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Minnesota Department of Health

Nursing Home Licensing and Certification

June 30, 2004

Admin Minnesota
DEPARTMENT OF ADMINISTRATION

MANAGEMENT ANALYSIS DIVISION

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Management Analysis Division
The Management Analysis Division is Minnesota government's in-house fee-for-service management consulting group. We are in our 19th year of helping public managers increase their organization's effectiveness and efficiency. We provide quality management consultation services to local, regional, state, and federal government agencies, and public institutions.

ACKNOWLEDGEMENTS:

The Management Analysis Division (MAD) would like to thank and acknowledge the many people that participated and assisted in this study.

In particular, we would like to thank Commissioner Dianne Mandernach, David Giese, Mike Tripple, Cecelia Jackson, and Mary Absolon for their responsiveness to our countless questions and requests for information. We would also like to extend a special thank you to the surveyors and administrative teams that participated in the surveys we observed, and, especially, the staff from Presbyterian Homes of Arden Hills, Vista Village of Cromwell, and Saint Otto's of Little Falls. MAD participated in surveys in each of these facilities and was impressed by the fine work by the facility staff and the surveyors.

In all of our work, we were impressed with the dedication, care, and resiliency of those we observed. We are grateful for how people allowed us into the intimate aspects of their work, even when the circumstances were not ideal and when the situations became stressful. We have new appreciation for the important and difficult work of providing and overseeing nursing home care, and we are amazed by the heart-felt desire of those involved to do their very best for the residents in their care.

Above all, we have new confidence that by working together, providers, residents and their families, ombudsmen, and the Department of Health have the opportunity and will to achieve the success they have always know possible, but have yet to fully realize.

Thank you,

The Management Analysis Division

Executive Summary

Introduction

Nursing homes provide care to thousands of frail Minnesotans at a cost approaching $2 billion a year. On an average day approximately 36,400 residents receive care in about 414 nursing homes across the state.[1] Nearly all (98 percent) of these facilities are certified to participate in Medicaid and/or Medicare programs.[2]

The process by which nursing homes are certified for participation in Medicare and Medicaid has become the subject of intense debate. This certification process is based primarily on periodic inspections, called nursing home surveys. The federal government's Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services takes its direction from Congress and contracts with state licensing agencies to conduct nursing home surveys.

MDH licenses and certifies nursing homes through the Licensing and Certification Program (LCP) of the Facility and Provider Compliance Division.[3] Under CMS guidelines, LCP staff work in ten district teams to conduct on-site inspections. When a nursing home is found not to meet a CMS standard, it is given a "deficiency" related to the standard. Deficiencies that are not corrected can result in penalties such as fines and denial of Medicare or Medicaid payments for new admissions.

The controversy

The controversy has been building for years, but a dramatic increase in deficiency citations, in mid 2003, was the flashpoint for provider and legislative frustration over the department's oversight of nursing homes. A day long hearing was held in the House, where the survey process was labeled "out of control," and surveyors where likened to the "Gestapo." MDH launched a series of efforts to examine and improve the survey process, including requesting MAD to conduct an independent review and prepare this report.[4]

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[1] This information is for the year ending 9/30/02, the last year for which the Department of Human Services (DHS) has resident data. As of April 12, 2004, there were 415 Medicaid-certified facilities. Source: Gary Johnson (DHS), e-mails, April 12 and 27, and May 6, 2004.

[2] Medicare (a federal program) and Medicaid (a state/federal program) provide funding for a range of health care services. The Medicaid program (called Medical Assistance in Minnesota) is the most significant payer of nursing home costs, followed by out-of-pocket payments, Medicare, and other sources. Of the estimated $1.98 billion spent on nursing home care in Minnesota in FY04, the state share of costs paid through Medicaid to nursing homes was approximately $456 million. Gary Johnson (DHS), e-mails, April 12 and 27, and May 6, 2004.

[3] Effective July 1, 2004, this division's name will be changed to the Division of Health Policy, Information, and Compliance Monitoring.

[4] Months earlier, the commissioner of health had formed a Long Term Care Issues Ad Hoc Committee composed of an array of stakeholders, two subcommittees were later established, and in May, the Office of the Legislative Auditor also began its own program evaluation, to name a few of the initiatives.

MAD's Review

MAD staff conducted an array of activities to gather the information and perspectives needed for developing this report and its recommendations. These methods included:

- interviews with more than 60 stakeholders (such as MDH leadership and staff; nursing home administrators and staff; legislators; representatives of patients, families and advocacy organizations; representatives of state and federal reimbursement programs; and other stakeholders);
- five focus groups held in various geographic locations;
- interviews with representatives of the nursing home survey processes in six other states;
- observation of three on-site inspections conducted by MDH;
- analysis of recent trends in Minnesota's nursing home deficiency citations;
- review of selected literature from other state and federal sources; and
- review of findings from the recent meetings of the commissioner's ad hoc committee and its subcommittees.

The administration of nursing home regulations is many-layered and complex. Understanding the federal guidelines is essential to understanding the department's options and constraints in improving Minnesota's survey process. This complexity is also a major challenge for providers, regulators, consumers, analysts and policymakers. The multiple layers of administration are highlighted in Appendix B.

The following report describes MAD's analysis of the current federal survey process and how it is administered by the Minnesota Department of Health, the controversy surrounding the nursing home survey, and the unrealized opportunity to improve the quality of care for nursing home residents. The report also examines recent increases and other patterns in regulatory citations as well as the department's efforts to reduce tensions around the survey and improve its administration. This executive summary highlights the report's findings, conclusions and recommendations.

Findings and conclusions

Public scrutiny

MAD found that both nursing home care and the oversight of that care understandably face intense public scrutiny. Providers are scrutinized because they are entrusted with caring for uniquely vulnerable people and are charged with assuring that residents achieve the "highest practicable physical, mental, and psychosocial well-being."[5] When care is perceived to be inappropriate, the public outrage makes front-page news. Additionally, when regulators exercise their authority it can have severe consequences for facilities and residents. For these reasons, it is not surprising that providers and regulators will be scrutinized by one another, consumers, and the legislative bodies that govern them.

[5] Center for Medicaid and Medicare Services (CMS) nursing home state operations manual (SOM).

Polarized and unproductive public debate

Consumer advocates and the facilities that provide care are polarized in their views, and the department is mired in the controversy. Rather than defuse the controversy, recent legislative hearings have been remarkably one sided and sympathetic to the industry, mirroring and magnifying the controversy. Some suggested this was a result of political tactics on the part of the industry. For example, local print media reported, "The industry – which has contributed more that $150,000 since 1996 to legislative campaigns – has made the inspectors themselves the issue."[6] Others said the providers had simply been more effective in telling their story. Most agreed, however, that a more measured and balanced policy discussion is needed.

MDH's survey improvement efforts examined

MAD reviewed MDH's efforts to improve the survey and found that these efforts are constrained by federal law. For example the notion of an "alternative survey" or a pilot test of innovative approaches hinges on federal approvals, which – despite the attempts of many states – have not been granted. Moreover, the fact that many of the stakeholders do not understand the administrative complexity and highly prescriptive nature of the federal directives makes MDH's position all the more difficult. Nonetheless, MDH has initiated several quality assurance efforts at the statewide and district office level to monitor and improve the survey.[7] MAD found that these survey improvement efforts have proven labor intensive, and of questionable value in improving survey performance.

MDH efforts to improve survey communications appear promising

Interactions between surveyors and facility staff have been an area of great concern and, the focus of a subcommittee created by the commissioner. If the testimonials of the members of the subcommittee are any indication, the results of this work appear promising. According to the subcommittee report, "Participants generally felt pleased with the openness and respectful attitude that prevailed in the group, and saw this as an accomplishment in itself, given the recent history of acrimonious interactions among the various groups." The communication patterns, and the prevalence of rumors, myths, and fear of retaliation for asserting one's concerns are deeply engrained, however, and improving communications will take a long-term concerted effort.

The survey controversy has become a preoccupation and distraction

There is no question that the nursing home survey process is a necessary and important part of assuring basic nursing home quality. Nearly all agree that the survey cannot and should not go away, and that it should be routinely monitored and improved. Most also agree, however, that the current preoccupation with the survey distracts the stakeholders from the goal they all say they share – providing and improving quality care for all residents.

> "Although regulatory compliance alone does not enable adequate care, the primary objective of many facility practices has become regulatory compliance."[8]

[6] "Inspectors: picky or prudent," St. Paul, Pioneer Press, May 23, 2004.

[7] See section on "State Training and Oversight Actions", pages 14-16, or Table 6 in that section.

[8] "Summary and Key Highlights: Recommendations for Regulatory and Survey Reform", American Medical Directors Association, Caring for the Ages, May 2002. On the Web at http://www.amda.com/caring/may2002/ltcregulations.htm

Sadly, the continual sparring of the stakeholders has distracted the most well-intentioned from their heart-felt desire to improve care for those who need it. MAD's review found that indeed deficiency citations have increased and that there is significant variation in deficiency rates across the state and across the nation. This variation has been a long-standing concern and the focus of several national, and now state, reviews. Yet there is no single, simple, or entirely satisfying explanation. The scientific research has not been able to disentangle the combined effects of variation in quality of care and the variation in the survey and enforcement process. Nonetheless, the feds, the states, and the stakeholders continue to analyze and argue over the survey process.

Internal operations, communications, and decision making

MDH participants in the study commonly expressed concern regarding high workloads and competing priorities, bureaucratic communications and decision making processes, and the excessively administrative and prescriptive nature of their jobs. When asked, several surveyors and even supervisors could only vaguely describe some of the many procedural requirements inherent in their jobs. For example, some supervisors reported confusion over the processing of plans of correction that they routinely receive from providers. This was partly due to the fact that when they take vacation, there is no set process for temporarily assigning that workload, which must meet certain timelines according to federal and state requirements. For federally related questions where MDH does not know the answer, communications within MDH and with CMS are cumbersome. For example, when a surveyor or supervisor raises questions about a survey procedure or interpretation, communications with CMS are typically processed through a hierarchical procedure that hampers both efficiency and effectiveness.

Historical opportunity to improve quality of nursing home care

The survey is one way – but not the only way – to help assure quality in nursing home care. Study participants familiar with health care quality improvement noted that quality improvement efforts in long-term care lag far behind those in the acute care setting (hospitals and clinics). In particular, they noted that:

- QI efforts in acute care are far more mature, well-financed, and clinically oriented.
- The clinical expertise and resources of the acute care arena are far more extensive than the LTC arena and acute care has many more years of field experience in applying quality principles to the care process.
- Acute care purchasers are more attuned to and rely on quality measures more than the purchasers of LTC.
- The acute care industry has been leading and facilitating systematic and nationwide quality improvement efforts.
- In LTC, QI efforts are often specific to individual facilities or, at best, specific to the corporate enterprise. Nationwide efforts are predominantly government driven.

Despite the fact that CMS now sponsors a statewide, collaborative, approach to improving quality of care in nursing homes, through Minnesota's Quality Improvement Organization (QIO) StratisHealth, most study participants were only vaguely aware and often had incomplete or inaccurate information aboutStratisHealth.

In summary, the almost exclusive focus on the survey as a way to assure quality is keeping the stakeholders from very promising opportunities to make significant gains in the quality of nursing home care.

Recommendations

This report addresses a wide variety of issues, many of them outside the direct control of the State. Even those issues within the department's control may be beyond its resources to achieve. Because of this, the recommendations focus on those efforts deemed by MAD and the stakeholders to be the most important and achievable. MDH will need to make its own determination and, clearly, the stakeholders must work together and share responsibility for implementing the following recommendations, if they are to succeed.

The report includes six categories of recommendations; each is described with examples and includes more detailed recommendations and specific options for implementation. In particular, the recommendations emphasize the importance of MDH working in partnership with the stakeholders and the legislature to:

- **Foster more factual and productive public policy discussion of the nursing home survey and quality of nursing home care.** To promote a more productive public discussion, the legislature should distinguish federal certification requirements from state licensure issues and base its discussions of the federal survey on a rigorous review of formal survey documentation and investigations – not anecdotal information. The legislature should also place renewed focus on statewide efforts to improve quality of care in nursing homes.

- **MDH should approach its nursing home and long-term care responsibilities from its broad public health mission.** The department has historically emphasized its administrative and regulatory duties under the CMS contract at the expense of a more comprehensive public health approach to long-term care. In particular, MDH should: use its scientific research and analytical ability to assess long term care needs and use assessment data to guide policy so that resources can be focused where they can have the greatest impact on long term care.

- **Continue to improve communications among the stakeholders regarding the survey.** In particular, MDH should formalize the ad hoc committee recently created by the commissioner and implement the recommendations of the communications subcommittee.

- **Focus survey improvement efforts on specific goals and implement routine monitoring.** Create a new position within MDH for coordinating survey improvement efforts and assign the district office supervisors, as a group, greater authority, responsibility, and accountability for interpreting CMS guidelines and for promoting consistent interpretation and application of CMS guidelines in the field.

- **Make improvements in the internal operations of the department.** This includes a variety of internal administrative improvements including a reexamination of staffing assignments, streamlining internal work processes, prioritizing work load, and developing and implementing an employee recruitment and retention plan for the licensure and certification program.

- **Work in partnership with StratisHealth to promote and coordinate statewide CMS sponsored quality improvement efforts in Minnesota.** MDH and StratisHealth have a unique opportunity to work with other stakeholders, on a collaborative basis, to make significant improvements in clinical and other nursing home care. To make the greatest use of their combined resources, MDH and StratisHealth must work in close coordination on training activities and the information sharing among the stakeholders. Specifically, MDH should work with StratisHealth to convene the stakeholders and develop an action plan for promoting and coordinating statewide quality improvement efforts. The action plan should define the various roles and responsibilities of the department, StratisHealth, providers, and others in coordinating and improving quality of care.

CONTENTS

INTRODUCTION

Nursing homes are a critical part of Minnesota's long-term care (LTC) continuum, with over 80 percent of all public dollars spent on LTC in Minnesota paying for nursing home care.[9] Nursing homes provide care to thousands of frail Minnesotans at a cost approaching $2 billion a year. On an average day approximately 36,400 residents receive care in about 414 nursing homes across the state.[10] Nearly all (98 percent) of these facilities are certified to participate in Medicaid and/or Medicare programs.[11]

Because nursing homes are unique health care environments, they involve regulatory procedures far beyond what is required in hospitals and clinics. In addition to clinical quality, nursing home regulations focus on the resident's personal rights, dignity, and living environment, since these individuals depend on the facility to provide a home-like environment and daily personal care. Additionally, many residents are frail, chronically ill, or severely impaired functionally and cognitively, making them especially vulnerable.

An increasingly contentious issue for those involved in providing, regulating or receiving nursing home care is the process by which nursing homes are certified for participation in Medicare and Medicaid. This certification process is based primarily on periodic inspections, called nursing home surveys. The federal government's Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services contracts with state agencies to conduct nursing home surveys.

In Minnesota, the state survey agency responsible for conducting nursing home surveys is the Minnesota Department of Health (MDH). MDH also licenses nursing homes under state laws and contracts with CMS to investigate complaints against nursing homes. MDH is spending approximately $12 million a year on nursing home surveys. About 88 percent of this goes toward nursing home surveys and the remaining 12 percent funds complaint investigations. The federal government is the major funder of survey process – the state share of the annual nursing home survey process is a little less than 10 percent of the total.[12]

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[9] DHS, *Status of Long Term Care in Minnesota 2003*. (St.Paul, MN:DHS, 2004), 22. See http://www.dhs.state.mn.us/agingint/ltctaskforce/reports for the full report. See Appendix A for more information on *Trends in Minnesota's LTC System*.

[10] This information is for the year ending 9/30/02, the last year for which the Department of Human Services (DHS) has resident data. As of April 12, 2004, there were 415 Medicaid-certified facilities. Source: Gary Johnson (DHS), e-mails, April 12 and 27, and May 6, 2004.

[11] Medicare (a federal program) and Medicaid (a state/federal program) provide funding for a range of health care services. The Medicaid program (called Medical Assistance in Minnesota) is the most significant payer of nursing home costs, followed by out-of-pocket payments, Medicare, and other sources. Of the estimated $1.98 billion spent on nursing home care in Minnesota in FY04, the state share of costs paid through Medicaid to nursing homes was approximately $456 million. Gary Johnson (DHS), e-mails, April 12 and 27, and May 6, 2004.

[12] Edward Potter (MDH), e-mail, June 7, 2004.

MDH licenses and certifies nursing homes through the Licensing and Certification Program (LCP)[13] of the Facility and Provider Compliance Division.[14] Under CMS guidelines, LCP staff work in teams to conduct on-site inspections to monitor each facility's compliance with CMS standards. When a nursing home does not meet a standard in the survey, it is given a "deficiency" related to the standard. Deficiencies that are not corrected can result in penalties such as fines and denial of payments for new admissions.

At both the state and federal level, the survey process has generated intense scrutiny and controversy. In Minnesota, stakeholders representing many different perspectives have been examining the nursing home survey process. In the past 12 to 15 months, for example:

- Commissioner of Health Dianne Mandernach began an initiative to "address concerns surrounding long-term care regulations, the survey process and other issues affecting the industry." As part of this initiative the commissioner created a LTC Issues Ad Hoc Committee and two subcommittees. One subcommittee, Survey Findings/Review, examined issues related to the number, type and severity of deficiencies issued by MDH. The second subcommittee on Communications focused on ways to "minimize tensions" in the survey process.[15]

- Associations representing workers, providers, and consumers have studied how inspections are conducted and developed recommendations for improvement. For example, the Seniors and Workers for Quality and the Office of the Ombudsmen for Older Minnesotans recently polled members to better "understand and record experiences with the nursing home survey process."[16]

- Many stakeholders have analyzed deficiency data and come to their own conclusions. Early in 2003, MDH observed increases in the number of deficiencies across the state and a pattern of variability among the district offices that had become extreme and well established. Providers and others also began analyzing the data and publishing their own analyses.

- Legislators have been involved in the survey process through various hearings and proposed legislation, most recently a February 25, 2004, hearing specifically on this issue. The 2003 Legislature passed a bill directing the commissioner of

[13] Other sections in the division that are impacted by CMS guidelines and directives include the Office of Health Facility Complaints (OHFC), Engineering Services, and Case Mix Review. Although these areas were not the focus of this review, it is clear that they will be impacted by the implementation of the report's recommendations.

[14] Effective July 1, 2004, this division's name will be changed to the Division of Health Policy, Information, and Compliance Monitoring.

[15] Information about the LTC Issues Ad Hoc Committee, subcommittees, and many related documents about the nursing home survey process can be found at: http://www.health.state.mn.us/ltc. The results of these analyses are incorporated into this report's findings and recommendations.

[16] For survey results, visit: http://www.health.state.mn.us/ltc and see *Questionnaire on the Nursing Home Survey Process: Results and Challenges*. MDH also solicited provider comments about the survey in 2003. For results see *Long Term Care Provider Survey Results* at the same Website.

health to implement an "alternative nursing home survey" and in 2004, the legislature passed a bill requiring the department to prepare annual quality improvement reports and request federal waivers and approvals needed to implement the alternative survey process.[17]

- In May 2004, the Office of the Legislative Auditor began conducting a program review to examine how citations by MDH have changed over time, what the department has done to ensure consistent application of standards, how much flexibility the department has in conducting the federal inspections and whether it has used that flexibility effectively, and to what extent other states have similar issues as Minnesota.

Stakeholders have raised many concerns with the way nursing home inspections are conducted. The number of deficiencies cited in Minnesota has risen in the last year, prompting providers to question whether the regulatory process has become more stringent or whether care problems are on the rise. Another area of debate is the variation among regions in the state in the number and type of deficiencies cited – do these variations represent real differences in how well nursing homes in a region are meeting standards, or are there regional variations in the way the process is conducted? A third concern is the apparently high and rising level of animosity between the various stakeholders.

The review by the Management Analysis Division

In early 2004 MDH asked the Management Analysis Division (MAD) at the Minnesota Department of Administration to examine the state's licensing and certification process to gain a better understanding of these and other important issues affecting the Licensing and Certification Program. MAD was also asked to make recommendations for improving the efficiency and effectiveness of the licensing and certification activities, with a particular focus on the survey process.

This organizational and management review was begun in February 2004 and completed in June2004.

2004. At the same time, MAD was hired to facilitate meetings of the subcommittee on communications.

Specifically, MAD's goal was to help the Division:

- clarify and refine its role and responsibilities;
- establish and focus on the most important priorities; and
- provide effective guidance to regulated parties and the patients and families they serve.

[17] MN statutes section 144A.37 and House File 2246, 3rd Engrossment: 83rd Legislative Session (2003-2004).
[17] House File 2246, 3rd Engrossment: 83rd Legislative Session (2003-2004).

Methods

MAD staff conducted an array of activities to gather the information and perspectives needed for developing this report and its recommendations. These methods included:

- Interviews with more than 60 stakeholders (such as MDH leadership and staff; nursing home administrators and staff; legislators; representatives of patients, families and advocacy organizations; representatives of state and federal reimbursement programs; and other stakeholders);
- Five focus groups in various geographic locations and representing a variety of stakeholders;
- Interviews with representatives of the nursing home survey processes in six other states;
- Observation of three on-site nursing home inspections conducted by MDH;
- Analysis of recent trends in Minnesota's nursing home deficiencies rates;
- Review of selected literature from other state and federal sources; and
- Review of findings from the recent meetings of the Communications and Survey/Findings Subcommittees of the MDH Long-term Care Issues Ad hoc Committee.

During its review, MAD recognized the importance of the administrative complexity and highly prescriptive nature of the federal nursing home survey process. The State survey is performed under the direction of the federal government. MDH administers the survey under federal law and a formal contract with the CMS. The department takes most of its licensing and certification program direction from CMS and the program's funding is overwhelmingly federal, directly tied to its contract with CMS. State licensing funding for nursing homes is primarily federal matching funds and there is little discretion in how the remaining funds can be used.

Understanding the federal law and interpretive guidelines is essential to understanding the department's options and constraints in improving Minnesota's survey process. The many layers of survey administration and oversight are summarized in Appendix B.

OVERVIEW of the SURVEY PROCESS

The first part of this section provides an overview of CMS guidelines for conducting nursing home surveys, such as the purpose of the survey and the way deficiencies are rated by severity and scope. The following subsection describes in more detail how the survey process is implemented in Minnesota (for example, how teams are organized and how LCP staff complete the major tasks outlined by CMS). The third subsection highlights federal and state activities to oversee and improve the survey.

CMS Guidelines

The federal nursing home survey is administratively complex and highly prescriptive. Understanding the federal guidelines is essential to understanding the department's options and constraints in improving Minnesota's survey process. The many layers of administration and oversight are described in Appendix B.

State survey agencies work under contract with CMS to conduct nursing home surveys. CMS has established detailed guidelines for how the surveys are completed in all states. CMS articulates its requirements in the State Operations Manual (SOM),[18] which contains over 198 regulations and hundreds of pages of technical and procedural explanations.

According to Interpretive Guidelines, the two functions of the nursing home survey process are:

- To ensure compliance with regulations; and
- To enter into a non-consultative information exchange for the purpose of information dissemination that may be of assistance to the facility in meeting long term care requirements.[19]

Inspections are to occur unannounced, at unpredictable times. Inspection teams use many sources of information to assess whether a nursing home is in compliance with federal standards, such as on-site observation of resident care, interviews with families, and a review of medical records. CMS provides specific investigative protocols for surveyors to use in completing the survey. These procedural instructions "are intended to make the on-site surveys thorough and consistent across the states."[20]

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[18] An overview of the nursing home inspection process can be found at: http://www.medicare.gov/Nursing/AboutInspections.asp. Specific CMS guidelines are outlined in the State Operations Manual, which can be found at http://www.cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp. Examples of the several forms used can be found at http://www.health.state.mn.us/ltc (See *MDH Survey Process: Interview Forms*).

[19] Department of Health and Human Services, Office of Inspector General. *Nursing Home Deficiency Trends and Survey and Certification Process Consistency*. (Washington, DC: DHHS, 2003), 24.

[20] CMS has modified the survey process in response to federal regulations and national studies. For examples, see Appendix C.

Deficiencies
Nursing homes that do not meet a standard are given a deficiency citation related to that standard. Deficiencies can fall within one of 17 major areas such as quality of care and physical environment. There are nearly 200 deficiency tag numbers that can be cited.[21]

Deficiencies are rated on a scale from A to L depending upon their severity and scope (Table 1). Generally, A through C deficiencies refer to situations with "no actual harm [to residents] with minimal potential for harm," while the highest levels, J through L, are associated with "immediate jeopardy to resident health or safety."

Penalties
Nursing homes are expected to address deficiencies through a plan of correction, or suffer the consequences in terms of fines (civil monetary penalties) and other punitive actions (Table 1). As CMS describes it:

> Depending upon the nature of the problem, CMS can take action against the nursing home. The law permits CMS to take a variety of actions; for example, CMS may fine the nursing home, deny payment to the nursing home, assign a temporary manager, or install a state monitor. If the nursing home does not correct its problems, CMS terminates its agreement with the nursing home. As a result, the nursing home is no longer certified to provide care to Medicare and Medicaid beneficiaries. Any beneficiaries residing in the home at the time of the termination are transferred to certified facilities.[22]

Dispute Resolution[23]
Federal law requires the CMS and each state to develop an Informal Dispute Resolution Process (42 CFR 488.331). In Minnesota there are two types of dispute resolution: informal dispute resolution (IDR) and independent informal dispute resolution (IIDR). The IDR is performed by an MDH employee who has not previously been involved in the case. The IIDR is reviewed by an Administrative Law Judge, independent of the department's review. At the time a facility submits a request for dispute resolution, they must select whether they prefer the IDR process or whether the facility is requesting a review by an ALJ under the IIDR. The facility decision is final.

Informal Dispute Resolution (IDR)
The informal dispute resolution process provides an opportunity for nursing home facilities to refute survey deficiencies or correction orders. Once a facility has requested an IDR, their case will be assigned to a person in the Licensing and Certification Program or the Office of Health Facilities Complaints who has not participated in issuing the disputed deficiencies.

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[21] Department of Health and Human Services, Office of Inspector General. *Nursing Home Deficiency Trends and Survey and Certification Process Consistency.* (Washington, DC: DHHS, 2003), 1. See: http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf.

[22] CMS. Nursing Homes: About Nursing Home Inspections at http://www.medicare.gov/Nursing/AboutInspections.asp. February 2, 2004.

[23] Minn. Stat. 144.10, subdivisions 15 and 16 provide for two types of dispute resolution. The processes are also detailed in MDH information bulletins 04-6, 04-8, and on the Web at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm#yr04

Independent Informal Dispute Resolution (IIDR)

An alternative review process called the Independent Informal Dispute Resolution Process (IIDR) for survey disputes was passed into law, effective July 1, 2003. It provides for a review by an Administrative Law Judge (ALJ) from the Office of Administrative Hearings (OAH) of facility information to support its dispute of any deficiency issued during a standard survey or an Office of Health Facility Complaints investigation. The statute specifies that the findings of the ALJ will not be binding on the Minnesota Department of Health, meaning that the department will continue to issue the final decisions in disputed cases. Decisions made by the department shall be in accordance with federal regulations and procedures. Final decisions of the Minnesota Department of Health are not binding on the CMS.

Table 1: Deficiency and CMS Remedy Table

		Scope of the Deficiency		
		Isolated	**Pattern**	**Widespread**
Severity of the deficiency	**Immediate jeopardy** to resident health or safety	J PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	K PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	L PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2
	Actual harm that is not immediate jeopardy	G PoC Required*: Cat. 2 Optional: Cat. 1	H PoC Required*: Cat. 2 Optional: Cat. 1	I PoC Required*: Cat. 2 Optional: Cat. 1 Optional: Temporary Management
	No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required*: Cat. 1 Optional: Cat. 2	E PoC Required*: Cat. 1 Optional: Cat. 2	F PoC Required*: Cat. 1 Optional: Cat. 2
	No actual harm with potential for minimal harm	A No remedies Commitment to Correct	B PoC	C PoC

Source: State Operations Manual. February 25, 2004.
http://www.cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp.

Table Notes:

*Required only when a decision is made to impose alternate remedies instead of or in addition to termination.

Deficiencies in F, H, I, J, K and L categories are considered substandard quality of care (**darker shade**).

Deficiencies in A, B and C are considered substantial compliance (**lighter shade**).

PoC refers to a plan of correction (a plan by the facility for correcting the deficiency).

There are three remedy categories referred to on the table (Cat. 1, Cat. 2, Cat. 3). These categories as associated with the following penalties:

Category 1	Category 2	Category 3
Directed Plan of Correction State Monitor; and/or Directed In-service Training	Denial of Payment for New Admissions Denial of Payment for All Individuals, Imposed by CMS; and/or Civil Monetary Penalties; up to $3,000 per day $1,000 to $10,000 per instance	Temporary Management Termination Optional: Civil Monetary Penalties: $3,050 to $10,000 per day $1,00 to $10,000 per instance

Minnesota's Implementation of the Nursing Home Survey Process

Under an interagency agreement, the Minnesota Department of Human Services (DHS) and MDH "have mutual and individual responsibilities" related to surveying nursing homes, conducting quality assurance reviews for Medicaid, providing nursing assistant training, and conducting other activities related to health care in Minnesota. Under CMS supervision, DHS also makes payments to nursing homes on behalf of residents whose care is funded by Medical Assistance.

At MDH, the task of completing nursing home surveys rests with the Licensing and Certification Program (LCP) within the Division of Health Policy, Information and Compliance Monitoring.[24] The division certifies nursing homes under federal requirements and licenses homes under state regulations. CMS sets out the survey process in detail in the state operations manual (SOM), which is hundreds of pages long and includes 198 regulations. Moreover, budget parameters established by CMS define the state's survey program including everything from the number and frequency of surveys performed, duration of surveys, the priority selection of facilities to be surveyed, and the training and assignment of survey staff, to name a few key program functions. Enforcement actions for the deficiencies that the state cites are predetermined by federal guidelines and the state has little flexibility in enforcing regulations once a deficiency is identified.

Staffing for LCP includes a Program Manager, two Assistant Managers, and ten teams of surveyors that conduct the surveys. The program has 78 surveyors. Each team has seven to ten surveyors and a supervisor. Most surveyors are registered nurses. The team always includes a nurse and may include sanitarians, dietitians, or other disciplines. The team members have been specifically trained in nursing home rules, inspection methods, and teamwork. A list of the types of staff who are currently employed to conduct surveys is shown in Table 2.

Table 2: State Surveyor Staff[25]

Type of Staff	Number of Staff	Percent of Staff
Nursing Evaluators	73	93.5
Health Program Specialists	2	2.6
Dietary Specialist	1	1.3
Sanitation Specialist	1	1.3
Medical Records Specialist	1	1.3
TOTAL	78	100%

[24] An organizational table for MDH is provided in Appendix D. The division has been reorganized. Prior to the reorganization, Licensing and Certification was in the Facility and Provider Compliance Division.
[25] Source: LCP, 2004. Excludes one nursing evaluator on leave. Not all positions are full time.

Survey Tasks

Survey teams complete seven major tasks when conducting a nursing home survey (Table 3). A more detailed overview of these tasks and examples of subtasks that surveyors complete during the survey are provided in Appendix E.

Table 3: Overview of Survey Tasks[26]

Survey Task Number	Task	Example of Activities Conducted During This Time
Task 1	Offsite Survey Preparation	Surveyors pre-select a sample of residents to further assess at the facility and otherwise prepare for the survey.
Task 2	Entrance Conference	Survey team asks for a list of admissions, transfers and discharges and other information as needed.
Task 3	Initial Tour	Surveyors obtain an overview of the facility's care and services.
Task 4	Sample Selection	The team selects a second sample of residents to review based on certain criteria.
Task 5	Information Gathering, including verify and clarify meetings[27]	Surveyors conduct resident reviews, observe medication passes, and make other detailed assessments. Survey staff meet with the facility to clarify and verify their concerns.
Task 6	Information Analysis for Deficiency Determination	Team notes where a facility is not in compliance with standards and documents these "deficiencies."
Task 7	Exit Conference	Team informs the nursing home staff of their preliminary findings.

Technical Assistance

The state operations manual provides for "information transfer" but prohibits surveyors from acting "as consultants to nursing homes." CMS states that, "It is not the surveyors responsibility to delve into the facility's policies and procedures to determine the root cause of the deficiency or to sift through various alternatives to suggest an acceptable remedy."[28]

[26] Sources: Primary taken from *Nursing Home Survey Process Power Point Presentation* at http://www.health.state.mn.us/divs/fpc/consinfo.html; April 2003. See also Dorothy K. Bertsch, *Nursing Home Inspections – It's About the Residents,* April 2003 at http://nsweb.nursingspectrum.com/ce/ce302.htm.

[27] "Verify/clarify" happens when the team presents areas of concern to the facility and gives the facility the opportunity to present additional information and clarification. This is not a federally required survey task.

[28] Steven A. Pelovitz, Director of the CMS Survey and Certification Group, December 12, 2002.

Survey teams serve seven different areas of the state. The survey teams generally conduct surveys in seven regions of the state (Figure 1). Teams are assigned to facilities in other geographic areas for reasons such as conflict of interest, workload, quality improvement or other program needs. Four survey teams complete their work in the Twin Cities Metropolitan Area. District Office teams in other areas of the state are based in Bemidji, Duluth, Fergus Falls, Mankato, Rochester, and St. Cloud.

Figure 1: Map of Nursing Home Surveyor Regions
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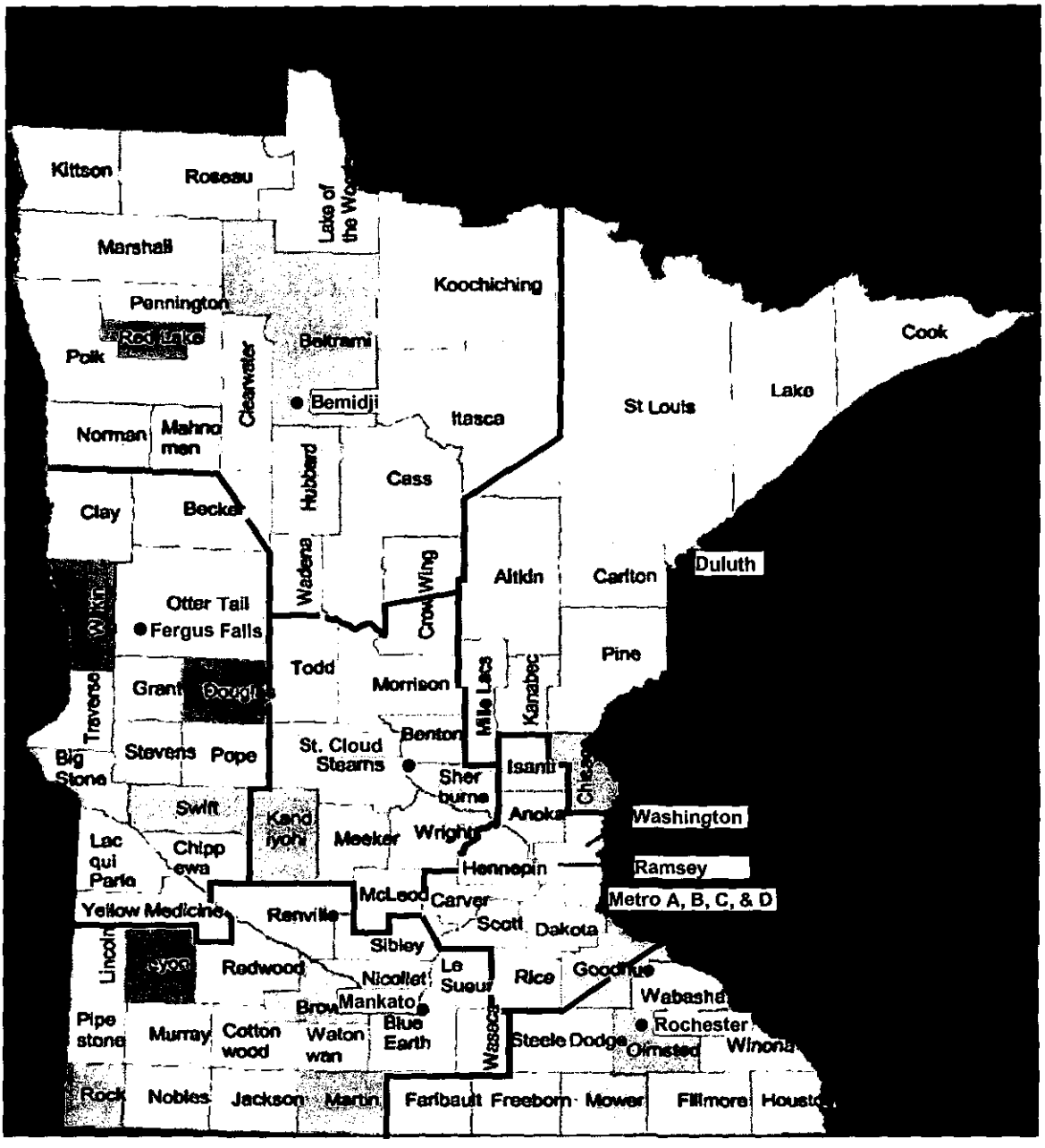

Federal and State Training and Oversight

CMS Training and Oversight: CMS has many strategies for monitoring state performance in conducting the survey (see Table 4). CMS conducts performance reviews to assess whether states are meeting requirements in several areas such as how frequently surveys are conducted and how well deficiencies are documented. CMS also sets minimum requirements for surveyors. For example, all surveyors must complete a federal basic long-term care training course and pass the Surveyor Minimum Qualifications Test (SMQT). CMS initiated several additional oversight activities as a result of the 1998 Nursing Home Oversight Improvement Program.[29]

Table 4: Examples of Federal Oversight of State Surveyor Performance

Type of Oversight	Examples/Description
Training Course	All State Survey Agency staff complete the federal basic LTC Training Course
Federal Examination	All surveyors must pass the Surveyor Minimum Qualifications Test
Federal Oversight/Support Survey (FOSS)	Federal surveyors accompany state surveyors and rate their performance on several measures
Federal Monitoring Survey ("look behind" surveys)	Federal Regional Office staff conducts a survey of a facility that the state surveyors recently surveyed, and federal/state results are compared.
CMS-Sponsored Workgroups	Workgroups are examining areas "which appeared to have less consistent interpretations by survey staff across the nation." For topics such as "pressure ulcers" and "incontinence," workgroups are developing clinical guidance, investigative protocols, and direction for making severity determinations. Training will follow.
State Performance Reviews	State performance reviews, implemented in October 2000, measure state performance against seven standards, including statutory requirements regarding survey frequency, requirements for documenting deficiencies, timeliness of complaint investigations, and timely and accurate entry of deficiencies into OSCAR (CMS's Online Survey, Certification and Reporting System).

Sources: Most of the information in this table is taken directly from: *MDH: Actions to Promote Integrity Through Consistent Implementation of the Survey Process*, 2004. CMS Performance Standards are taken directly from United States General Accounting Office. *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight.* (Washington, DC: July 2003), 2. To view the report go to: http://www.gao.gov/cgi-bin/getrpt?GAO-03-561.

[29] U.S. Department of Health and Human Services, Office of Inspector General. *Nursing Home Deficiency Trends and Survey and Certification Process Consistency,* (Washington, DC: DHHS, 2003), 2.

State Training and Oversight

The state of Minnesota requires extensive training and oversight of new and experienced nursing home surveyors.

Training for New Nursing Home Surveyors

During a new surveyors first nine weeks of employment, MDH provides 180 hours of didactic training and 160 hour of on-site survey experience under a preceptor's supervision. The week-long federal "CMS Basic Long Term Care" didactic training occurs about 6-12 months later and is followed by a written exam. An overview of the training is provided in Table 5.

On-going training

All new and experienced surveyors are required to maintain and enhance their clinical and surveying skills via several available resources.

- CMS's Web-based training in topics such as principles of documentation (about four hours) and Basic Health Long Term Care (about eight hours) is required for all surveyors.
- Based on a needs assessment, the Facility and Provider Compliance Division provides an inservice each year to address specific clinical concerns and provide program or regulatory updates.
- CMS satellite broadcasts, focusing on clinical conditions and survey guidance, are required viewing for all surveyors and supervisors.
- Other mandatory CMS training classes, such as Abuse Prohibition and Prevention, are provided and attended as required.
- Surveyors and supervisors participate in periodic statewide teleconferences where new or clarifying information is disseminated to the participants.
- Surveyors and supervisors attend MDH sponsored training sessions designed for provider education.
- Surveyors and supervisors receive ongoing intra-net updates.

Table 5: Overview of State Training for New Nursing Home Surveyors

Type of Training	Brief Description
1. New employee orientation (one day)	New surveyors, like other new MDH employees, attend an orientation to the Department presented by Human Resources Management.
2. Classroom training (160 hours)	During this time surveyors learn about the requirements of all 198 federal regulations and the MN State Licensure Rules for Nursing Homes.
3. Observational survey	After about two weeks of class work, the new surveyor observes an experienced survey team conducting a survey.
4. Surveys conducted under preceptor guidance	For the next three surveys, new surveyors work under the guidance of a preceptor (an experienced surveyor). The preceptor uses skill check-sheets that help MDH and the surveyor see the evidence of learning and skill achievement.
5. Surveyor works under supervisor's monitoring	The new surveyor is not expected to be independent at this point and receives additional mentoring and supervision by the team supervisor. The supervisor also evaluates the new surveyor's skills according to the checklist in order to verify competence in the required areas.
6. Surveryor completes the federal Basic Long Term Care Course (36 hours) and takes the federal Surveyor Minimum Qualifications Test.	There are five sites in Minnesota where surveyors can take this test. The basic course and test are taken within the first year of employment.

Source: Alberts, Sylvia. E-mail, June 11, 2004.

Oversight of Survey Activities

LCP has initiated many oversight activities to help assure that survey tasks are conducted consistently across the state. A list of activities LCP conducts to oversee and improve the survey process can be found in Table 6.

Table 6: Examples of State-Initiated Oversight of Surveyor Performance

Level	Type of Oversight	Examples/Description
Statewide	Onsite Mentoring and Coaching Surveys	Each survey team will be accompanied by at least five different supervisors/assistant program managers in FY04.
Statewide	Deficiency Review	In October 2003, the state conducted training to improve deficiency writing and review. Deficiencies (especially higher-level ones) are often reviewed by supervisor and CMS Regional Office.
Statewide	Routine Review of environmental and dietary deficiency tags	All environmental and dietary tags are sent electronically to the assistant program managers; the tags may be changed prior to the final report of deficiencies (CMS form 2567). Results are summarized and used to monitor variation and identify training topics.
Statewide	Supervisor Meetings/Weekly Telephone Conferences	Monthly supervisor meetings "provide an opportunity for supervisors from all district offices to discuss survey findings, identify clarifications needed, share information" and more. Staff also holds weekly phone calls, including supervisors, program assurance staff, and others.
Statewide	Statewide Surveyors	Five surveyors with expertise in different health care disciplines accompany each team at least once a year, integrating with surveyors across the entire state and providing feedback on survey consistency and variability.
District Office	Monthly Staff Meetings	Each team conducts monthly staff meetings to share any new information, clarifications, and updates.
District Office	Mixed Team Surveys	Each team has several surveys throughout the year where members of their own team work together with surveyors from other teams.
District Office	Supervisors On-Site	Supervisors spend time on-site with their own team, mentoring and evaluating surveyor performance.

Source: Most of this is taken directly from: MDH, *Actions to Promote Integrity Through Consistent Implementation of the Survey Process*, 2004.

Recent Efforts to Provide Consumer Information and Improve Quality of Care

Minnesota's nursing home survey process and its suggested reforms have not occurred in a vacuum. On the contrary numerous changes have recently taken place, which are intended to provide consumers with helpful information and improve quality of care. This section summarizes the current array of improvement efforts.

CMS is now posting quality-related information

Some basic information about all certified nursing homes in Minnesota and throughout the country is now available on Nursing Home Compare, a service accessible on CMS's http://www.medicare.gov/ Website.[30] A consumer can find three categories of quality information on Nursing Home Compare: information on 14 quality measures, the number of deficiencies on recent nursing home surveys, and nursing staff hours per resident day.[31]

CMS now requires quality improvement organizations (QIOs) to improve nursing home care

Another important component of CMS's efforts to monitor and improve the quality of nursing home care is Quality Improvement Organizations. QIOs have been a part of the Medicare program for over 30 years.[32] These organizations were created to improve the effectiveness, efficiency and quality of Medicare services. QIO activities have historically focused on hospital care. Today, however, QIOs work with a range of Medicare providers including Medicare managed care organizations, home health care agencies, and nursing homes. In their work on nursing homes, QIOs enter into three-year contracts with CMS to provide certain services to nursing homes generally, and to a subset of nursing homes more intensively.

Minnesota's QIO is StratisHealth in Bloomington, Minnesota. Stratis' current scope of work calls for them to concentrate their efforts in three areas: pain management, pressure ulcers, and infections. Stratis must show improvement in these indicators among the state's nursing homes as part of its contract with CMS.[33]

[30] In 1998 HCFA (the former name of CMS) started posting nursing home deficiency data on its Website to "assist individuals in differentiating among nursing homes." In 2002, CMS augmented the deficiency data with 10 clinical indicators of quality care, such as the percentage of residents with pressure sores. For more information on Nursing Home Compare, see Appendix F.

[31] The data used to report on quality measures comes from resident assessments that nursing homes routinely collect (referred to as the Minimum Data Set, MDS). Staff enters MDS assessment data into the CMS Online Survey, Certification and Reporting (OSCAR) database. For more information on the MDS, see http://www.cms.hhs.gov/states/mdsreports/default.asp.

[32] Since their inception in the early 1980s, the name of these organizations has changed from Professional Standard Review Organizations (PSROs) to Peer Review Organizations (PROs), to QIOs. For general information on QIOs, see: Marisa Scala, *The Role of QIOs*, at http://www.medicareed.org/ (Issue Brief 2, Volume 2, May 2003). See also Appendix G.

[33] For more information on StratisHealth see http://www.stratishealth.org/. See also Appendix G.

Governor's Office Call for a Nursing Home Report Card
In this year's state of the state address Governor Tim Pawlenty called for the development of a "report card" for nursing homes. In a March 1, 2004, News Release, the Commissioner of Health expanded upon this idea, saying that "We want our new report card to look at such things as whether the staff are friendly and responsive, whether the environment is warm and inviting, and whether the food is good. To consumers, these "softer sides" of a facility are equally important when deciding where a loved one should live." It appears that the report card being developed by MDH will reflect the quality indicators currently under discussion for use in DHS's "quality profiles."[34]

MDH Posting of Survey Results on its Website
At the state level, consumers and other interested parties can view a facility's survey results on the MDH website. This is much more extensive than just a listing of the number of deficiencies – the Website includes a summary statement of each deficiency cited, as well as the provider's plan of correction.[35]

Minnesota Department of Human Services
Value-Based Reimbursement: DHS is pursuing major changes in how it pays nursing homes, linking payment to certain quality indicators such as a facility's performance on its nursing home survey. Deficiency data are one of the seven quality-based measures included in the formula.[36]

Quality Profiles: DHS is planning to use the type of quality-related measures just described, along with other measures of quality of life, consumer satisfaction and family satisfaction, to develop "quality profiles for consumers to use to make better decisions about their long-term care needs and about which providers would best meet their needs." DHS reports that MDH is working to incorporate these same quality indicators in a nursing home report card "that would also be Web-based and available to consumers when they wanted to make a decision regarding nursing home care."[37]

Policy Work: DHS helps to shape LTC policy in Minnesota and produces a status report of Minnesota's Long-term Care System each year. For 2003, this report includes five long-term care benchmarks that measure the progress made on key elements of reform in Minnesota (for example, reducing the reliance on institutional care)." The report also "describes achievements in long-term care reform, future challenges and goals, and needed policy changes and resource needs." [38]

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[34] These profiles are described below after the "MDH posting of survey results."
[35] See http://www.health.state.mn.us/divs/fpc/directory/surveyselect.cfm.
[36] Four of the indicators relate to staffing. Two measures relate to the proportion of single rooms and quality indicators on the Minimum Data Set used by CMS. One measure, which accounts for 10 of 100 points in the quality adjustment, relates to survey deficiencies. Nursing homes are rewarded for not having serious deficiencies (for example, ten points if all facility deficiencies were below level F). Sources: Bob Held, interview, March 23, 2004; see also DHS, *Value-Based Reimbursement: A Proposal for a New Nursing Facility Reimbursement System*, March 1, 2004. To obtain a copy call 651-297-3583.
[37] DHS, *Status of Long term Care in Minnesota 2003.*
[38] DHS, *Status of Long term Care in Minnesota 2003.*
http://www.dhs.state.mn.us/agingint/ltctaskforce/reports

The Office of Ombudsman for Older Minnesotans
Like all other states, Minnesota has an Ombudsman Office that can assist seniors with issues related to health and long-term care. It is a statewide service administered by the Minnesota Board on Aging, with regional ombudsmen located throughout the state. Nursing home residents and their families can contact the Ombudsman with concerns or questions related to such things as: quality of services; rights; termination of services or discharges; service agreements or care plans; building sanitation and safety; access and referrals to services; appeals; fees and billing; and public benefit issues.[39]

Consumer/Advocacy/Worker Associations
Major consumer/advocacy/worker associations in Minnesota include AARP, the Seniors and Workers for Quality Association, and the Senior Federation. In the fall of 2003 the Seniors and Workers for Quality and the Office of the Ombudsmen for Older Minnesotans came together to better "understand and record experiences with the nursing home survey process" by asking members eight open-ended survey questions. Over 300 people responded to the survey including 272 nursing home workers and 50 consumers and ombudsmen.[40] A theme among respondents was that they expected improvements in the survey to more actively involve consumers and workers. They said, "positive changes in the survey system should take account of consumers' and workers' experiences and viewpoints."

In 2002, the AARP also conducted a Long-term Care Survey of 818 Minnesotans aged 35 and older to elicit opinions on many aspects of the long-term care system, including nursing home regulations. According to this survey, nine in ten respondents support strengthening enforcement standards (73 percent strongly and 17 percent somewhat) to ensure quality of care in nursing homes and the health and safety of nursing home residents. More than eight in ten respondents rate working to improve the quality of care in nursing homes and assisted living facilities as a top (32 percent) or high (50 percent) priority for AARP.[41]

Provider Organizations
Provider organizations have proposed numerous ideas for improving Minnesota's LTC and nursing home systems. For instance, two provider organizations (the Minnesota Health & Housing Alliance and Care Providers of Minnesota) have joined to form the Long-Term Care Imperative, "a Minnesota Collaboration for Changes in Older Adult Services." The Imperative calls for a new vision for long-term health and supportive services, one in which nursing homes "will be transformed and converted to – or replaced by – a smaller number of state-of-the-art care centers." They also call for a new approach to regulations and quality enforcement:

[39] DHS, *Office of Ombudman for Older Minnesotans*, June 10, 2004, http://www.dhs.state.mn.us/, subheading "aging."
[40] MDH, Questionnaire on the Nursing Home Survey Process: Results and Challenges: A Joint Project of Senior and Workers for Quality and the Office of Ombudsman for Older Minnesotans, January 15, 2004 meeting , http://www.health.state.mn.us/ltc/ombuds.pdf.
[41] From Joanne Binette, *Minnesota Long-term Care: An AARP Survey of Minnesotans*. AARP Knowledge Management: Washington DC, Page 5. December 2002. See http://research.aarp.org/health/mn_ltc.html.

"Consumer experience should define quality. Quality enforcement in our vision is based on the principle that the consumer knows what's right, versus a paternalist government definition of what's right. Reliance on prescriptive regulations as the only indicator of quality has given consumers a false sense of security when choosing long-term care services.

"In our vision, universal customer satisfaction measures would be developed and could be used by consumers to reach personal decisions about value. We would encourage independent third parties, such as JD Powers and Associates, to craft new long-term care customer choice and satisfaction rankings. In our vision, the provider community will assume responsibility for credentialing programs and peer review programs to advance best practices."[42]

Other Stakeholder Efforts

Providers, consumer organizations, researchers, and policymakers are all working on various strategies to improve the quality of care in nursing homes. These include but are not limited to: addressing staffing issues, developing broad measures to rate quality and customer satisfaction with care; improving physical environments; and examining the financial issues associated with the provision of quality care.[43]

[42] LTC Imperative, *Principles for Change*, June 10, 2004, http://www.careproviders.org/vision.html.

[43] For example, see the special series of articles in the April 2003 issue of *The Gerontologist*, available online at http://gerontologist.gerontologyjournals.org/content/vol43/suppl_2/index.shtml; also see the thirteen part series on the Survey Process in *Caring for the Ages*, a monthly publication of the American Medical Directors Association at http://www.amda.com/.

Findings and Conclusions

Nursing home care for frail and vulnerable people is an important and emotionally charged topic. Recent trends in defining citations and other events in Minnesota have fueled a debate over the Minnesota Department of Health's performance of its regulatory duties. Consumer advocates and the facilities that provide care are polarized in their views, and the department is mired in the controversy. Sadly, the continual sparring of the stakeholders has distracted the most well-intentioned from their heart-felt desire to care for those who need it most.

The following findings and conclusions describe the current controversy regarding the nursing home survey, highlight how the pattern in citations has changed and offers possible explanations for the changes, and discusses the unrealized opportunity to improve the quality of care for nursing home residents. This section also focuses on the department's efforts to improve communication with the stakeholders, to restore the integrity of the nursing home survey, and other findings related to the department's internal operations, communications, and decision making.

The providers and regulators of nursing home care face intense public scrutiny

The providers of nursing home care and the government agencies that regulate them face intense public scrutiny. Providers are entrusted with caring for uniquely vulnerable people and are to assure that residents achieve the "highest practicable physical, mental, and psychosocial well-being."[44] When care is perceived to be inappropriate, the public outrage makes front-page news. Additionally, when regulators exercise their authority it can have severe consequences for facilities and residents. It is not surprising that providers and regulators will be scrutinized by one another, consumers, and the legislative bodies that govern them.

The public debate regarding the survey has become polarized and unproductive

The narrow and polarized debate regarding the survey process has precluded the stakeholders and the legislature from having thoughtful and productive discussions. In fact, the legislature's recent discussions regarding the survey has only mirrored and magnified the polarity of the debate.

> The continual sparring among the stakeholders and the "relentless imposition of new projects, laws, regulations, and demands, and the shifting of political and regulatory landscape, merely exhaust and confuse those trying to provide [and improve] care."[45]

[44] Center for Medicaid and Medicare Services (CMS) nursing home state operations manual (SOM).
[45] "Identifying and Implementing Effective Statewide Approaches to Nursing Home Regulation," *Caring for the Ages*, American Medical Association, November 2002. Go to: http://www.amda.com/caring/november2002/ltcregulations.htm

The Legislature

Rather than defuse the controversy, recent legislative hearings have been remarkably one-sided and sympathetic to the industry. Some suggested this was a result of political tactics on the part of the industry. For example, local print media reported, "The industry – which has contributed more that $150,000 since 1996 to legislative campaigns – has made the inspectors themselves the issue."[46] Others said the providers had simply been more effective in telling their story. Most agreed, however, that a more measured and balanced policy discussion is needed.

Providers and their associations

Providers said that the regulatory standard of the "highest practicable physical, mental, and psychosocial well-being" is subject to wide differences in interpretation. They added that the consequences of the deficiencies are unfairly disproportionate to the problems they reflect and have only exacerbated the intense financial pressure on facilities.[47] For example, they point out that the enforcement penalties – even for isolated and less severe deficiencies – may result in financial losses (due to civil monetary penalties, denial of payments for new admissions and for all residents). They said the combination of a highly subjective set of regulatory standards, a "zero tolerance" philosophy by regulators, and the lack of consultation and advice from MDH[48] is hurting the financial condition and the staff morale of an already stressed industry. Taken together, providers said that these factors have created a punitive, adversarial climate that is hostile toward the industry.

Consumer advocates

Consumers advocates said that serious care problems continue and, because nursing home residents are particularly vulnerable, regulatory leniency is inappropriate. They stressed that the enforcement provisions – which arose from serious problems in nursing homes – represent a minimum standard for a nursing home industry. They said that the industry has long promoted distorted anecdotes about specific surveys and downplayed the serious problems that turned up in the same surveys. They are dismayed by the apparent assumption of many legislators that there is something wrong with the survey process or the way the department administers it. Consumer advocates described many examples of substandard care that still exist, despite what has been characterized as overzealous regulator oversight. In fact, they said that MDH is not as rigorous in its investigations and responses to complaints as the advocates would like.

[46] "Inspectors: picky or prudent," St. Paul, Pioneer Press, May 23, 2004.

[47] See "The Long Term Care Imperative" legislative survey results. The imperative survey findings also show that liability insurance is increasing for Minnesota nursing homes and suggests that the increase is a direct result of relatively high deficiency findings in Minnesota and in certain districts of the state. Others, including nursing home administrators, reported that liability insurance increases are a national phenomenon affecting a variety of areas and are not a direct result of the nursing home survey.

[48] State survey agencies are specifically prohibited by the CMS state operations manual from providing consultation or advice on care processes as part of the survey. See "survey tasks" in the "overview" section, page 10.

Much of the controversy has focused on recent changes in enforcement activity across the state and the nation

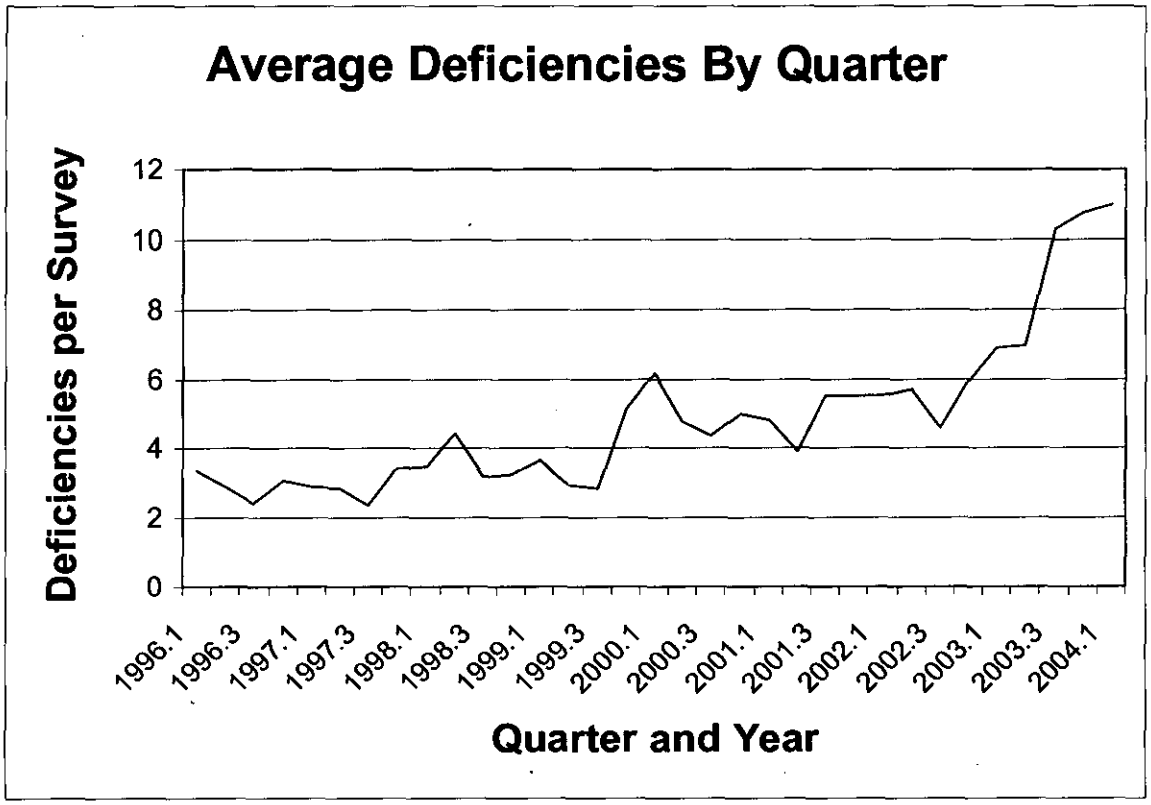
As described in the overview, many groups have analyzed and researched the survey process and, most recently, have focused in particular on the number and type of deficiencies that have been issued by MDH. The department, providers, and others have looked at deficiency rates among Minnesota nursing homes and concluded that rates are rising, and variation among state districts and among states is high.[49] As part of this review, MAD also reviewed certain aspects of the deficiency data and made the following observations.

The number of deficiencies cited for Minnesota's nursing homes is rising.
As described earlier, when a survey team inspects a nursing home, they evaluate whether the home has met standards in many areas, and issues "deficiencies" related to areas where the facility is not meeting the standards. Deficiencies can range from A to L depending on the scope and severity of the problem.[50]

When looking at all deficiencies, it is clear that Minnesota surveyors are citing an increasing number of deficiencies. Overall, the average number of deficiencies cited in Minnesota facilities has more than tripled – rising from approximately 3.5 in early 1996 to about 11 in 2004.

[49] See the Commissioner's "Survey Findings/Review Subcommittee" report. Representatives from all the stakeholder groups participated in an analysis of survey findings and made recommendations.
[50] See "Overview of the Survey Process," page 5.

Graph 1: Average Number of Deficiencies per Facility, 1996 – 2004

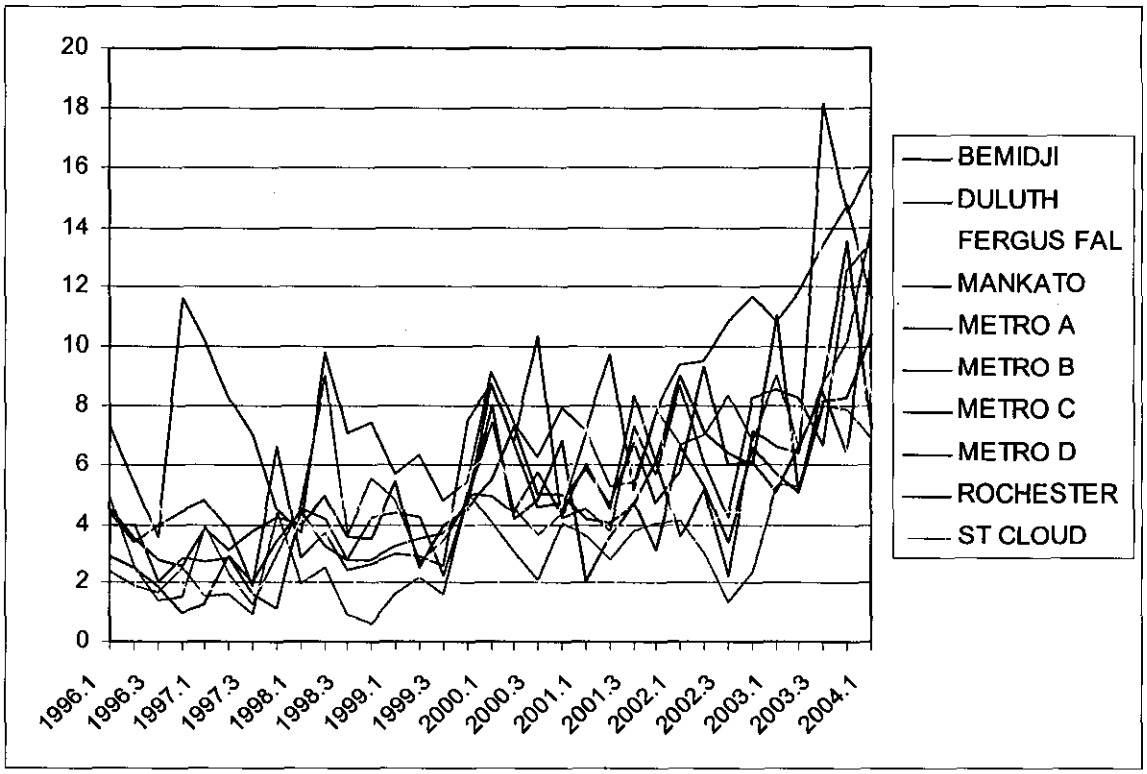


This chart shows total statewide average deficiencies per facility, by quarter from 1996 through the first quarter of 2004.[51] There are two notable increases in the average number of deficiencies cited. The first starts in the fourth quarter of 1999. Prior to that time, the average number of deficiencies had only exceeded four deficiencies per facility once. After that quarter, the number goes below four only once. The second notable increase starts in early 2003 and then continues to climb into the present.

The data was also examined to determine if one or a few districts drove the increase in average number of deficiencies, or whether this was a statewide phenomenon. The following chart shows the trend in each individual district. It is difficult to read, but it shows that, as a group, the districts increased the number of citations issued by the third quarter of 2003. The Fergus Falls district increase, beginning in late 2002 is extreme compared to the rest of the districts. The Metro C district also has a fairly pronounced increase. Overall, the graph shows that all districts increased their deficiencies over the past year, as well as in late 1999.

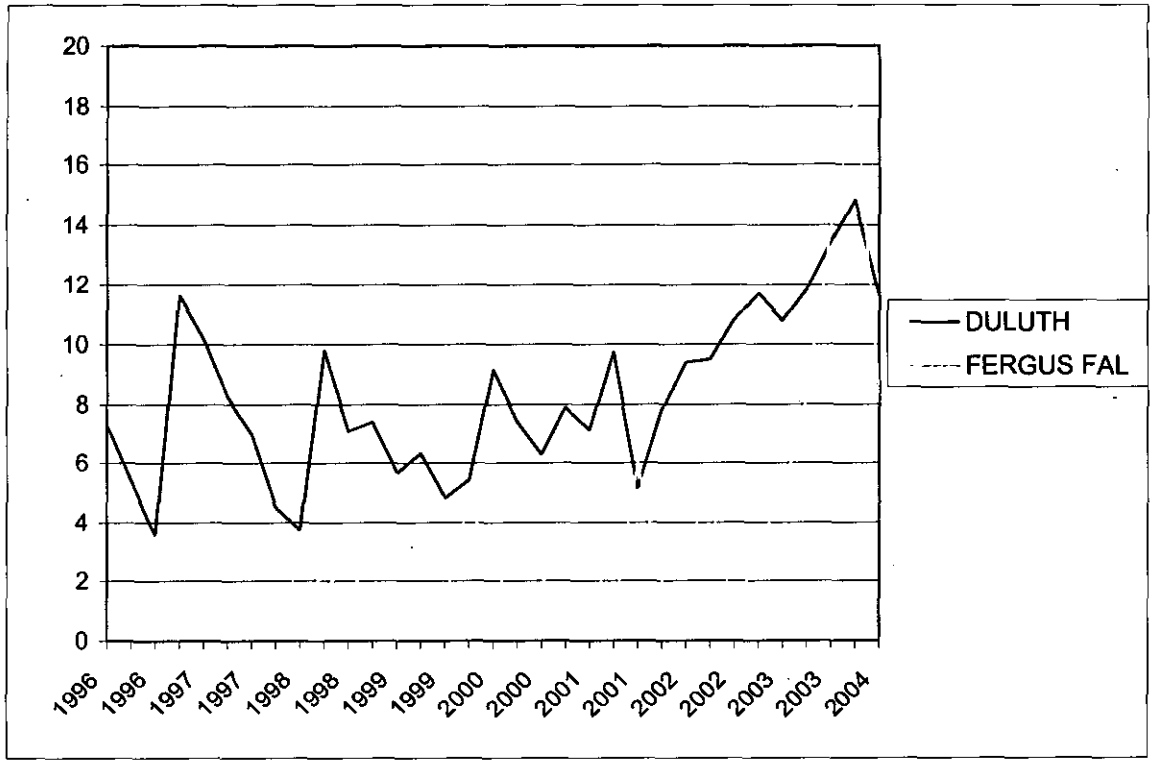
[51] The data for this table was taken from the CMS online survey, certification and reporting (OSCAR) database. 1996.1 means first quarter of 1991, 2001.3 means third quarter of 2001, etc.

Graph 2: Deficiency Trends by District, 1996 – 2004



The next chart is identical to Chart 2, except that it only graphs Fergus Falls and Duluth; the two districts that have historically had the lowest and the highest average number of deficiencies per survey, respectively.

Graph 3: Deficiency Trends for Fergus Falls and Duluth Districts, 1996 – 2004



There is significant variation among districts but variation has recently decreased. Analysis done by the department and other groups in early 2004 suggested that not only are the number of deficiencies across the state increasing, the variability among districts is also increasing. MAD analyzed variation in average deficiency rates across the state and the variation between specific districts.[52] In both cases variation has actually decreased during the last eighteen months, once the overall increases in total number of deficiencies are taken into account.[53]

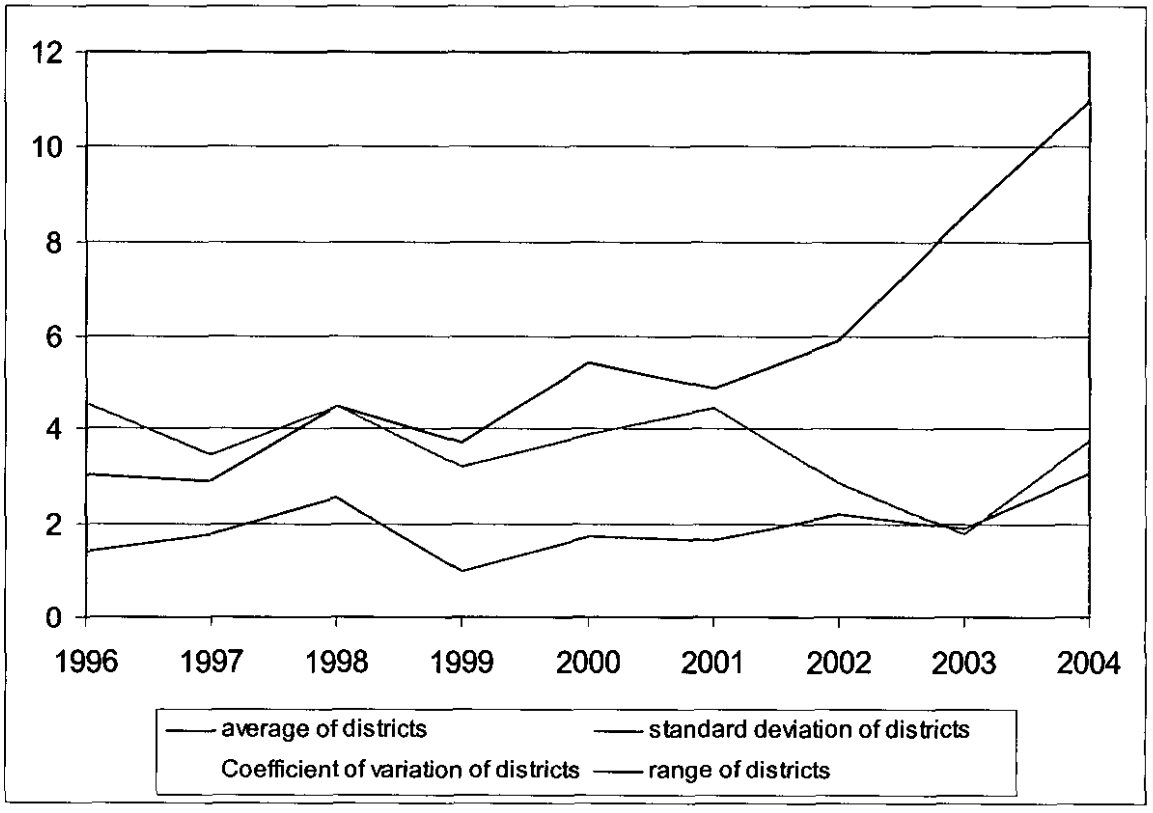
The following chart compares averages for each district and shows changes in the statewide mean, range, standard deviation, and coefficient of variation, from 1996 to the present. While the standard deviation and range are increasing, the coefficient of variation is actually decreasing.[54] In other words, there is little evidence that districts have gotten less consistent in enforcing policies over time. Instead, the recent increases in variation that have been discussed are merely a mathematical side effect of the increased number of deficiencies being cited.

[52] No CMS performance standard or MDH policy on variability in deficiency citation exists with respect to what is acceptable or not acceptable variability.

[53] An analysis of this issue is complicated by the fact that as the number of observations (deficiencies) increase, common measures of variation will also show an upward trend. For instance, if you double the number of deficiencies in every Minnesota district, thereby maintaining the ratios between all districts, standard deviation and range will double as well, and variance will increase by a factor of four. The coefficient of variation, however, controls for changes in the underlying mean. The coefficient of variation equals the standard deviation divided by the mean.

[54] The abbreviation "sd" stands for "standard deviation" and "Cvdist" stands for "coefficient of variation."

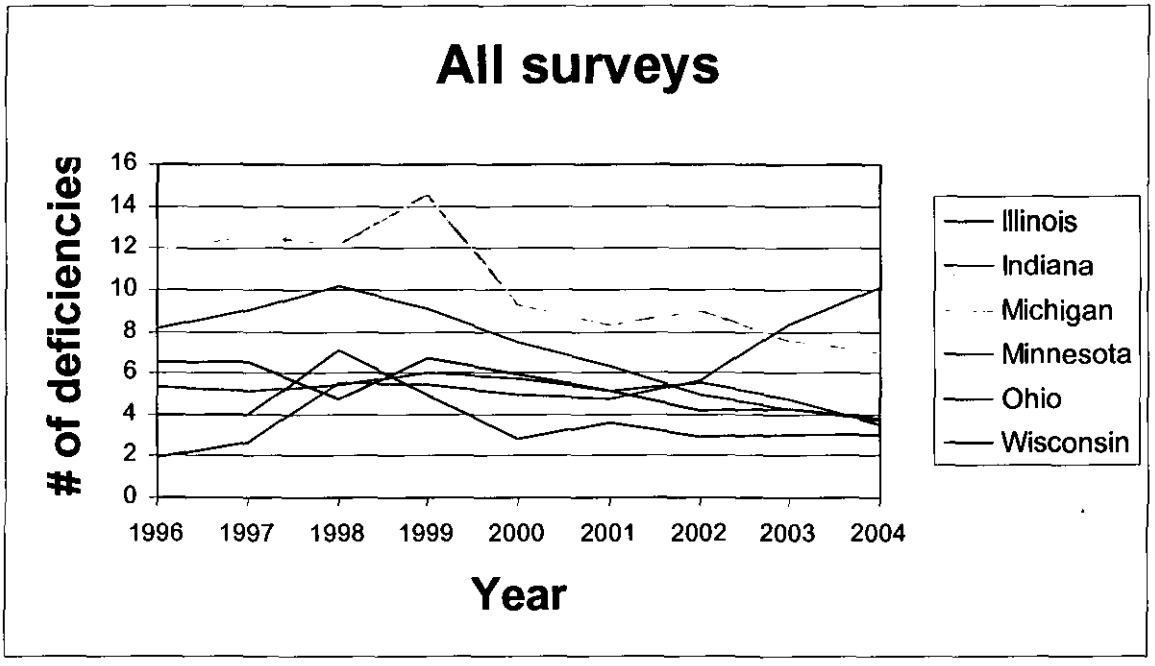
Graph 4: Statewide Variation in the average number of deficiencies by facility, 1996 – 2004



This decrease in variation among districts may be explained by the fact that those districts with a history of the lowest number of deficiencies, such as the Fergus Falls district, have seen the most dramatic increases in the last eighteen months, bringing them in line with other districts (see findings on "Several factors may account for the change and variability in enforcement activity").

Compared to other states, deficiency rates in Minnesota are high.
Minnesota has the highest average number of deficiencies in federal region V, and is the only state with a general upward trend in the number of deficiencies.[55] In fact, Minnesota has gone from having the lowest average number of deficiencies in 1996 and 1997, to the highest number in 2003 and 2004.

Graph 5: Average number of deficiencies by state, 1996 – 2004



The types of deficiencies cited in Minnesota differ from other states
A review of deficiencies cited by category show that overall, Minnesota tends to have noticeably higher numbers for the lowest severity deficiencies, somewhat high numbers for medium severity, and very low numbers for the highest severity deficiencies.

The following table summarizes Minnesota's ranking for each category of deficiency.

[55] Region V includes the states of: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin.

Table 7: Comparison Between Minnesota and Other States in Region 5 by Deficiency Category, 1996-2004.

Severity Level	Category[56][57]	How Minnesota Compares
No actual harm with potential for minimal harm	B	MN has the second highest average number of deficiencies in this category, with relatively little difference between the states.
	C	MN has the highest average.
No actual harm with potential for more than minimal harm[58]	D	MN has by far the highest average number of deficiencies.[59]
	E	MN has the highest average. MN and MI stand out from the other states.
	F	MN is in a two-way tie for the second highest average, well behind MI.
Actual harm[60]	G	MN has the highest average.
	H	All states have zero deficiencies for 2004.
	I	All states have zero deficiencies for 2004.
	J	MI is the only state to have any J-level deficiencies this year (but in recent years, MN has had the highest average).
	K	MN has not had a K-level deficiency for four years (although other states have).
	L	MN has not had a L-level deficiency for four years (although other states have).

Source: MAD analysis, April 2004.

Cross-referencing:

The commissioner's Survey Findings/Review Subcommittee reviewed certain deficiency groupings to determine if there was evidence that Minnesota was citing multiple tags for a single outcome more often than other states.[61] The data was not analyzed in depth to determine if the was actually the case. The committee concluded, however, that increases were very likely due to "cross-referencing."[62]

[56] Category A is excluded because it relates to an isolated incident with no actual harm to residents, and no remedies are required.

[57] Within the severity levels, there are three categories related to the scope of the deficiency (i.e., whether the deficiency is an isolated case, part of a pattern, or a widespread problem). See Table 1 for a full description of the severity and scope levels.

[58] "Immediate jeopardy" is not included in this category.

[59] Almost twice as high as the next state, Michigan, and almost three times as high as the third state.

[60] "Immediate jeopardy" is not included in this category.

[61] The term "cross-referencing" was commonly used to describe the practice of citing multiple deficiencies for a single care problem. For example, if a poor patient outcome was identified, the facility could be cited for both the poor outcome and the failure to properly assess the risk of the outcome or to plan accordingly.

[62] See also "cross-referencing" under the section, "A review of other states shows common problems and a variety of approaches to improving the survey," p. 34.

Follow-up Surveys

If a survey team finds deficiencies at the B through L level, the nursing home is required to write a plan of correction and submit it to the team. The team later conducts a follow-up survey to determine whether the deficiency has been addressed according to the plan of correction. The commissioner's Survey Findings/Review Subcommittee analyzed deficiencies issued on follow-up visits and observed that:

- Both the number of new citations issued and the re-issuance of previous citations on follow-up (PCRs) have increased in all Minnesota districts since June of 2003.
- The number of surveys having a re-issue of a previous deficiency during follow-up has increased from approximately 15 percent in 2002 to 30 percent in the last half of 2003 in Minnesota.
- The number of surveys having a new-issue of a previously un-cited deficiency during follow-up visit has increased from 5.7 percent in 2002 to 14.5 percent in the last half of 2003 in Minnesota.
- Minnesota and Michigan have the highest frequency of surveys having at least 2 follow-up PCR visits. Both are near 20 percent for the most recent survey cycle. This rate is almost twice the next highest state in the region, which is Illinois at 11 percent. Wisconsin is the lowest with 2.9 percent of surveys having a second follow-up visit.

Several factors may account for the change and variability in enforcement activity

As discussions about deficiency rates have become more heated in the last year, many people and organizations have offered explanations for why these increases have occurred. MAD's analysis concludes that it is impossible to know for sure why rates have risen – there are simply too many factors to analyze given the complexity of the issue and the limitations of time and money in completing this study. Researchers at the national level have found this to be true as well.

According to one researcher, "...changes in deficiency rates found in nursing home surveys over time or variation in these rates across states may result from differences in the stringency, scope, or implementation of the survey process or from real differences in quality of care, and it is not possible to disentangle the two."[63]

Given these caveats, MAD offers at least a partial explanation for why deficiency rates have risen.

Events at one facility may have been a flashpoint for statewide increases in deficiencies

In early 2003, as part of its efforts to improve the survey process, MDH sent a questionnaire to all nursing home administrators, asking them for comments about the current process. An administrator from a nursing home in the Fergus Falls district responded, indicating that when survey team members were recently in the facility to conduct a survey, they failed to identify some care deficiencies.

MDH conducted an informal, follow-up survey to examine these concerns, explaining to the facility that no deficiencies would be cited. The informal findings were sent to the facility by MDH. Later CMS told MDH that an informal survey was inappropriate and deficiencies must be cited. Despite the department's attempts to negotiate a compromise, CMS insisted MDH conduct a formal survey. A formal survey was conducted resulting in several deficiencies, including findings of substandard care.

The department's response to the findings were swift and decisive, leaving a strong impression on supervisors and surveyors around the state. The supervisor for the Fergus Falls district was temporarily reassigned duties outside of the district, and the Fergus Falls staff were supervised by other district supervisors. Division management held special meetings with the Fergus Falls district staff and with all survey staff to emphasize the importance of following CMS survey protocols. The Commissioner of Health also sent a two-page e-mail to all division staff, which many staff said reinforced the message that they were to perform the survey in strict "accordance with federal requirements."[64]

[63] Walshe, Kieran, "Regulating U.S. Nursing Homes: Are We Learning From Experience?" *Health Affairs*, 20:6 (2001): 128-144.

[64] The quote is taken from a two-page e-mail from Commissioner Mandernach to the Facility and Provider Compliance Division, on September 9, 2003.

Nearly all supervisors and surveyors interviewed said that they got the message loud and clear – "cite all deficiencies, regardless of how isolated or minor." One surveyor said, "In some ways the new approach is easy because you don't have to think. The bad news is that it doesn't make sense and it certainly isn't helping the residents." Whether or not it is fair, the department's reaction to this incident was seen by surveyors and providers as the final blow to "common sense" in the survey process.

Most interviewees felt that this communication phenomenon was the primary explanation for the dramatic and recent increases in the number of deficiencies being cited by surveyors. While the data on deficiencies discussed earlier in the findings generally support this perspective, it should be noted that gradual increases in deficiencies were occurring – both in the Fergus Falls district and around the state – prior to these events.

Financial and other pressures place a strain on nursing home quality
While most interviewees did not claim that the dramatic increase in deficiencies was a direct result of equally dramatic declines in nursing home care, many emphasized that the pressures on nursing homes were undoubtedly a factor.

Providers and others stressed that nursing homes are under intense pressure from rising costs, reimbursement rates that have not kept up with those costs, ongoing staffing shortages, and growing competition from alternative forms of long term care.[65]

Surveyor staff turnover
In her legislative testimony in February, 2004, the commissioner noted several possible explanations for the increase and statewide variability in deficiencies cited. In particular, she reported that there was unusually high turnover among nursing home survey staff in 2002 and suggested that new staff may be responding to new CMS efforts to promote more deliberative investigative techniques, which encourages surveyors to ask more probing questions.

Several interviewees, internal and external, also raised concern about the turnover of nursing home surveyor staff. Many interviewees reported that the rate of staffing turnover was over 40 percent. An analysis of MDH employment data showed that approximately 15 percent of the nursing home survey staff resigned in 2002, compared to a department resignation rate of 9 percent. In 2001 and 2003, however, the resignation rates of the nursing home survey staff were 7 percent and 7.8 percent respectively – lower than the department wide resignation rates of 9.9 percent and 7.9 for 2001 and 2003.[66]

[65] See "The Long Term Care Imperative" legislative survey. The Imperative survey findings also show that liability insurance is increasing for Minnesota nursing homes and suggests that the increase is a direct result of relatively high deficiency findings in Minnesota and in certain districts of the state. Others, including nursing home administrators, reported that liability insurance increases are a national phenomenon affecting a variety of areas and are not a direct result of the nursing home survey.
[66] Information and analysis provided by Ron Olson, Director of Human Resources, MDH.

Varying surveyor attitudes and enforcement cultures across district offices
Surveyors expressed wide-ranging perspectives as to the extent of discretion they believe are allowed and should exercise as part of the survey.

Some surveyors and supervisors said that a strict application of the CMS survey guidelines is unreasonable and results in deficiencies that are not likely to improve care for the residents. Rather, they said, a "letter of the law" approach only frustrates facility staff and distracts them from providing the needed care. They said it was reasonable to consider the reality of the facility's resources when determining whether a deficiency should be cited. Other surveyors did not agree and stressed that surveyors should conduct rigorous observations, investigations, and base determinations solely on the basis of documented findings. They said that the facility's resources and ability to respond to the deficiency should not be considered in any part of the surveyors decision making.

These differing philosophies can become distinguishing cultural features of the district offices and teams, especially where those teams have had long term working relationships, the team is isolated from influences of other team philosophies and practices, and where the district office supervisor tends to reinforce the district's culture and practice, rather than continually adapting the team's approach based on sharing of knowledge and practices with other districts.

Again, it is important to recognize that MDH has initiated and expanded several survey improvement efforts over the last year, many of them specifically designed to address varying practices across district office teams. These efforts continue and the results are yet unclear. MAD's analysis, however, found stark differences in surveyor and supervisor perspectives on how much discretion they can exercise in the deficiency determination process.

State-to-state variation
The state-to-state variations described earlier can largely be explained by many of the same factors that contribute to district-to-district variation within Minnesota. These national variations have been explored in detail by the Office of the Inspector General (OIG), General Accounting Office (GAO), academics, and others. For instance, the GAO has reported wide variations among states in the proportion of facilities cited with serious deficiencies[67] and the OIG found that states appear to differ in how they determine specific deficiency citations.[68] OIG. Factors contributing to variations among states in citing deficiencies, OIG suggests, include inconsistent survey focus, unclear guidelines, lack of a common review process for draft survey reports, and high surveyor staff turnover.

[67] GAO, 2003. See especially Table 7, page 56.
[68] OIG, 2003, 15-17.

MDH receives mixed messages about its survey effectiveness and has initiated a variety of quality assurance efforts

MDH receives mixed messages about its effectiveness. CMS gives MDH high marks for its survey work as evidenced by its FOSS survey scores and look behind survey reports.[69] Also, MDH has historically done well in negotiating a relatively high federal share for the state's survey costs.[70] Advocacy organizations and resident and family representatives report they are aware of the department's good standing with CMS and tend to agree, although they have been less visible and vocal at the legislature. Providers and legislators, in contrast, have complained that the survey is "out of control."[71]

In response to recent trends and variation[72] in deficiency data, MDH has initiated several quality assurance efforts at the statewide and district office level to monitor and improve the survey.[73] These quality assurance efforts, however, have proven labor intensive leaving precious little staff time to manage the efforts, analyze results, and apply lessons learned from the experience.

Collectively, MDH's internal quality assurance (QA) efforts are labor intensive and of questionable value in improving survey performance.
For example, the "on-site mentoring and coaching surveys" require each supervisor to supervise five surveys in facilities outside his or her district. Because each survey lasts approximately one week, the 10 supervisors will commit a total of about 50 weeks of work or the equivalent of one full time position. About half of the planned mentoring and coaching surveys had been completed at the time of this report. It will take a full year, substantial staff time, and significant travel costs, before this activity will yield results.

The measures used to judge quality are not clearly articulated and data collection and analysis activities are not specifically assigned.
Using the example of the coaching surveys, qualitative information is collected from each supervisor and then summarized. The questions that the coaching survey is designed to answer are only generally described and the process for analysis and decision making is not clear.

Each of the efforts summarized in table 6 are broadly qualitative and are done on faith that by doing the activity, the solutions will become evident and will be implemented. Formal responsibility for the coordination of the survey improvement activities has not been specifically assigned and there is no formal process in place to evaluate whether consistency or other qualities of the survey have actually improved as a result of these significant and fairly costly efforts.

[69] For an explanation of these activities, see Table 4.
[70] An analysis done by the Health Care Financing Administration in May, 2000, showed that Minnesota was the only state in its region that paid less that 10 percent of the total survey costs. No other state was less than 15 percent state share, and one state paid nearly 25 percent of its total nursing home survey costs.
[71] Hearing of the House Health and Human Services Policy Committee, February 25, 2004.
[72] Although variations in deficiency citations over time and across geographic areas has been an ongoing concern, nationally and in Minnesota, there is no federal or state performance standard relating to variability in deficiency citations.
[73] See section on State Training and Oversight", pages 13-16, or Table 6 in that section.

The quality assurance efforts are almost exclusively based on internal data and bear no apparent relationship to quality improvement efforts statewide.
At each survey, teams are expected to provide facility staff, residents, and family representatives with a feedback questionnaire. The questionnaires, however, are not always provided, they are rarely completed, and the responses are not routinely summarized, analyzed, or used.

Incorporating external information and perspectives on the QA efforts could promote a broader understanding of the survey process and its inherent challenges, and promote a shared effort to identify and address root causes of the deficiencies.[74]

A review of other states shows common problems and a variety of approaches to improving the survey

Many states are wrestling with the same issues confronting MDH in its implementation of the survey process. States are responding to these challenges in different ways, indicating that states actually have a fair amount of discretion in the way certain aspects of the survey process are conducted. Research and interviews with staff in other states indicates a wide variety of practice.[75]

Geographic assignment of staff
Some survey agencies have divided their states into regions, and survey teams based in each region conduct surveys only in that part of the state. In other states there is state-wide staffing for the survey process, with no district offices, and survey staff conduct surveys in many parts of the state. Nearly all states participating in interviews for this study cited the value of using a "maximum mix" of team members within and across regions of the state. This was said to help reduce regional variations in the number and types of deficiencies cited in different regions, a common problem experienced by many state survey agencies.

"Cross-Referencing"
The term "cross-referencing" is used in different ways, but for the purposes of MAD interviews with other states it referred to the situation in which "one observed incident results in the tagging of multiple deficiencies." States generally reported that, "we don't do that to a great extent," or "we don't do too much of that."

Some states reported that they are more likely to cite multiple deficiencies if the problem is more severe, and/or if it is clear that there was a major breakdown in the entire care process. One state reported that they "cut down" on cross-referencing because the process "loses its impact if we cite everything." Other respondents said CMS should provide clarification on this issue.

[74] This type of review is described in an internal draft memorandum from Dr. Colleen Cooper to Commissioner Mandernach, March 2, 2004. It is included in Appendix I.
[75] In May 2004, MAD staff conducted structured interviews with state survey agency staff in six states.

In mid-April, Commissioner Mandernach and other department staff met with CMS officials from the central office, the regional office, and with other state survey agency representatives to discuss the topic of cross-referencing. During the meeting, it became clear that there is wide variability in Region 5 and border states around Minnesota. It was pointed out that Minnesota uses cross-referencing significantly more that the other states in Region 5 and the states that border Minnesota.

Based on the information presented at the meeting, CMS attendees agreed to take this issue back for further discussion and respond to the other attendees within 6 weeks. At the time of this report, no formal response had been received. MDH has also issued a bulletin regarding its policy on cross-referencing called, "Federal SNF/NF Deficiencies Related to Outcome, Assessment and/or Care Planning Findings." The effective date of this bulletin is June 21, 2004.[76]

Follow-up surveys

Interviews with other states indicate that follow-up surveys – surveys conducted to verify that a plan of correction has been implemented – may take the form of a phone call, documentation of the correction of a problem, or, most commonly, an on-site visit.

On-site visits are preferred by many states, interviews suggest, especially for higher-level deficiencies and/or for facilities that have a poor quality-of-care record ("problem facilities"). Some states allow a facility to use the plan of correction or other paper documentation to attest that the deficiency was addressed, particularly if it was a lower-level deficiency. For example, if a stove was broken, the facility could fax in a receipt showing that it had been repaired.

States had mixed opinions on the benefits and drawbacks of using phone calls as revisits. Most states did not advise it. One state said it would provide "one more chance for inconsistency" in how surveys are conducted, if some facility revisits were by phone and others weren't. Other respondents appeared to think that on-site visits and paper documentation offered stronger evidence that a problem had been corrected than did phone revisits.

Technical Assistance (TA)

Interviews with staff in other states showed that some states had separate TA programs related to nursing home quality of care and/or the compliance with the nursing home survey, but most did not. For states with TA programs, the programs appeared to be set up to encourage compliance, promote cultural change, communicate with providers, and/or answer provider questions. States without a TA program generally said that they and/or providers would like such a program, but reported "we just don't have the money." States without formal TA programs indicated they provided TA by working with nursing home associations and/or being available to take questions from providers.

In May 2003, the U.S. Department of Health and Human Services released a study of nursing home technical assistance programs in seven states. In general, this study found that TA programs vary by state, most profoundly in whether the purpose of the program

[76] See http://www.health.state.mn.us/divs/fpc/profinfo/ib04_9.html

was to promote regulatory compliance or improve nursing home care practices. Common elements shared across programs include the provision of on-site consultation and training, and the use of a collaborative approach to problem-solving.[77]

Alternative Approaches to the Survey

Stakeholders in Minnesota and other states have been considering alternatives to the current survey process as required by CMS. The use of any alternative processes would require changes in state and federal regulations. Staff in one state pursuing this type of alternative reported that the development of an alternative process "would literally take an act of Congress." Still, there is ongoing interest in this issue in Minnesota and other states.

The alternatives identified during this review take at least four forms: (1) facilities with good compliance records would receive abbreviated surveys, while facilities with poor compliance record would receive longer surveys; (2) facilities with a good history of compliance have the option of participating in a joint provider/consultant survey that would be paid for by providers; (3) facilities with good compliance records would be surveyed less frequently (for example, every 30 months instead of every 12 – 15 months); and (4) development of new regulatory standards, based on the Baldrige criteria.[78]

Abbreviated surveys

Interviews with other states indicated that at least one state is pursuing a survey process in which the state would be permitted to focus more hours on "problem facilities" and use an abbreviated process in facilities with good compliance records. Specifically, this state noted that where CMS now says that surveys should average 110 to 115 hours per facility, they would like to spend more time in problem facilities (perhaps 150 hours) and less time in other facilities (perhaps 100 hours).

Joint provider/consultant surveys

In 2001 Pathway Health Inc., a private business located in White Bear Lake, Minnesota, developed a white paper proposing a new process that would allow MDH to focus more of its attention on chronic problem facilities by allowing for an alternative survey process for nursing homes with a history of positive survey results. For facilities with a strong record, the typical survey could be skipped for a year "if a credible, alternative survey process was applied."[79]

This alternative process, Pathway proposed, would use the Pathway Comprehensive Quality Assessment tool. The assessment would mimic a full regulatory survey. It would include a tag review of all federal requirements, an "action plan" to address problems, and a "complete follow-up and confirmation of full compliance." Providers would pay a fee to participate in the alternative process.

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[77] U.S. Department of Health and Human Services, 2004. For more information, see Appendix H.

[78] The Baldrige Health Care Criteria are designed to help organizations use an integrated approach to organizational performance management that results in improved health care quality, improved organizational effectiveness, and organizational and personal learning (see http://www.quality.nist.gov/HealthCare_Criteria.htm).

[79] McDougall, Duncan. "Alternative Survey Process": Pathway Health Inc., February 2001.

Less frequent surveys
Legislation was introduced in May 2003 to allow for an alternative survey process. According to the legislation, this process seeks to:

(1) use department resources more effectively and efficiently to target problem areas;

(2) use other existing or new mechanisms to provide objective assessments of quality and to measure quality improvement;

(3) provide for frequent collaborative interaction of facility staff and surveyors rather than a punitive approach; and

(4) reward a nursing home that has performed very well by extending intervals between full surveys.

Under this alternative method, the time period between standard surveys would be extended to up to 30 months for facilities with good compliance records (in contrast, current regulations require an average of 12 months between surveys).

This legislation passed and stated that "the commissioner shall pursue changes in federal law necessary to accomplish this process and shall apply for any necessary federal waivers or approval."[80] CMS did not allow for the alternative processes in 2003, and in 2004, legislation was passed requiring the resubmittal of request for federal waivers and approvals.[81]

New regulatory standards
In another state, an alternative survey process was developed for state licensed-only facilities (in other words, CMS approval was not required). This new process was a quality-based inspection based on Baldrige criteria. Ultimately, it was discontinued because providers perceived it to be more difficult than the federal survey.

[80] MN statutes section 144A.37
[81] House File 2246, 3rd Engrossment: 83rd Legislative Session (2003-2004).

Suggestions from States

States interviewed in the course of this study indicated what they felt were the most important elements of success in their survey programs (Table 8). These elements included using quality improvement coordinators in different state regions, mixing up members of separate survey teams, and working with the QIO.

Table 8: Suggestions from Other States for Improving the Survey Process

- Use quality improvement coordinators in each region of the state.
- Implement a technical assistance program.
- Establish a closer relationship with providers through joint provider/surveyor training.
- Get away from having set survey teams;" We mix people up."
- Elicit best practices from facilities at the time of survey and post them on the website as appropriate.
- Give a questionnaire to facilities at the end of the survey so that they can rate surveyors and the survey process.
- Work with the quality improvement organization (QIO).
- Develop communication infrastructures for sharing information across the department and among different departments.
- Develop an alternative survey process.
- Have surveyors take laptops along and work on deficiencies while they are at or near the site.
- Provide extensive training of staff (four to six months).

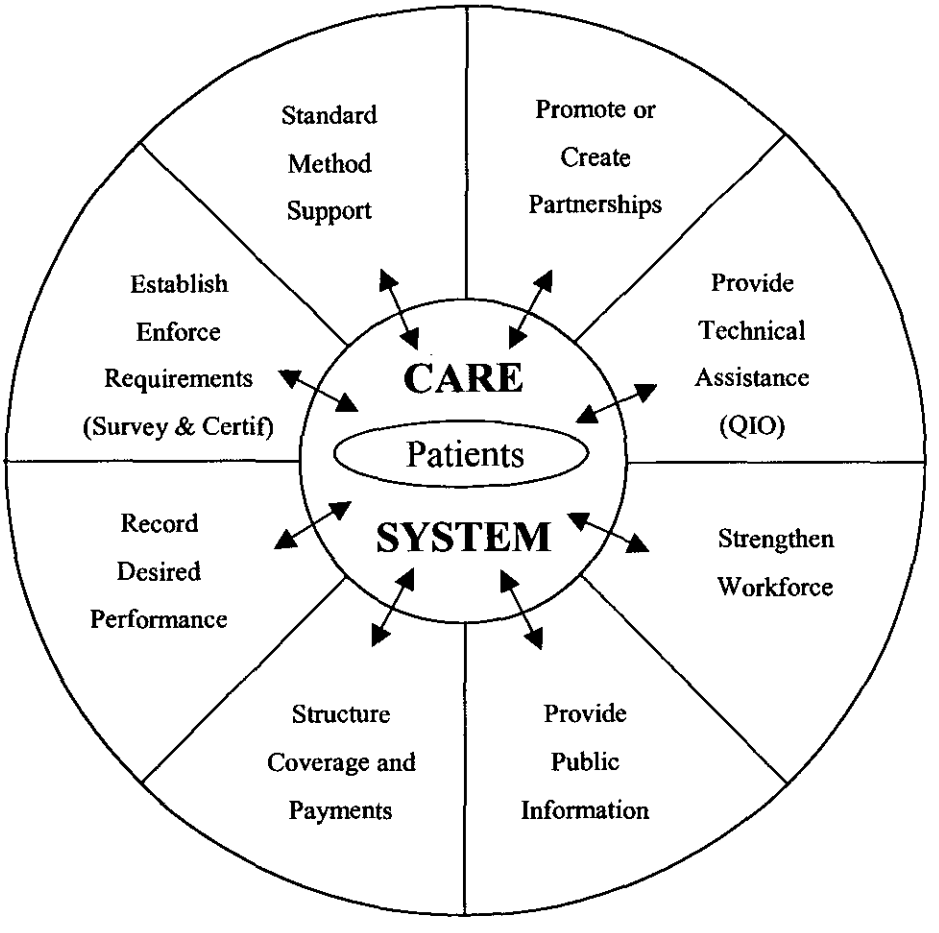
Source: Management Analysis Division interviews with staff from states, including: Iowa, Kansas, Massachusetts, Michigan, South Dakota, and Wisconsin.

Preoccupation with the survey distracts from quality care

There is no question among the respondents that the nursing home survey process is a necessary and important part of assuring basic nursing home quality. Nearly all agree that the survey cannot and should not go away, and that it should be routinely monitored and improved. Most also agree, however, that the current preoccupation with the survey distracts the stakeholders from the goal they all say they share – providing and improving quality care for all residents.

> "Although regulatory compliance alone does not enable adequate care, the primary objective of many facility practices has become regulatory compliance."[82]

As the following image illustrates,[83] the survey is one way – but not the only way – to help assure quality in nursing home care. "Establish and Enforce Requirements" is one part of a comprehensive approach to quality improvement.



[82] "Summary and Key Highlights: Recommendations for Regulatory and Survey Reform," American Medical Directors Association, Caring for the Ages, May 2002. On the Web at http://www.amda.com/caring/may2002/ltcregulations.htm

[83] This model of the "Care System" was provided to the state survey agencies by CMS during the "Leadership Summit" meeting in Baltimore, MD, in April, 2004.

CMS sponsored QI is relatively new and not well understood by the stakeholders
As noted earlier, CMS does not expect state survey agencies to perform the lead role in quality improvement. Instead CMS has a contract with separate organizations in each state – referred to as "quality improvement organizations" or QIOs. In Minnesota, CMS has contracted with StratisHealth, a private non-profit entity with many years of experience in health care quality improvement. The relationship between the state survey agencies and the QIOs are ill-defined and still developing. The first formal meeting between state survey agencies and the QIOs was sponsored by CMS and held in Baltimore on April 20, 2004. While the relationship between the Minnesota's QIO and MDH is very positive, many states report acrimony between the QIOs and the state survey agencies.

Many Minnesota stakeholders have limited knowledge of this separate, CMS sponsored, quality improvement effort already underway. Moreover, many stakeholders tended to confuse the purpose of the survey with the purpose of the QIO. MDH survey staff and some consumer advocates were very clear that the sole or primary purpose of the nursing home survey is to ensure that facilities meet regulatory standards. Providers acknowledged the necessity of regulatory oversight but emphasized that the purpose of the survey *should* be: "a collaborative approach to improving resident care and outcomes." They often stressed that the survey should be more oriented toward helping facilities measure and improve quality.

Coordination between QIO and state survey agencies still developing
In some states, the QIOs are perceived as a leader in the movement to improve nursing home quality, and the QIO and the state survey agency (SSA) work together frequently. For example, the SSA may assist the QIO in selecting nursing homes to participate in the QIO's group of facilities receiving intensive TA. The QIO may speak at SSA staff meetings. The QIO and SSA might work together to develop strategies for addressing a particular issue such as wound care. In some states, the QIO and SSA staff have monthly meeting by phone or in person. SSA staff in some states sit on the QIO's advisory boards.

In other states, contact between the QIO and the SSA appears to be quite limited. For instance, the SSA will answer the QIO's questions about the survey process if someone from the QIO calls them. Other states indicate that the QIOs in their area "aren't doing anything." Some interviewees suggested that other states believe the QIO has siphoned off CMS money that would have otherwise would have gone to the SSA, providing the SSA with little incentive to work with the QIO.

Quality improvement efforts in LTC lag behind acute care
Stakeholders familiar with health care quality improvement noted that quality improvement efforts in LTC lag far behind the acute care setting (hospitals and clinics). In particular, they noted that:

- QI efforts in acute care are far more mature, well-financed, and clinically oriented.

- The clinical expertise and resources of the acute care arena are far more extensive than the LTC arena and acute care has many more years of field experience in applying quality principles to the care process.

- Acute care purchasers are more attuned to and rely on quality measures more than the purchasers of LTC.

- The acute care industry has been leading and facilitating systematic and nationwide quality improvement efforts.

- In LTC, QI efforts are often specific to individual facilities or, at best, specific to the corporate enterprise. Nationwide efforts are predominantly government driven.

In summary, the almost exclusive focus on the survey, as a way to assure quality, is keeping the stakeholders from very promising opportunities to make significant gains in the quality of nursing home care.

MDH efforts to improve survey communications and relationships appear promising

Interactions between surveyors and facility staff have been an area of great concern and, as discussed in the introduction, a subcommittee was formed to address this issue. If the testimonials of the members of the subcommittee are any indication, the results of this work appear promising. According to the subcommittee report, "Participants generally felt pleased with the openness and respectful attitude that prevailed in the group, and saw this as an accomplishment in itself, given the recent history of acrimonious interactions among the various groups." The communication patterns, and the prevalence of rumors, myths, and fear of retaliation for asserting ones concerns are deeply engrained, however, and improving communications will take a long-term concerted effort.

It is also important to keep in mind that the customer service approaches to regulatory reform have hidden perils and often fall short of their goals.[84] When the department is administering the nursing home survey, it is not, primarily, delivering a service. It is delivering an obligation of law. The state surveyors do not provide a service to the facility, or even the resident, directly. They simply hold the facility accountable to standards.

This distinction is important because it helps explain why the quality of interpersonal interactions between surveyors and facility staff cannot and should not serve as the primary metric of regulatory performance.

[84] Sparrow, Malcolm K., *The Regulatory Craft* (Washington, D.C.: The Brookings Institution, 2000).

"Of course, [regulated parties] are entitled to be treated fairly and with human dignity. But when law is put in action against them, they receive treatment they do not request, did not pay for directly, will not enjoy, and will not want to repeat."

This is not to say that the department should be careless or unconcerned with how facilities experience the survey process. To the contrary, the quality of the interpersonal interactions during a survey can make the difference between a survey that completes its investigations and a survey that is cut short by acrimony.

Internal operations, communications, and decision making are overloaded and cumbersome

MDH participants in the study commonly expressed concern regarding high workloads and competing priorities, bureaucratic communications and decision making processes, and the excessively administrative and prescriptive nature of their jobs.

High work loads and competing priorities
Surveyors and supervisors commonly reported that they are overwhelmed by workload and by the multiple and sometimes competing priorities. For example, supervisors reported that it is both a priority to conduct coaching surveys with five survey teams other than their own and yet it is a priority for them to supervise and coach their own staff.

When asked, several surveyors and even supervisors could only vaguely describe some of the many procedural requirements inherent in their jobs. For example, some supervisors reported confusion over the processing of plans of correction that they routinely receive from providers. This was partly due to the fact that when they take vacation, there is no set process for temporarily assigning that workload, which must meet certain timelines according to federal and state requirements.

Internal program communications and decision making are slow and ineffective
Many of the survey staff and supervisors reported that internal communications and decision making processes are slow and ineffective. They reported that the monthly supervisor staff meetings are very time consuming and produce few clear decisions or results.

Many of the internal communications and decisions revolve around interpretation and clarification of federal law and CMS survey guidelines. MDH staff who need assistance with a clarification, seek guidance from federal written guidelines, the division's medical director and other resources on an ongoing basis for a majority of questions raised. Most of the questions regarding the interpretation of CMS guidelines are clarified based on review of guidelines and by division staff. However, for federally related questions where MDH does not know the answer, communications within MDH and with CMS are cumbersome. Clarifications that go to CMS are typically processed through a hierarchical procedure that hampers both efficiency and effectiveness (Table 9). In particular, supervisors expressed frustration that clarifications, once received from CMS, were not adequately discussed or summarized so that they could be consistently interpreted and applied in the field.

Table 9: Steps in Obtaining Clarification of a Survey Issue

Step	Process
1	Surveyor comes up with a question in the field, asking for clarification about an issue or process.
2	Survey or other staff review the federal guidelines or directives for clarification. Most questions are resolved at this point.
3	If the question is not resolved, it is forwarded through the chain of command via the district supervisors, the assistant program managers, OHFC staff, medical director, other staff in the L&C program, the program manager, and then to one of the assistant division directors.
4	The ADD or the PM normally forwards the requests for clarification or direction to CMS.
4	Once CMS responds to the department, the response is distributed back through the chain of command.
5	Once CMS responds to the department, the response is distributed back through the chain of command.
6	The surveyor's question is addressed. However, surveyors and supervisors report that the response is often not discussed by the district supervisors and is subject to various interpretations at the various levels in the chain and that the process is open to multiple interpretations and varying practices across survey teams.

According to many surveyors and supervisors, the process illustrated in the above table reflects the same general pattern for decision making, resulting long delays in decisions, inconsistent understandings of the decision, and frequent reevaluation of the decisions.

Recommendations

This report addresses a wide variety of issues, many of them outside the direct control of the State. Even those issues within the department's control may be beyond its resources to achieve. Because of this, the recommendations focus on those efforts deemed by Management Analysis and the stakeholders to be the most important and achievable. MDH will need to make its own determination of feasibility, based on the resources available. Clearly, the stakeholders must work together and share responsibility for implementing the following recommendations, if they are to succeed. It is also important to note that the nursing home survey has been subject to several reviews, and improvements are being made on an ongoing basis. The following recommendations are made with that in mind and in the spirit of offering ideas and options as the department seeks to continually enhance its efficiency and effectiveness.

In particular, the recommendations emphasize the importance of MDH working in partnership with the stakeholders and the legislature to:

- Foster more factual and productive public policy discussion of the nursing home survey and quality of nursing home care;
- Continue to improve communications among the stakeholders regarding the survey;
- Craft more focused and efficient efforts to routinely improve the quality of the nursing home survey;
- Promote and coordinate CMS sponsored quality improvement efforts in Minnesota; and to
- Make other improvements in the internal operations of licensing and certification program.

Foster factual and productive public policy discussions of the nursing home survey and quality care

The public policy discussion has become narrowly focused on the controversy of how the survey is, or should be, conducted. This controversy is a distraction from the important work of administering an effective survey in Minnesota and from making measurable improvements in quality care.

1. **The legislature should help defuse the controversy by insisting on a factual and more productive public policy discussion. Specifically, the legislature should:**

- **Distinguish federal certification requirements from state licensure issues and base legislative discussions of the survey on a rigorous review of formal survey documentation and investigations – not anecdotal information.**

- **Task MDH and DHS with providing sound scientific information and policy advice concerning the cost, quality, and future demand and availability of nursing home care and alternative forms of long term care.** DHS currently collects this type of information and MDH is better positioned, as a result of the recent reorganization of the division, to contribute more and to bring new focus to the way public policy choices may impact the health and safety of nursing home residents.

- **Place renewed focus on statewide efforts to improve quality of care in nursing homes.** There is much more to be gained in clinical and other care improvements by promoting statewide, scientifically-based quality improvement efforts, than there is in debating the procedural aspects of the federal survey. This is not to suggest that the Legislature should, or could, ignore future concerns about the survey. There is a high level of readiness, however, for the stakeholders to jointly and systematically improve quality of care and the Legislature should seize this opportunity.

2. **MDH should approach its nursing home and long-term care responsibilities from its broad public health mission.** The department has historically emphasized its administrative and regulatory duties under the CMS contract at the expense of a more comprehensive public health approach to long term care. The department has taken initial steps toward a broader approach through its development of a nursing home report card and initiating coordination with StratisHealth. These efforts exemplify a more balanced approach to the department's regulatory duties and its mission to protect and promote the public's health. The department should continue to play a broader role and make special efforts to communicate its intention to do so. Specifically, MDH should:

    - **Develop and broadly communicate a clear statement of the values and principles that will guide its survey and other work in long term care.** The Licensure and Certification program, for example, does not have its own mission statement – other than the MDH mission statement (which is too broad) or CMS's statement of purpose for the nursing home survey (which is too narrow). The department should clearly and realistically state its own guiding philosophy for the nursing home survey and its broader long term care responsibilities.

    - **Use its scientific research and analytical ability to assess long term care needs and system capacities.** The division has a new opportunity to do so, given the combination of staff that compose the new division. In particular, the scientific research and analytical ability of the center for health statistics, health economics, and the public information reporting functions of the division can be most helpful.

- **The department should also use its assessment information to guide policy[85] so that resources can be focused where they can have the greatest impact on long term care.** This will require close coordination with DHS in its long term care policy leadership role.

Continue to improve communications among the stakeholders, regarding the nursing home survey.

Due to the gravity of the survey for consumers, providers, workers, and others, MDH should continue recent efforts to improve communications and its working relationships with the various stakeholders. In particular, MDH should:

3. **Continue to convene the Ad Hoc Committee[86] to advise the department on matters pertaining to the survey process. The Committee should play a more clearly defined and ongoing role in advising the department. Potential duties of the committee could include:**

    - **Monitoring and helping implement the Committee's recommendations pertaining to survey findings and survey communications.[87] The Ad Hoc Committee, through its subcommittees, has recently completed study on a number of issues identified by the 2004 Legislature and this report.**

    - **Participating in and advising on the development of the new legislatively required "agency quality improvement program" and "annual report on the survey process."[88] Statute now requires that MDH regularly consult with consumers, consumer advocates, representatives of the nursing home industry, and representatives of nursing home employees. The Ad Hoc Committee can provide a forum for ongoing consultation and accountability.**

    - **Addressing other issues relating to the survey process. For example, the Ad Hoc Committee could provide a forum for future discussions of the "alternative survey process."[89]**

[85] Policy development can apply to public policy of state and federal government; or it can apply to organizational policy of, for example, MDH or long-term care providers.
[86] The Ad Hoc Committee was also known as the Commissioner's "Kitchen Cabinet."
[87] The Committee created two subcommittees in 2004. The "Survey Findings" subcommittee analyzed deficiency data and made recommendations to improve consistency in survey findings. The "Survey Communications" subcommittee discussed communications relating to the survey and made recommendations to reduce tensions and improve communications.
[88] House File 2246, 3rd Engrossment: 83rd Legislative Session (2003), posted May 15, 2004.
[89] The alternative survey process is discussed in the findings and conclusions section, pages 34 – 37.

4. **MDH should implement the recommendations from the "Communications for Improving the Survey Subcommittee" and take other steps to improve communications as part of the survey process.** Specifically, MDH should work in partnership with the other stakeholders to:

   - **Hold regional meetings to discuss the findings and recommendations of the Communications for Improving the Survey Subcommittee.** The purpose of the meetings would be to create a broader understanding of the issues addressed by the subcommittee, its recommendations, as well as highlight key steps all parties can take to reduce tensions as part of the survey and improve communications among the stakeholders.

   - **Conduct joint training for ombudsmen, long-term care administrators and staff, surveyors, and industry associations.** The training should clarify the role of the nursing home survey and highlight aspects of surveyor training that focus on survey methods and criteria for deficiency determination. It should also include best practices information on how providers prepare a facility for a survey. Most importantly, the training should focus on developing mutual respect and professional interaction between providers and surveyors, with clear statements about expected behavior.

   - **Continue to promote active family and resident involvement in the survey.** MDH, working with the provider associations and consumer advocates, should encourage facilities to make family and resident councils take an active part in the survey. Surveyors should meet with at least one family council member as part of the survey process.

   - **Implement the recommendations regarding the establishment and use of consistent communication and behavioral protocols by both surveyors and facility staff throughout the survey process.** This should include the recommendation that all parties set the expectation that retaliation will not be tolerated between or within any groups. MDH should develop a separate bulletin on retaliation, expanding on the language that is currently included in bulletin 04-6, regarding the informal dispute resolution process. Facilities should develop similar policies and communicate them broadly to their staff, residents, and family councils.

   - **Create a nursing home surveyor set of values and principles, similar to that recently developed for the assisted living program (also known as "10 Commitments").** Facilities should consider developing a similar oath for their staff conduct.

Work in partnership with StratisHealth to promote and coordinate statewide CMS sponsored quality improvement efforts in Minnesota

MDH and StratisHealth have a unique opportunity to work with other stakeholders, on a collaborative basis, to make significant improvements in clinical and other nursing home care. To make the greatest use of their combined resources, MDH and StratisHealth must work in close coordination on training activities and the information sharing among the stakeholders. Specifically, MDH should:

5. **Work with StratisHealth to convene the stakeholders and develop an action plan for promoting and coordinating statewide quality improvement efforts.[90] The action plan should define the various roles and responsibilities of the department, StratisHealth, providers, and others in coordinating and improving quality of care. In particular, the plan should:**

    - **Clarify each organizations' roles and responsibilities for training and technical assistance.**

    - **Promote the sharing of knowledge and best practices in the area of quality improvement.** For example, MDH and Stratis should consider jointly sponsoring an annual statewide meeting that would draw upon national and local examples of administrative leadership, clinical improvements, and active involvement of all stakeholders in improving quality of care. They should also consider jointly sponsoring an award process that would recognize Minnesota models of excellence in quality improvement efforts.

Focus survey improvement efforts on specific goals and implement routine monitoring

Although the department has initiated a variety of activities generally designed to improve the consistency and the overall "integrity" of the survey, these activities need additional staff support, should be more focused on specific improvement goals, and should be coordinated with training and other survey quality assurance efforts. Specifically, MDH should:

6. **Establish a quality assurance and improvement coordinator position.** The primary responsibilities of the position should include:[91]

    - **Coordinate efforts related to improving the survey process, as directed by the 2004 Legislature.**

[90] It is recommended that a neutral facilitator professionally facilitate the development of an action plan.
[91] The term "quality assurance" is generally used in this report to refer to the department's efforts to improve the survey process and other internal operations. The term "quality improvement" is generally used to describe a wide array of efforts focused on improving clinical and other aspects of resident care.

- **Establish clear survey improvement objectives and measures related to timeliness and consistency, and implement routine monitoring procedures.** For example, the objectives relating to the department's routine reviews of environmental and dietary tags and on-site mentoring and coaching surveys, should be explicit and measurable. Moreover, the monitoring data should be routinely collected, analyzed, and discussed by the district office supervisors and others who can act on the information.

- **Coordinate internal quality assurance activities with other quality improvement efforts of StratisHealth and others involved in statewide quality improvement efforts.** For example, share findings of common tags with the QIO and other groups that provide technical assistance to the facilities.

7. **MDH should assign the district office supervisors, as a group, greater authority, responsibility, and accountability for interpreting CMS guidelines and for promoting consistent interpretation and application of CMS guidelines in the field.**[92] It is impossible to predict for certain how this would affect the number of deficiencies cited, or the variation in citations across districts. MAD expects, however, that the recommended approach would result in fewer requests being made to CMS for clarification. Many of the requests for clarification can be resolved based on the surveyors' extensive knowledge of the CMS guidelines and their Minnesota-specific field knowledge. It is also expected that more questions would surface for clarification. Many interviewees said that they suspect many of the questions surveyors have never get raised due to the onerous decision process and the constant time pressure to complete surveys.[93] Finally, by jointly reviewing and deciding on common interpretations of the CMS guidelines, the supervisors would establish an ongoing mechanism for guiding and monitoring more consistent survey practices across the state. In particular, the district office supervisors should identify and recommend survey practices relating to specific survey issues, including:

    - **Cross-referencing: MDH issued an information bulletin which clarifies the department's policy on deficiencies related to outcome, assessment and/or care planning findings.**[94] The implementation of this policy will require ongoing monitoring and clarification by field staff. Rather than asking CMS for clarification as it relates to the department's policy, the district office supervisors and management staff should discuss and recommend consistent statewide practices, based on their understanding of the intent of the policy and current practices in the field.

[92] It is also recommended that the work of the district office supervisor group, at least initially, be professionally facilitated and involve a representative group of surveyors, supervisors, assistant program managers, the program manger, and others involved in this work.
[93] See Table 9, "Steps in Obtaining Clarification of a Survey Issue," page 43.
[94] See http://www.health.state.mn.us/divs/fpc/profinfo/ib04_9.html

- **"Clarify and Verify":** The department should continue its voluntary practice of conducting "clarify and verify" meetings.[95] Additional guidance should be provided to surveyors regarding the objectives of the "clarify and verify" meeting, the preparation of materials and data for the meeting, and the meeting procedures. For example, the department should produce a form for summarizing key concerns and related questions that could be used to focus the "clarify and verify" discussions. The form should also contain a written statement of the purpose of the meeting and the expected duration of the meeting.

8. **Implement routine reviews of deficiency data as part of the monthly district office supervisor meetings.** It is critical that the district office supervisors routinely review and monitor data relating to priority survey practices. As part of these meetings, the supervisors should:

    - **Develop criteria for evaluating summary deficiency data.** For example, supervisors periodically review the hours expended on interviews compared to the budgeted number of hours available. These and other measures of timeliness and efficiency should be reviewed on a regular basis; either monthly, bi-monthly, or quarterly.

    - **Develop other measures relating to survey consistency, by district.** For example, the supervisors should routinely review updated analyses similar to that which was conducted by the "survey findings/review subcommittee." Initial priority consideration should be given to total number of deficiencies by district, multiple tags from outcome and assessment tags (also known as "cross-referencing"), and citations resulting from follow-up surveys.

9. **Develop and implement external reviews of deficiencies, to promote greater confidence that deficiencies indicate a problem that will have a likely have serious impact on the resident.**[96]

Make improvements in the internal operations of the department

The department has taken several measures to improve the overall operation and management of its nursing home survey program. Other improvements should be made, particularly regarding internal communications and decision making regarding interpretation and application of CMS guidelines; streamlining the preparation of survey findings and processing plans of correction; and improving staff recruitment and retention.

[95] See Table 6, page 15, in the "Overview" section.

[96] This form of review is described in an internal draft memorandum from Dr. Colleen Cooper to Commissioner Mandernack, March 2, 2004. It is included in Appendix I.

10. **The department should explore alternative approaches to varying staffing assignments by geographic area.** Nearly every state interviewed by MAD recommended assigning staff to more than one geographic area and, in some cases, recommended the elimination of district offices, all together. While eliminating district offices would be an extreme solution, and would impact department operations beyond the licensing and certification program, options for disrupting the district specific enforcement cultures and geographic specific practices should be pursued. The current "onsite mentoring and coaching surveys" have potential to promote uniformity in survey practices across the state. The method is extremely labor intensive, however, and if continued, they should be done less frequently.

11. **The department should explore alternatives to the current staff and team lead assignments for the survey.** Specifically the department should consider discontinuing rotating the assignment of the team lead role among all surveyors. Instead, the department should explore the possibility of formalizing the team lead role, assign it to specific individuals, and change the surveyor and team lead position descriptions to reflect the distinctions between surveyor and team lead roles. It is understood that this may well involve consultation with the labor representatives and potentially creating a new job class or class option, and compensating the assigned team leads accordingly.

12. **The district office supervisors should analyze and streamline its current internal procedures.**[97] Priorities for review and streamlining include the workflow process and administrative procedures used in the:

    - **Final internal review and determination of tags for each survey;**
    - **Documentation of the survey findings and the preparation of material packets for mailing to the facilities; and**
    - **Processing of plans of correction.** In considering new approaches to the plans of correction, MAD recommends that the department seriously consider and decide whether to adopt the practice of other states that accept certain plans of correction as an attestation that the corrections have been made.[98] The benefits of this approach would be more survey time available for full surveys and investigations.

[97] It is recommended that the workflow analysis be professionally facilitated and involve the active participation of a representative group of surveyors, supervisors, assistant program managers, the program manager, and others involved in this work.

[98] See "Follow-up survey" in the section of the Findings titled, "A review of other states shows common problems and a variety of approaches to improving the survey," page 34.

13. **The district office supervisors should recommend and clarify work load priorities, role and responsibility assignments, and decision making authority for critical work tasks.**[99] The resulting clarification should help surveyors and their supervisors sort among their competing priorities. For example, supervisors should be able to decide how they will balance the expectations of their job to participate in surveys, supervising their staff, and the requirement that they be available in the office to process documents on time.

14. **MDH should develop a staff recruitment and retention plan, specific to the unique needs of the licensing and certification program.** Many of the respondents expressed concern about the "high turnover" in the licensing and certification program. Analysis of the program's employment data showed that in 2002, the program's turnover was higher than the department as a whole.[100] The department would benefit from an ongoing staff recruitment and retention effort that would include:

    - **Routine exit interviews;**
    - **Routine monitoring of staff turnover and other employment data; and**
    - **Recruitment efforts that would yield surveyor candidates that have long-term care experience and other attributes desirable in the survey position.**

[99] It is recommended that the workload prioritization and role and responsibility clarification be professionally facilitated and involve the active participation of a representative group of surveyors, supervisors, assistant program managers, the program manager, and others involved in this work.
[100] See "Surveyor Staff Turnover," page 31.

APPENDICES

Appendix A: Trends in Minnesota's Long-term Care System

Trends in Nursing Home Use[101]

Minnesota's population is aging, "and along with that change, the need for long-term care (LTC) is increasing." Between 1990 and 2000, the number of people aged 65+ grew nearly 9 percent, rising from 550,000 to 600,000. This population is expected to grow about 14 percent in the next ten years, with the most growth occurring among people over the age of 85. Increases in the number of older persons means increased demand for long-term care services that include nursing homes, assisted living facilities, and an array of home and community-based services.

A major trend in Minnesota's LTC system is the reduced reliance on the institutional model (i.e., nursing homes) and the increased availability of home and community based care such as informal care (for example, family caregivers) and formal care (for example, home health agencies). Several strategies are underway to reduce nursing home care and increase community-based care. In addition to Minnesota's long-standing moratorium on nursing home beds, for example, the state has given nursing homes incentives for closing beds, and provided grants for home and community-based service projects. Trends in nursing home use include:

- In the last two years **the state's supply of nursing home beds has decreased**, continuing a long declining trend that began over 10 years ago. The number of nursing home beds peaked in 1987 at 48,307 beds, and as of September 30,2003, the number of beds had decreased to 39,530, a decrease of 8,777 beds.

- **Occupancy in Minnesota's nursing homes had been decreasing along with the number of beds since 1987.** However, beginning in 2000, occupancy rates started to rise, most likely in response to the ongoing decrease in bed supply. The statewide occupancy rate in September 2002 was 93.5 percent.

- **Nursing home utilization rates have been declining over the past 20 years.** In 2002, the utilization rate was 5.5 percent for people 65+, and less than 1 percent for people 0 to 64.

- Using three different rates of declining utilization, DHS recently found that "utilization will most likely not decline at the steeper projected rate for the next 25 years, but even a modest decline will mean **no beds will be needed for another 10 to 15 years**, and that Minnesota will have an adequate supply of beds available to meet demand until at least 2015."

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[101]Information is taken almost directly from DHS, *Status of Long-term Care in Minnesota 200,* especially pages 1, 2 and 13-17.

Appendix B: Layers of Administration and Responsibility in the Nursing Home Survey Process

The administration of nursing home regulations is many-layered and complex: This complexity is a major challenge for providers, regulators, consumers and policymakers. The multiple layers of regulation are highlights in the Table A below.

Table A: Layers of Administration and Responsibility in the Nursing Home Survey Process

State/Federal Role	Brief Description
The State survey is performed under the direction of the federal government.	MDH administers the survey under federal law and a formal contract with the CMS. The department takes most of its licensing and certification program direction from CMS and the program's funding is overwhelmingly federal, directly tied to its contract with CMS.
Federal requirements are detailed and highly prescriptive.	CMS sets out the survey process in detail in the state operations manual (SOM), which hundreds of pages long includes 198 regulations. Enforcement actions for the deficiencies that the state cites are predetermined by federal guidelines. The state has little flexibility in enforcing the regulations once a deficiency is identified.
Federal direction to the states is split between central and regional offices.	The CMS central office in Baltimore is responsible for developing and promulgating regulations and creating guidelines for state survey agencies; and five regional offices oversee the negotiation and execution of contracts with individual state survey agencies, oversee state agency performance, and enforce regulations (such as denial of payments to nursing homes who are found to be in substantial non-compliance). State agencies reported that these separate roles and lines of authority are, at times, unclear.
Minnesota has dual responsibility and accountability for the survey.	In addition to the federal *certification* requirements, Minnesota requires nursing homes to be *licensed.* Minnesota's separate licensing standards run parallel to the federal certification requirements – leading to some reports of duplication, conflicts and confusion. This also creates a situation where MDH has dual responsibility and accountability – to CMS and to state government

Appendix C: OBRA and National Studies of the Survey Process

OBRA: The federal government's requirements and oversight of nursing homes changed significantly in the late 1980s when Congress passed the Omnibus Budget Reconciliation Act (OBRA). OBRA was passed in response to widespread reports of problems in nursing homes and nursing home regulations. Based in part on a 1986 report by the Institute of Medicine, OBRA and related regulations mandated the use of uniform comprehensive assessments of all nursing facility residents upon admission and periodically thereafter; development of quality indicators that were more outcome-oriented than process-oriented; and changes in federal survey procedures to make them more oriented toward the residents through interviews and assessments of residents rather than simply reviewing medical records.[102]

1999 Revisions:[103] A two-phase revision to the survey process was initiated in 1999. In the first phase, CMS[104] instructed states to:

(1) Begin using a series of new investigative protocols covering pressure sores, weight loss, dehydration and other key quality areas;

(2) Increase the sample of residents reviewed with conditions related to these areas; and

(3) Review "quality indicator" information on the care provided to a home's residents, before actually visiting the home. Quality indicators are essentially numeric warning signs of the prevalence of care problems, such as greater-than-expected instances of weight loss, dehydration, or pressure sores. They are derived from nursing homes' assessments of residents and rank a facility in 24 areas compared with other nursing homes in the state.

The focus of revisions in phase two is to:

- improve the on-site augmentation of the preliminary sample selected off-site using the quality indicators; and
- strengthen the protocols used by surveyors to ensure more rigor in their on-site investigations.

National studies of the survey process

Several major studies have examined the survey process at the national level and made recommendations for change. For instance, the General Accounting Office has reported wide variations among states in the proportion of facilities cited with serious deficiencies[105] and the Office of the Inspector General (OIG) found that states appear to

[102] K. Walshe and C. Harrington, "Regulation of Nursing Facilities in the United States: An Analysis of Resources and Performance of State Survey Agencies," *Gerontologist* 24:4 (2002): 475-487.
[103] This description is taken almost directly from GAO, 2003: 6-7.
[104] At that time, HCFA, the Health Care Financing Administration.
[105] GOA, 2003. See especially Table 7, page 56.

differ on in how they determine specific deficiency citations.[106] OIG Factors contributing to variations among states in citing deficiencies, OIG suggests, include inconsistent survey focus, unclear guidelines, lack of a common review process for draft survey reports, and high surveyor staff turnover.

The GAO also found that state surveyors seem to be understating the prevalence of serious problems in nursing homes.[107] Other researchers have found that "a complex regulatory system of state licensure and federal certification is in place, but problems of poor quality and neglect and abuse of patients still appear to be endemic. "[108]

Specific recommendations to CMS include:

- Require states to implement a quality assurance process to test the validity of cited deficiencies for surveys that include deficiencies at the level of "actual harm."[109]

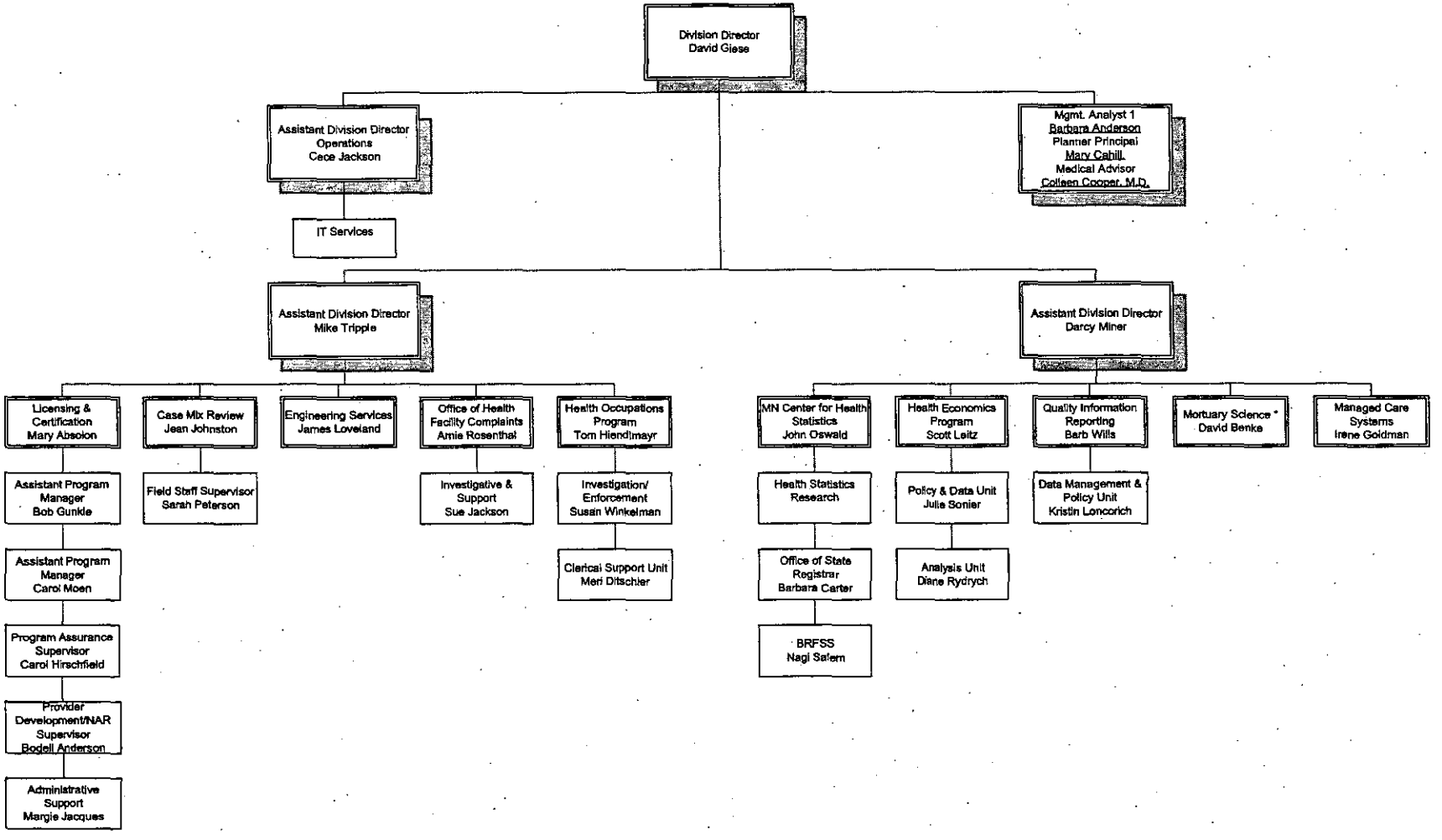
- Continue to improve its guidance to state agencies on citing deficiencies by providing guidelines that are both clear and explicit [and provide] more specific guidance on quality of life tags and clearer directives on when to cite single or multiple deficiencies.[110]

- More clearly communicate to states that the focus of the nursing home survey process is not consultative.[111]

[106] OIG, 2003, 15-17.
[107] GOA, 2003, 11.
[108] Kieran Walshe, "Regulating U.S. Nursing Homes: Are We Learning From Experience," Health Affairs 20:6 (2001): 128-144.
[109] GAO, 2003, 5.
[110] OIG, 2003, 24.
[111] OIG, 2003, 24.

Appendix D: MDH Organizational Chart

Division of Health Policy, Information & Compliance Monitoring



* Becomes Part of HOP 7/1/05

Appendix E: Overview of Tasks in the Survey Process

Task 1 – Offsite Survey Preparation:[112] Before surveyors arrive at a facility, they identify and pre-select potential concerns about the facility and select a sample of the residents for further assessment. Pre-selecting these concerns and residents is based on such factors as the characteristics of residents (for example, getting a mix of acuity levels, looking at reports of quality indicators) and looking at last year's deficiency information.

> For example:
> Several days before an annual survey, the team coordinator collects forms and reports needed for preselection of residents and observations during the on-site inspection. One such form, the Facility Quality Indicator (QI) Profile, is a facility-generated quarterly report of falls, fractures, indwelling catheters, urinary tract infections, tube feedings, weight loss, pressure ulcers, and cognitive impairment. Another form, the Resident Level Summary, lists residents who have experienced any of the treatments or events listed on the Facility QI Profile.[3] From the summary, the team chooses or tags residents for evaluation during the survey. For example, if an unusual number of residents were checked under the QI, "falls," surveyors would list this as a concern to be investigated.
>
> Staff use the latest report of deficiencies and other information, as well as Roster/Sample Matrix form that characterizes residents according to the categories [of] elimination, nutrition, physical function, and quality of life, to finish up their preselection of residents.

Task 2 – Entrance Conference: When the survey team arrives at a facility, the team leader announces their arrival to the administrator and meets with the administrator to explain the survey process and request information.

> For example:
> [the team leader] explains the survey process to the administrator and asks for a nursing work schedule for the current time period; a list of admissions, transfers, and discharges; and a report of accidents/incidents. She requests that a notice announcing the survey be posted and a current Roster/Sample Matrix be completed.

[112] Much of the text describing the seven tasks is taken directly from a recent MDH presentation, shortened and sometimes paraphrased for the purposes of this report. To view the entire MDH presentation, see "Nursing Home Survey Process Power Point Presentation" at http://www.health.state.mn.us/divs/fpc/consinfo.html. For a practical overview of the survey process from a nurse's perspective, see also *Nursing Home Inspections — It's About the Residents by Dorothy K Bertsch* http://nsweb.nursingspectrum.com/ce/ce302.htm. All of the examples are taken from that document. The examples are not specific to any nursing home in Minnesota (or anywhere else) but are based on a typical survey.

Task 3 - Initial Tour: During this time the team obtains an overview of the facility's care and services and begins to lay the groundwork for gathering information (for example, noting which residents can and can't be interviewed). The team also confirms information about any pre-selected concerns, identifies any new concerns, and verifies that the pre-selected sample of residents is still in the nursing home.

> For example:
> inspectors [conduct] initial tours to review the facility, residents, and staff; evaluate the environment; confirm or invalidate preselected concerns; and add any new concerns. While talking with residents, surveyors focus on physical appearance, interaction between residents and staff, and the manner in which staff communicate with residents. [They also] focus on residents' behaviors and on how special care needs are met.

Task 4 - Sample Selection: In an on-site meeting, the team reviews pre-selected residents [Phase 1 sample] and chooses additional people to include in the sample as needed [Phase 2 sample]. The sample may change, and a second sample may be selected, based on the need to make sure the sample includes residents with a range of acuity levels and/or meet other concerns.

> For example:
> The survey team meets to determine areas of concern for Phase 2 of the survey and select the remaining sample. These are added to the Phase 1 sample. Team members highlight each concern on a clean copy of the Sample Matrix worksheet, and enter the selected residents' names on the sheet. Selections are largely based on observation of special care needs, recent admissions, residents most at-risk for neglect and abuse, and those with mental illness.

Task 5 – Information Gathering:[113] The team gathers information from a variety of sources such as:

- general observation of facility,
- kitchen/food services observation,
- resident review,
- quality of life assessment,
- medication pass observation,
- quality assessment and assurance, and
- abuse prohibition review.

General observation of the facility: In this general overview, usually conducted with the facility's Environmental Services staff, team members examine the physical features in the facility's environment that affect quality of life, health, and safety.

[113]Examples of the several forms used during the information gathering process can be found at http://www.health.state.mn.us/ltc (See "MDH Survey Process: Interview Forms").

Kitchen/food services observation: A survey team member (for example, a dietician) looks at how food is stored, prepared, distributed and served to prevent food-borne illness. The surveyor also examines such factors as whether equipment in the kitchen is clean and if food is properly cooled.

Resident Review: The purpose of the "resident review" is to answer this question: are the quality of care and quality of life needs being met? The goal is to promote the resident's "highest practicable physical, mental and psychosocial well-being." Resident reviews include an examination of the resident's room (for example, is it homelike?), daily life (for example, how do staff and the resident interact?), drug therapies (for example, are they any unnecessary drugs?), and a comprehensive and focused care review (for example, is the care plan being implemented?).

Quality of the Life Assessment. Surveyors collect information on the resident's quality of life from interviews with residents, family members, and groups (for example, the facility's resident council). For example, at a Council Group Meeting, a surveyor might as such questions as, "do you enjoy the activities here?" and "do you feel staff treat residents with respect?"

Medication Pass Observation: Surveys observe as many medication passes as possible to evaluate whether medication is being given appropriately.

Quality Assessment and Assurance: This assessment is done to determine if the facility has identified and addressed quality issues and implemented corrective action plans as necessary.

The Information-Gathering Phase also includes "information transfer" and "verify/clarify." With information transfer, the team provides information about care and regulatory topics. It is "not consultation with facility" and should not exceed one hour.

"Verify/clarify" happens when the team presents areas of concern to the facility and gives the facility the opportunity to present additional information and clarification. This is not a federally required survey task.

Task 6 - Information Analysis for Deficiency determination: Building upon the observations, daily team meetings, and verify/clarify meetings, the team reviews of all the information collected to determine if any federal requirements are not met. Unmet requirements result in a deficiency. The team notes deficiencies on a document called the CMS 2567.

> For example:
> This day, survey team members identify concerns and specific evidence relating to requirements that [the nursing home] has failed to meet. The team must determine the scope and severity of the deficiencies, whether they are isolated or widespread occurrences, and whether they result in actual or potential harm to residents. Penalties range from an accepted plan of correction to civil penalty fees, loss of participation in Medicare and/or Medicaid programs, or a ban on admissions.

Task 7 - Exit Conference: The team conducts a meeting at the end of the survey to inform the facility of the team's observations and preliminary findings.

For example:
Facility staff, a resident council officer, and perhaps several residents attend the final conference. [The team leader] thanks the staff for their cooperation and describes the team's deficiency findings. She then provides facility staff an opportunity to supply additional information, usually a rationale for cited deficiencies. In conclusion, she advises that a report of the survey listing deficiencies will be mailed. The facility will be expected to respond with a plan of corrections.

Appendix F: Nursing Home Compare

Table A: Information Available on Nursing Home Compare (http://www.medicare.gov/).

Quality/Compliance-related Information	Example
Quality measures are derived from resident assessment data that nursing homes routinely collect on all residents at specific times during their stay. The information collected pertains to the resident's physical health, clinical conditions and abilities.	Percent of residents who have moderate to severe pain. The percent of residents with a given condition in a particular nursing home is compared to state and national averages.
Inspection Results Information refers to the regulatory requirements that nursing the nursing home failed to meet but does not reflect the entire inspection report.	List of deficiencies, such as "inspectors determined that the nursing home failed to give each resident care and services to get or keep the highest quality of life possible." Tables also show, for each deficiency, the date of correction, the level of harm, and how many residents were affected.
Nursing Home Staffing information comes from reports that the nursing home reports to its state survey agency. It contains the nursing staff hours for a two-week period prior to the time of the state inspection. CMS receives this data and converts the reported information into the number of staff hours per resident per day .	A table shows number of nursing home staff hours per resident day, by total staff and broken down by staff type (for example, RN or LPN). Data show comparisons between the particular home being looked at, state averages, and national averages.

Source: Adapted from http://www.medicare.gov/NHCompare, May, 2004.

Appendix G: Overview of QIOs and StratisHealth

Quality Improvement Organizations[114]

Quality Improvement Organizations (QIOs) have been a part of the Medicare program for over 30 years. These organizations were created to improve the effectiveness, efficiency and quality of Medicare services. Since their inception in the early 1980s, the name of these organizations has changed from Professional Standard Review Organizations (PSROs) to Peer Review Organizations (PROs), to QIOs.

The name changes reflect changes in the organizations' focus. Initially PROs and PSROs focused on utilization review – assuring that the care received under Medicare was medically necessary. The focus shifted toward quality of care in the late 198Os, and toward community-based quality improvement in 1992 as part of CMS's Health Care Quality Improvement Program.

Generally, QIOs activities are conducted in three areas: quality improvement; case review (including complaint investigations and appeals); and beneficiary education. QIO activities have historically focused on hospital care. Today, however, QIOs work with a range of Medicare providers including Medicare managed care organizations, home health care agencies, and nursing homes.

There are 39 QIOs in the US serving the 50 states, US territories and the District of Columbia. All QIOs work under the direction of CMS. There is variation among QIOs in their capabilities and what other types of work they do beyond working with the Medicare program. For example, many QIOs have contracts with Medicaid programs, employers and/or health plans in addition to their contract with the Medicare program.

QIO work in the area of nursing homes: Current QIO work related to nursing homes includes a wide range of activities related to educating consumers and assisting providers in improving quality of care. For example, QIOs:

- Help nursing home management to "identify what is necessary to create a quality improvement culture and empower staff to build quality improvement processes into everyday work";
- Give all nursing homes materials, methods, guidelines and tools for improving and assessing care; and
- Offer intensive technical assistance to a significant number of nursing homes in each state.[115]

[114] Taken largely from: Marisa Scala, *The Role of QIOs*, at http://www.medicareed.org/ (Issue Brief 2, Volume 2, May 2003).

[115] American Health Quality Association, *New National QIO Effort: Improving Nursing Home Quality of Care* , at http://www.ahqa.org/, June 10, 2004. The AHQA "represents Quality Improvement Organizations (QIOs) and professionals working to improve the quality of health care in communities across America."

QIO activities in these areas are part of CMS's Nursing Home Quality Initiative. Launched in 2002 by CMS, the Quality Initiative is a four-pronged approach "to improve the quality of care in nursing homes." The four prongs are:

- Regulation and enforcement efforts conducted by state survey agencies and CMS;
- Improved consumer information on the quality of care in nursing homes;
- Continual, community-based quality improvement programs designed for nursing homes to improve the quality of care; and
- Collaboration and partnership to maximize knowledge and resources.[116]

Minnesota's QIO is StratisHealth[117]

Minnesota's Quality Improvement Organization is StratisHealth located in Bloomington, Minnesota. Stratis enters into three-year contracts with CMS to provide QIO services. Development of CMS/Stratis contracts involve the selection of several quality indicators that will receive special attention among Minnesota's facilities. In Stratis' current scope of work, these areas of concentration are pain management, pressure ulcers, and infections. Stratis must show improvement in these indicators among the state's nursing homes.

Stratis provides statewide assistance for all of Minnesota's nursing homes, and intensive technical assistance (TA) to a subgroup of facilities that want to partner with Stratis to improve care.

> **Statewide Assistance** includes quality-related "resources, materials, and training" for nursing homes. For example, Stratis holds conferences that all nursing homes can attend, and makes available a pressure ulcer quality resources kit and a pain training video and CD-ROM. Stratis also facilitates the transfer of information from CMS to providers, by letting nursing homes know about such items as conference calls and quality manuals.
>
> **Intensive TA**: Like QIOs in other states, Stratis conducts intensive quality work with 10 to 15 percent of the state's nursing homes. In Minnesota, 112 nursing homes indicated their interest in receiving intensive TA from Stratis. Stratis selected 68 of these facilities, representing a range of facility types and knowledge of quality measures and processes. Stratis has a nursing home liaison who assists nursing home in obtaining quality-related information and support.

[116] CMS, *Nursing Home Quality Initiative*, January 20, 2004; June 10, 2004, http://www.cms.hhs.gov/quality/nhqi. See "overview."
[117] Sources: http://www.stratishealth.org/, 2003, April 2004. Also Patsy Riley, Marilyn Ryerson and Jane Pedersen, interview, March 25, 2004.

Appendix H: Highlights of 2003 Study of State-Initiated Nursing Home Quality-Improvement (QI) Programs in Seven States

Purpose of TA Programs	All programs shared the "common goal of improving quality of care," but they differed in "how much this goal was pursued by a focus on improving the care furnished by nursing homes vs. promoting regulatory compliance."
Two Types of Programs	Specifically, researchers found two types of programs: **TA programs with a focus on nursing home care practices.** "Underlying the choice of program focus in these states was a general belief that regulatory compliance, while important, was separate from quality improvement, and that compliance with survey and certification requirements would not necessarily ensure that facilities are furnishing high quality care..." **TA programs with a focus on promoting regulatory compliance.** "Underlying the choice of program focus in these states was a belief that an emphasis on monitoring and enforcement is the best way to improve quality."
Areas of Common Practice	Although the design and focus of TA programs vary by state, they share the following characteristics: ▪ TA program staff provide **on-site consultation, training, and/or sharing of best practices** with nursing facility staff. ▪ Programs emphasize a **collaborative approach** between facilities and the TA staff, which often contrasts with the relationship between facilities and LTC surveyors. ▪ **Programs are non-punitive,** with results not typically shared with survey and certification staff unless there is a serious violation
Areas of differences	**State TA programs differed with respect to**: whether TA staff have surveyor training; whether TA staff perform surveys; extent to which TA findings are shared with surveyors; working relationships between TA staff and surveyors (for example, whether the TA is separate from the survey process).
Effectiveness	**A rigorous assessment of the effectiveness of these programs is "not possible at this time."** However, extensive study in one state indicates that TA has had a positive impact on quality indicators. Informal assessments suggest that TA has helped to boost quality of care and improved provider/surveyor relationships. Problems noted include a lack of consistency between surveyor and TA information and inexperienced QI staff.

Source: U.S. Department of Health and Human Services/Abt Associates, Inc. *State Nursing Home Quality Improvement Programs: Site Visit and Synthesis Report.* Washington, D.C.: May 15, 2003. This report is available at: http://aspe.os.dhhs.gov/search/daltcp/reports/statenh.htm.

Appendix I

MEMO

DATE March 2, 2004

To: Commissioner Mandernach, Carol Woolverton, F&PC Mgmt Team

From: Colleen Cooper, MD, MPH

Subject: Draft Proposal for an External Deficiency Review Process

This is a proposal to bring together MDH-FPC survey staff with providers and advocates to evaluate current deficiencies in a collaborative quality improvement activity. The purpose is four-fold:

1) To attempt to achieve consensus on the substance of deficiencies and the implication for residents' well-being if deficiencies are not corrected; and
2) To identify areas of common concern around resident care and to have these areas be reflected in deficiency; and
3) To provide this information to caregivers to foster improved care for residents and identify areas that need more educational emphasis. (This could have the dual purpose of promoting improvement so that the facility reaction to survey isn't restricted to a response to tags but is an effort to understand root causes of problems and implement systemic improvements. It also could have the secondary effect of alleviating some of the stress for caregivers that occurs during the survey by supporting staff with tools and knowledge needed to provide care.)
4) To diminish the adversarial nature of survey by bringing stakeholders together to discuss and evaluate deficiencies.

Organization

Consortium of MDH survey staff, providers, professionals, advocates, other industry representatives to meet at designated intervals (monthly, every 6 weeks).

Process

Review actual deficiencies written (and already issued). The type of deficiencies reviewed could be decided by the group: specific tags, outlier tags, specific types of tags (quality of care, quality of life, residents rights) or comparisons of sample 2567s written from teams across the state.) The deficiencies would have to be provided to the participants before the meeting with enough time to review. The materials would need the appropriate redacting to insure privacy of residents and facilities. The nature of the deliberations would be determined by the group at the initial meeting with some directions acquired by states that have engaged in similar quality improvement activities.

While there would be a commitment from MDH participants to develop informational materials for surveyors and a commitment among community participants to disseminate information from the group to its constituents, the exact form of these activities would be developed by the group during the first meeting.

Evaluation

Specific parameters for evaluation depends on the way the group decides to approach the deficiency review. A process for determining how many deficiencies are supported by the group, are questioned and are rejected by a consensus of the participants should be fairly straightforward and easily developed.

Implications

After a predetermined interval (1 year), the group would issue a summary of its evaluation of the deficiencies chosen for review. I would envision that this report would detail a numeric tabulation of the response to the content of deficiencies in terms of validity, consistency and significance for residents. There should also be a status report on how the information is being used or will be used by both the survey staff and providers for improving care. Educational programs that are developed as a result of this activity would be described.

Future Directions

1) Continuation of above activities
2) Development of a consortium (MDH, providers, professionals, Stratis) that provides consultation to facility around quality improvement on an on-going basis—geared to moving facilities, especially troubled facilities, beyond survey deficiencies to improved quality of care.

Infrastructure Considerations:

1) MDH provides setting for meetings, copies of deficiencies, orientation to survey process (crash course), data tracking and reporting (unless other stakeholders wish to oversee this and have the capacity.)
2) Other participants agree to read materials before meetings and to disseminate findings or materials to their colleagues, partners or members.
3) Privacy of reviewed materials (individuals and facilities and MDH staff performing surveys) is respected.

Appendix J

10 Commitments
for MDH Nurses Who Survey Assisted Living Home Care Providers

I, _____, R.N. as an employee of the Case Mix Review (CMR) section, Facility Provider Compliance Division, Minnesota Department of Health, have read the following commitments, thoughtfully considered their implications and agree to incorporate them into my practice:.

1. First and foremost, I will work to carry out our mission to protect, improve, and maintain the health of Minnesotans.
2. I will treat people I meet with dignity and respect, including clients receiving assisted living home care services and the workers who provide their care.
3. I will smile and use my "people skills" to make others feel as comfortable as is possible during my on-site visit.
4. I will maintain an open dialogue with health care workers and managers I meet during home care surveys. I will ask for information I need in order to complete a fair evaluation of the Assisted Living home care provider.
5. I will not make up my own regulations or interpretation of the regulations. My job is to review the Assisted Living home care regulations that exist.
6. I will not be "nit-picky" or prescriptive but look for true patterns of noncompliance with regulatory requirements and/or the potential for serious adverse outcomes to the clients.
7. I will remain objective during my information gathering. I will remember that things are not always as they appear at first glance.
8. I will not discuss confidential information received during an Assisted Living home care survey with anyone other than those who have authority to receive the information. I will protect confidential data.
9. If I have questions, feel uncomfortable, or emotionally upset with the way a survey is going, I will stand back, take a moment for myself, and then contact my supervisor.
10. I will remind myself at the end of the day of what things I did well and learn from the things I may not have done so well. I will work with my colleagues to help identify ways to improve the survey process and my own practice.

I have read and agree to the 10 Commitments for surveying Assisted Living Home Care Providers.

_____ _____

(Signature) (Date)