

- Thoughts from the room?
- Do we have clinicians in the room? Regulators?
- Patient satisfaction and the effect on clinical outcomes
- Multidisciplinary care and the effect on clinical outcomes
- Timely diagnostics during evaluation and the effect on clinical outcomes
- Financial success in value-based care programs (due to clinical outcomes, efficiency . . .)

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So We Have a Rationale for Co-Location – How Do We Co-Locate in a Compliant Manner?

- Evaluate the applicability of the rules to your entity.
 - The Guidance speaks to hospital CoPs – not other Medicare-participating entities, e.g., psychiatric hospitals, ASCs, rural health clinics, or IDTFs.
 - Payor-specific analysis necessary (e.g., Medicaid, Managed Care, Commercial)
- If you determine the Guidance applies, consider the Guidance that CMS Surveyors will follow when assessing your co-located space.

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Basic Rules on the Use of Shared Space

Distinct Space (Could NOT be shared)	Shared Space(Could be shared)
Hospital to have defined and distinct spaces of operation - maintaining control at all times.	Draft guidance limits "shared spaces".
Distinct spaces include clinical spaces designated for patient care.	Shared spaces are considered those public spaces and public paths of travel that are utilized by both the hospital and the co-located healthcare entity.
Example of issue: co-mingling of patients in a clinical area such as a nursing unit, from two co-located entities, could pose safety risk to patient due to two different infection control plans.	Examples of public spaces and paths of travel: public lobbies, waiting rooms and reception areas (with separate "check-in" areas and clear signage), public restrooms, staff lounges, elevators and main corridors through non-clinical areas, and main entrances to a building.

Please note prior sub-regulatory interpretations prohibited co-location of hospitals with other healthcare entities. The Draft guidance changes that to ensure safety and accountability.

Source: DRAFT ONLY- Guidance for Hospital Co-Location with Other Hospitals or Healthcare Facilities

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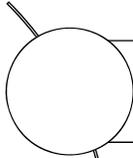
Use of Shared Space - What Will Surveyors Assess ?

Travel between separate entities utilizing a path through clinical spaces of a hospital by another entity co-located in the same building would not be considered acceptable as it could create patient privacy, security, and infection control concerns:

- ✓ The draft guidance instructs state surveyors to review floor plans for compliance with rules regarding "distinct" versus "shared" space. The floor plan must clearly identify which health care entities use the spaces.
- ✓ Surveyors must ask hospital leadership to provide a list of all services that the hospital has contracted to use from the other co-located entity or healthcare entities.
- ✓ Other thoughts from the room on how the rules apply and could be scrutinized?

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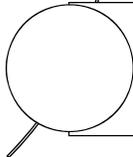
Basic Rules Regarding Contracted Services



Services may be provided under contract or arrangement with another co-located hospital or healthcare entity, such as laboratory, dietary, pharmacy, maintenance, housekeeping, and security services.



Each Medicare-certified hospital is responsible for independently meeting staffing requirements of the CoPs and any of the services the hospital provides whether or not those staff are provided under arrangement or contract with another entity.



Staff obtained under arrangement from another entity must be assigned to work solely for one hospital during a specific shift. They must not “float” between two hospitals during the same shift or work at one while concurrently “on-call” at another. They must not provide services simultaneously. Medical staff are exempt from this limitation, provided that they hold privileges and credentials at both co-located providers.

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Contracted Services - What will Surveyors Assess?

The Draft Guidance specifies - a hospital’s governing body must be prepared to confirm, describe, or demonstrate the following:

- ✓ Contracted clinical services are not simultaneously “shared” with another entity.
- ✓ The hospital monitors the performance of its contracted services.
- ✓ All individuals providing services under contract have been oriented and trained in accordance with hospital policies and procedures.
- ✓ Personnel files of contracted individuals who provide services record the education and training.
- ✓ Staffing and schedules of staff ensure that staff are immediately available at all times to perform services required by the hospital.

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Basic Rules Regarding Emergency Services

- The current CoPs provide that hospitals without emergency departments must have appropriate policies and procedures in place to address individuals' (contrast with patients') emergencies.
- Under Draft Guidance, hospitals may contract with another hospital or entity for the appraisal and initial treatment of patients experiencing an emergency when the contracted staff are not working/on duty simultaneously at another hospital or health care entity.
- Under the Draft Guidance, it may be appropriate for a hospital to transfer a patient to the co-located entity for continuation of care after appraisal and initial treatment (e.g., between a rehabilitation hospital and an acute care hospital for a patient suffering a heart attack).
- Hospitals without emergency departments that contract for emergency services with another hospital's emergency department are then considered to provide emergency services and must meet the requirements of EMTALA. See §§489.20-24

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Emergency Services - What will Surveyors Assess?

Surveyors will evaluate the emergency care of patients in a hospital without an emergency department that is co-located with another healthcare entity:

- ✓ Does the hospital respond to its own in hospital emergencies, with its own trained staff (not another hospital's or entity's staff)?
- ✓ Does the hospital have proper emergency equipment in the event that a patient requires resuscitation, e.g., AED, code cart, intubation tray, medications?
- ✓ Is hospital staff properly trained in the use of the emergency equipment?
- ✓ Is the hospital's emergency equipment properly maintained, e.g., unexpired, sterile, stocked?
- ✓ Is hospital staff properly trained for appraisal of emergencies, initial treatment, and referral when appropriate?

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Basic Rules Regarding Billing

- Hospital services take place *only* in hospital space and are billed as hospital services.
- Physician services that take place in physician office space are billed as physician office.
- Physician services that take place in hospital space are billed as professional services.

Place of service codes:

11 = physician office; 19 = off campus outpatient hospital space; 22 = on campus outpatient hospital space

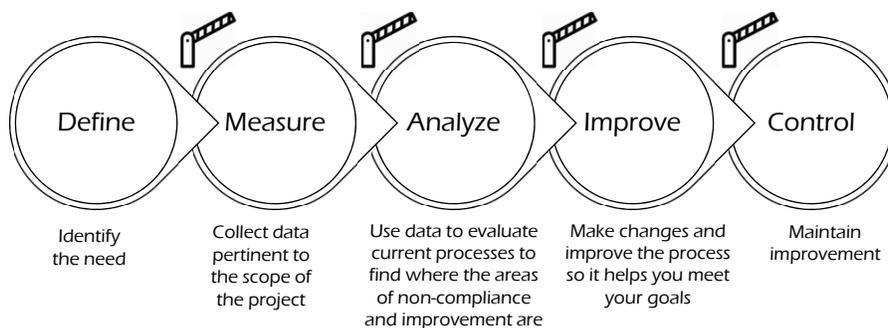


Thought Question:

How can we code service provided by Physician B in Physician A's office?

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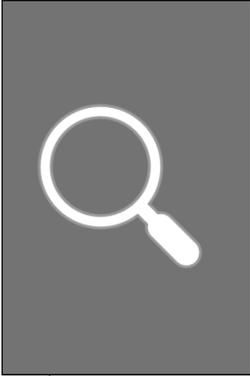
TOOLS & TECHNIQUES



Tollgate is a checkpoint at which the team members meet with a project Champion and determine whether the work has been performed as indicated in the project plan and whether the objectives mentioned have been achieved.

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STAGE 1: DEFINE PROBLEM, GOALS, POTENTIAL RESOURCES, PROJECT SCOPE, AND HIGH-LEVEL PROJECT TIMELINE

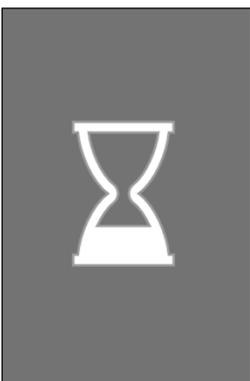


IDENTIFY PROBLEM

Achieving compliance with the Medicare Conditions of Participation for hospitals (CoPs) for shared spaces, services, personnel and emergency services when co-locating with another healthcare provider while supporting clinical excellence.

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STAGE 1: DEFINE PROBLEM, GOALS, POTENTIAL RESOURCES, PROJECT SCOPE, AND HIGH-LEVEL PROJECT TIMELINE



REVIEW TIMELINE AND HISTORY OF PROBLEM

Determine nature (e.g., systemic, service line specific) and whether this has been an ongoing problem or a recent problem.

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STAGE 1: DEFINE PROBLEM, GOALS, POTENTIAL RESOURCES, PROJECT SCOPE, AND HIGH-LEVEL PROJECT TIMELINE



IDENTIFY STAKEHOLDERS

Determine who should be involved in the project?

- Division Administrators
- Patient Care Operations Manager
- Example: Form a Task Force with one representative from each of the following: Revenue Cycle Physician Billing, Revenue Cycle Hospital Billing, Physician Group(s), Ambulatory Services, Ancillary Services, Compliance

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STAGE 1: DEFINE PROBLEM, GOALS, POTENTIAL RESOURCES, PROJECT SCOPE, AND HIGH-LEVEL PROJECT TIMELINE

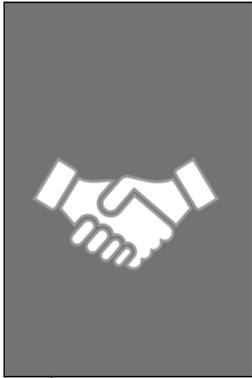


PROJECT CHARTER

Define focus, scope, direction for the team. Summarize the information gathered into one document for approval from leadership.

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STAGE 1: DEFINE PROBLEM, GOALS, POTENTIAL RESOURCES, PROJECT SCOPE, AND HIGH-LEVEL PROJECT TIMELINE



GET SUPPORT

Meet with leadership to make sure you have support.

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STAGE 1: DEFINE PROBLEM, GOALS, POTENTIAL RESOURCES, PROJECT SCOPE, AND HIGH-LEVEL PROJECT TIMELINE

Develop a data collection plan



- Methodology: Checklist, Excel Worksheet, etc.
- Collect Data: Service Line/Division, Locations, Division Administrator, Ambulatory Services Leader
- In-person meetings with the Division Stakeholders, Leaders

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STAGE 2: MEASURE – COLLECT DATA PERTINENT TO THE SCOPE OF THE PROJECT

Create and use a checklist of specific questions based on co-location requirements in in-person meetings. Example:

- Service Line and Site Location
- Physician group/Contracted Clinical Services present in the clinic
- Confirm any contracted clinical services are not being simultaneously “shared” with another hospital or entity
- Designated Hospital Space or Physician Office/Contracted Clinical Space?
- Individuals who provide services under contract and verify if they receive requisite education and training
- Staffing and schedules of staff to ensure that staff are immediately available at all times to perform services required by the hospital
- Floor plans to identify which health care entities use the spaces
- Are Clinical Services integrated with the main provider/Hospital?
 - Medical staff privileges at main provider?
 - Same monitoring and oversight as for other hospital departments?
 - EMTALA / anti-dumping rules apply (on-campus clinics)?
 - Inpatient and outpatient services are integrated and patients treated at facility have full access to all services of the main provider?
 - Medical records: unified retrieval system?
- Description of the billing process
 - Is the clinic operated and billed as a service or program of another entity, including another hospital, an individual physician or a physician group
 - Obtain patient claims



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STAGE 2: MEASURE – COLLECT DATA PERTINENT TO THE SCOPE OF THE PROJECT

Tour the space and gain an understanding of the operations. Example:

- Are there separate “check-in” areas and clear signage for the Hospital and Co-located entity?
- Clinic is 100% physician leased space? If No,
 - How many rooms are Hospital Space?
 - How many rooms are Hospital Procedure/Treatment rooms?
- In any Physician Leased Space, are there any areas sub-leased to other physician groups?



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STAGE 2: MEASURE – COLLECT DATA PERTINENT TO THE SCOPE OF THE PROJECT

- ✓ Verify your data once it has been collected.
- ✓ Collect reliable baseline data to compare against regulatory requirements.
- ✓ Create a detailed map of all interrelated service line processes to elucidate areas of non-compliance.
- ✓ Summarize Information.

Sample:

Name/Location	*Medicare Enrollment Information	Physician Clinic Services Provided in Physician Leased Space	Outpatient Hospital Services Provided in Hospital Designated Space (*exceptions)	Comments
	Effective Date: Medicare ID NPI TIN CLIA	•	•	

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STAGE 3: ANALYZE AND UNDERSTAND – WHERE IS THE PROBLEM



Define Compliance requirements and objectives.

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STAGE 3: ANALYZE AND UNDERSTAND – WHERE IS THE PROBLEM



Analyze the data collected and process map to determine root causes of non-compliance and opportunities for improvement.

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STAGE 3: ANALYZE AND UNDERSTAND – WHERE IS THE PROBLEM



Identify gaps between current performance and goal performance

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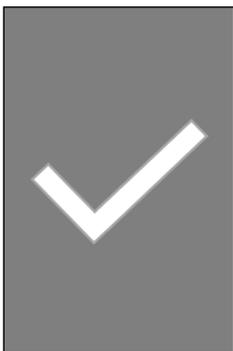
STAGE 4: IMPROVE THE TARGET PROCESS TO FIX ISSUES OF NON-COMPLIANCE



Improve the target process by recommending solutions to fix and prevent issues of non-compliance.

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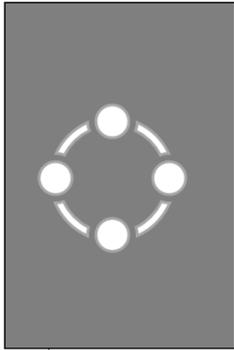
STAGE 4: IMPROVE THE TARGET PROCESS TO FIX ISSUES OF NON-COMPLIANCE



Assess; correct identified non-compliance (example: billing for services in the wrong space).

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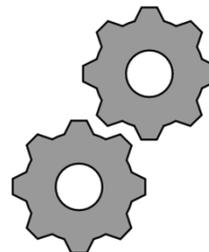
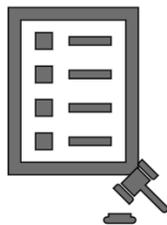
STAGE 4: IMPROVE THE TARGET PROCESS TO FIX ISSUES OF NON-COMPLIANCE



Create a consistent workflow to use as new co-located entities are planned and implemented.

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Your work has only just begun when you implement a new process



Now it's time to sustain that process!

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STAGE 5: CONTROL THE IMPROVEMENTS



Control the improvements to keep the process on the new course.

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STAGE 5: CONTROL THE IMPROVEMENTS



Prevent reverting back to the “old way”.

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STAGE 5: CONTROL THE IMPROVEMENTS



Require the development, documentation, and implementation of an ongoing monitoring plan that demonstrates how standards and improvements can be sustained and risks managed.

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STAGE 5: CONTROL THE IMPROVEMENTS

Example: Monitoring Tool for Operators – Self Assessment Checklist

Component	Regulatory Questions	Compliance Strategy	Description of Current Operations
A	REQUIRED ELEMENTS FOR CO-LOCATED ENTITIES		
A1	Public Awareness Requirements Is it clear to visitors who "owns" or controls what space? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the signage identify when moving from "the hospital" to another entity? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do all areas where hospital services are provided identified with clear signage that designates space as hospital or non-hospital so that families and visitors know when moving from hospital to another entity? <i>(e.g., waiting area, registration, physician office space, exam rooms)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No Employees who interact directly with patients, especially those involved in the delivery of patient care: Are identifiable as hospital staff by name badge or clothing? <input type="checkbox"/> Yes <input type="checkbox"/> No Identify their affiliation when introducing themselves to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Communicate clearly who the provider is that the patient will be seeing, possibly using scripted introductions or providing written materials to ensure patients understand which entity is providing their services? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do the current operations include clear signage to indicate what space is dedicated to hospital services vs. physician offices? <input type="checkbox"/> Yes <input type="checkbox"/> No



Self-Assessment checklist collaboration available.

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CONTACT INFORMATION

Questions? Please, feel free to ask now or later!

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