Annual Quality Improvement Report on the Nursing Home Survey Process and Progress Reports on Other Legislatively Directed Activities

Report to the Minnesota Legislature 2004

Minnesota Department of Health

December 15, 2004

MINNESOTA MDH DEPARTMENT OF HEALTH

Commissioner's Office
85 East Seventh Place, Suite 400
P.O. Box 64882
St. Paul, MN 55164-0882
(651) 215-1300
www.health.state.mn.us

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For more information, contact:
Health Policy, Information and Compliance Monitoring Division
Minnesota Department of Health
85 East Seventh Place, Suite 300
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Phone: (651) 215-8758
Fax: (651) 215-8710
TDD/TYY: (651) 215-8980

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Introduction

During the 2004 Legislative Session, a number of legislative requirements were either added or amended relating to the federally required nursing home survey process administered by the Minnesota Department of Health (MDH). These changes included establishing new procedures, requiring an annual quality improvement report, providing additional requirements for provider and surveyor training, requiring progress reports, and making other related changes. A copy of Minnesota Session Laws 2004, Chapter 247 is attached as Appendix A.

This report fulfills the legislative requirement for providing an annual nursing home survey and certification quality improvement report and progress reports on other legislatively directed activities, including the analysis of the frequency of defensive documentation, status of the nursing home providers work group and progress on implementing the independent informal dispute resolution process.

The report is organized into four parts. Part I provides the data and other information required to be included in the annual report. Part II describes MDH's progress on the other legislatively directed activities. Part III includes a summary of some of the activities implemented to improve the nursing home survey process. The last section of the report, Part IV, identifies areas that MDH intends to focus on in the future.

I. Annual Survey and Certification Quality Improvement Report

Minnesota Statutes, section 144A.10, subdivision 17 (2004) requires the Commissioner to submit to the legislature an annual survey and certification quality improvement report. The report must include, but is not limited to, an analysis of:

(1) the number, scope, and severity of citations by region within the state;
(2) cross-referencing of citations by region within the state and between states within the Centers for Medicare and Medicaid Services region in which Minnesota is located;
(3) the number and outcomes of independent dispute resolutions;
(4) the number and outcomes of appeals;
(5) compliance with timelines for survey revisits and complaint investigations;
(6) techniques of surveyors in investigations, communication, and documentation to identify and support citations;
(7) compliance with timelines for providing facilities with completed statements of deficiencies; and
(8) other survey statistics relevant to improving the survey process.

The report must also identify and explain inconsistencies and patterns across regions of the state, include analyses and recommendations for quality improvement areas identified by the commissioner, consumers, consumer advocates, and representatives of the nursing home industry and nursing home employees, and provide action plans to address problems that are identified.

A. Number, Scope and Severity of Citations by Region within the State

Data Source

The data provided in this report has been extracted from the Center for Medicare and Medicaid Services' (CMS) Online Survey Certification and Reporting System (OSCAR). The data used in the report was extracted from the OSCAR system as of December 9, 2004. Tables, which identify data for "current surveys", consist of data from the nursing home survey in the current survey cycle, which can extend for a 15-month period.

Background

Federal law requires that each nursing home be surveyed annually during each federal fiscal year. Surveys can be conducted up to 15 months from the last survey; however, states are required to maintain a 12 month statewide average among all nursing homes.

Surveys evaluate the nursing homes compliance with the federal regulations, which are contained in 42 Code of Federal Regulations (CFR) 483.1 to 483.75. A nursing home is issued a Statement of Deficiencies for findings of noncompliance. The Statement of Deficiencies, often referred to as the "2567", which is the federal form number, identifies the area of noncompliance by a specific "tag" number, e.g. F309. The tag numbers are contained in the interpretive guidelines for the nursing home regulations issued by CMS. The 2567 contains the regulatory language and specifies the survey findings that support the finding of noncompliance.

The federal regulations cover 15 major areas such as resident rights, quality of life, quality of care, physical environment, etc. There are nearly 200 tags that can be cited. This does not include provisions relating to the Life Safety Code.

The 2567 also identifies the specific scope and severity of the deficiency. CMS has developed a scope and severity grid, which allows for the classification of deficiencies based on the degree of harm presented to a resident and the extent of the finding of noncompliance. Severity ranges from findings that there is a potential for minimal harm to findings of immediate jeopardy to a resident; scope ranges from isolated findings to widespread concerns within a nursing home. See Appendix B.

MDH is required to follow the survey process and survey protocols that have been issued by CMS. These provisions are detailed and address the specific procedures to be completed during the survey, such as the entrance interview, the tour of the facility, selection of the resident sample for review, resident interviews, observations, specific survey tasks for observation such as medication passes and review of kitchen sanitation, staff interactions with residents etc. The interpretive guidelines provide information which surveyors are required to review and consider during the decision making process of the survey.

Once the survey is completed, MDH staff will prepare the 2567 and send it to the nursing home. For tags with a scope and severity greater than an "A", the nursing home is required to submit a plan of correction (POC). In most cases, MDH will conduct a follow-up survey, referred to as a post certification revisit (PCR) to verify compliance.

Deficiency Citations

During late 2003 and the first quarter of 2004, Minnesota's average number of deficiencies per survey were much higher than the CMS Region V average. In addition, there was a wide variation in deficiency citations among the survey districts within the state.

These variations raised a number of questions regarding MDH's implementation of the survey process. Steps to address these questions will be discussed later in the report. However, it needs to be recognized that there are multiple variables that need to be taken into consideration. These include adherence to the survey protocols and process mandated by CMS, the training of MDH staff, and the conditions that are found in the facility at the time of a survey. During 2003, MDH staff identified situations when the survey protocols were not being fully implemented and efforts were untaken to better monitor and evaluate the survey process. As mentioned earlier, the survey process is prescribed by CMS and MDH, as the state survey agency, is responsible for implementing that process. However, when survey statistics from other states and other regions are reviewed it is clear that significant differences in the implementation of the national survey program exist. The variation among states and even within states in not a new issue and several reports from the Government Accountability Office and the Inspector General's Office of the federal Department of Health and Human Services have identified this issue. While these concerns have been raised with CMS staff, it is important to remember that MDH can only address our survey performance within the state. We do not minimize the concerns that providers express when our survey findings are compared to those of other states; however, our primary obligation is to assure that steps are taken to appropriately monitor our survey activities. Later in the report, we will discuss issues relating to one potential variable – "cross-referencing."

Table 1-A and 1-B identify the average number of deficiencies per survey team.

Table 1 A - Average Deficiencies per Health Survey" Current surveys - Last survey performed on each provider
Data from Federal OSCAR data system extracted on 12-9-04
Federal Center for Medicare and Medicaid Services Region V

Current Surveys Prior to 1-1-04

State	Surveys	Total Defs. Issued	Average Defs. per Survey
Illinois (IL)	283	1315	4.6
Indiana (IN)	89	433	4.9
Michigan (MI)	49	313	6.4
Minnesota (MN)	90	898	10.0
Ohio (OH)	161	1001	6.2
Wisconsin (WI)	44	102	2.3
Total	**716**	**4062**	**5.7**

Current Surveys 1-1-04 through 3-31-04

State	Surveys	Total Defs. Issued	Average Defs. per Survey
Illinois (IL)	183	911	5.0
Indiana (IN)	127	535	4.2
Michigan (MI)	116	868	7.5
Minnesota (MN)	98	1000	10.2
Ohio (OH)	146	860	5.9
Wisconsin (WI)	95	285	3.0
Total	**765**	**4459**	**5.8**

Current Surveys 4-1-04 through 6-30-04

State	Surveys	Total Defs. Issued	Average Defs. per Survey
Illinois (IL)	191	883	4.6
Indiana (IN)	123	559	4.5
Michigan (MI)	118	775	6.6
Minnesota (MN)	122	926	7.6
Ohio (OH)	176	1066	6.1
Wisconsin (WI)	108	318	2.9
Total	**838**	**4527**	**5.4**

Current Surveys After 6-30-04

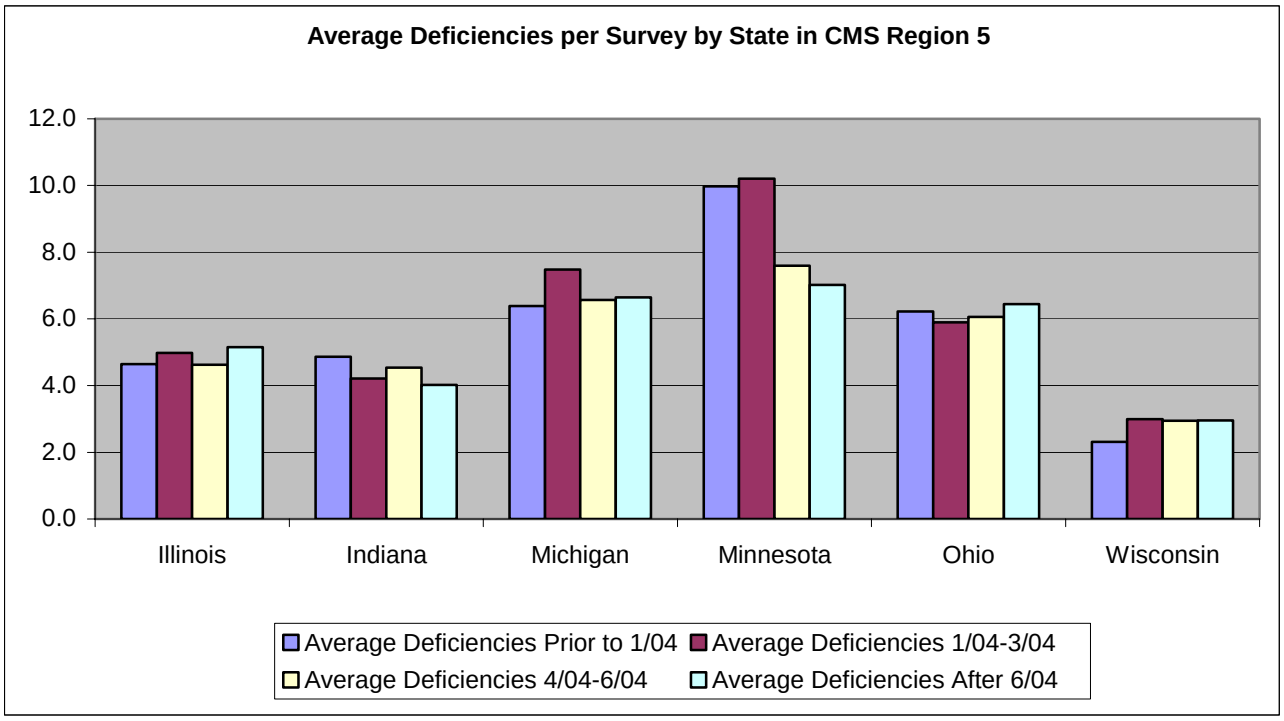
State	Surveys	Total Defs. Issued	Average Defs. per Survey
Illinois (IL)	90	464	5.2
Indiana (IN)	173	696	4.0
Michigan (MI)	146	970	6.6
Minnesota (MN)	105	737	7.0
Ohio (OH)	213	1372	6.4
Wisconsin (WI)	153	452	3.0
Total	**880**	**4691**	**5.3**

Total Current Surveys

State	Surveys	Total Defs. Issued	Average Defs. per Survey
Illinois (IL)	747	3,573	4.8
Indiana (IN)	512	2,223	4.3
Michigan (MI)	429	2,926	6.8
Minnesota (MN)	415	3,561	8.6
Ohio (OH)	696	4,299	6.2
Wisconsin (WI)	400	1,157	2.9
Total	**3199**	**17,739**	**5.5**

Table 1A cont.
"Average Deficiencies per Health Team Survey"
Current surveys - Last survey performed on each provider
Data from Federal OSCAR data system extracted on 12-9-04
Federal Center for Medicare and Medicaid Services Region V

State	Average Deficiencies Prior to 1/04	Average Deficiencies 1/04-3/04	Average Deficiencies 4/04-6/04	Average Deficiencies After 6/04
Illinois	4.6	5.0	4.6	5.2
Indiana	4.9	4.2	4.5	4.0
Michigan	6.4	7.5	6.6	6.6
Minnesota	10.0	10.2	7.6	7.0
Ohio	6.2	5.9	6.1	6.4
Wisconsin	2.3	3.0	2.9	3.0
Total	5.7	5.8	5.4	5.3



It needs to be noted that the deficiency numbers are based only on the health component of the survey process and do not include deficiencies that are issued under the provisions of the Life Safety Code or complaint investigations. Minnesota was 4.3 deficiencies per survey above the CMS regional average for current surveys done prior to January 2004, but this difference was reduced to 1.7 for surveys performed after June of 2004. Minnesota has moved from a quarterly high average of 10.2 deficiencies per survey in early 2004 to approximately 7.0 for the quarter ending 9-30-2004.

Table 1B
"Average Deficiencies per Health Survey"
Data from Federal OSCAR data system extracted on 12-09-04
Minnesota Survey Districts

Total Current Surveys

District	Surveys	Tags From Each Group	Average Defs. Per Survey
Bemidji	45	408	9.1
Duluth	36	467	13.0
Fergus Falls	42	372	8.9
Mankato	65	425	6.5
Metro A	34	406	11.9
Metro B	35	219	6.3
Metro C	38	345	9.1
Metro D	36	197	5.5
Rochester	47	412	8.8
St Cloud	37	310	8.4
Total	**415**	**3,561**	**8.6**

The variability between the highest and lowest Minnesota district for the current survey cycle was 7.5. In order to develop a clear understanding of the reasons for this variation, it is necessary to monitor the survey process and the decision making process. Was the federal process appropriately carried out, was there evidence to support the deficiency that was issued, are survey teams following the same procedure and decision making process? It also needs to be determined if there are system issues and concerns at the facility level which leads to higher findings of noncompliance. Efforts to address these issues range from ongoing monitoring of the survey process, seeking better federal direction and clarification, and identifying areas where facility training could enhance compliance.

Tables 2A-2B identify deficiencies by scope and severity. Most of the deficiencies issued in Minnesota and the other CMS Region V states are in the D and E category – a situation when there is a potential for harm, but actual harm has not been identified. In Minnesota the percentage for D and E deficiencies is 83% and the percentages in other Region V states range from 73% to almost 85%. The CMS Region V average is 79%. Within Minnesota, the percentages of D and E deficiencies in each survey district range from 75 % to 87%. The statewide average is 83%.

Table 2A
Scope and Severity Distribution CMS-Region V
Current surveys - Last survey performed, each provider, OSCAR data system extracted on 12-9-04

Current Surveys

	Number of tags issued in each scope and severity during the time period.												
State	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**Total**
Illinois	0	345	359	1,965	656	70	156	4	0	15	1	2	3,573
Indiana	0	132	19	1,263	623	21	136	11	0	9	7	2	2,223
Michigan	0	268	71	1,427	872	147	123	12	0	2	2	2	2,926
Minnesota	0	269	161	2,069	905	75	75	2	0	1	4	0	3,561
Ohio	0	463	229	2,470	840	154	131	6	0	5	1	0	4,299
Wisconsin	0	58	66	701	255	18	48	2	0	5	3	1	1,157
Total	0	1,535	905	9,895	4,151	485	669	37	0	37	18	7	17,739

Current Surveys

	Percent of tags issued in each scope and severity during the time period.												
State	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**Total**
Illinois	0.0%	9.7%	10.0%	55.0%	18.4%	2.0%	4.4%	0.1%	0.0%	0.4%	0.0%	0.1%	100.0%
Indiana	0.0%	5.9%	0.9%	56.8%	28.0%	0.9%	6.1%	0.5%	0.0%	0.4%	0.3%	0.1%	100.0%
Michigan	0.0%	9.2%	2.4%	48.8%	29.8%	5.0%	4.2%	0.4%	0.0%	0.1%	0.1%	0.1%	100.0%
Minnesota	0.0%	7.6%	4.5%	58.1%	25.4%	2.1%	2.1%	0.1%	0.0%	0.0%	0.1%	0.0%	100.0%
Ohio	0.0%	10.8%	5.3%	57.5%	19.5%	3.6%	3.0%	0.1%	0.0%	0.1%	0.0%	0.0%	100.0%
Wisconsin	0.0%	5.0%	5.7%	60.6%	22.0%	1.6%	4.1%	0.2%	0.0%	0.4%	0.3%	0.1%	100.0%
Total	0.0%	8.7%	5.1%	55.8%	23.4%	2.7%	3.8%	0.2%	0.0%	0.2%	0.1%	0.0%	100.0%

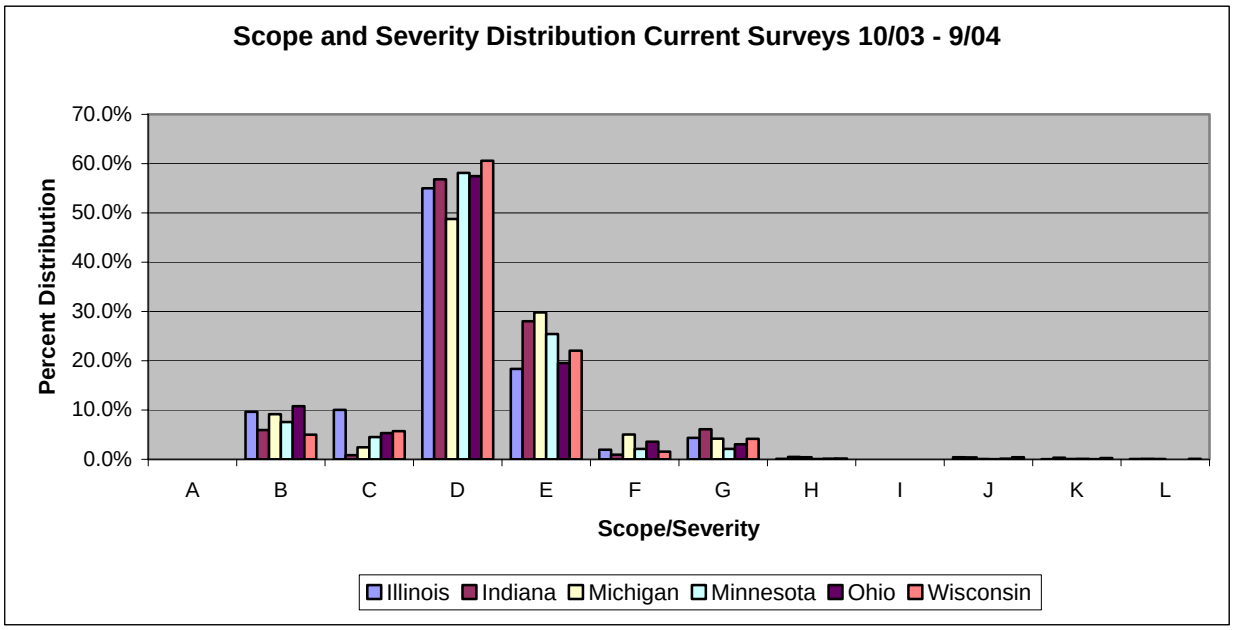


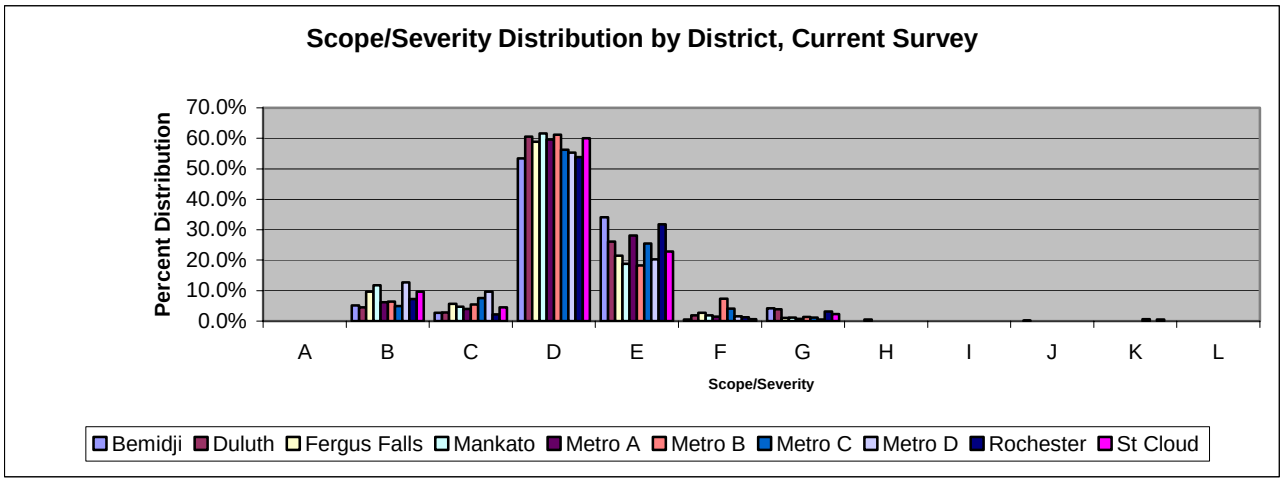
Table 2B
Minnesota District Scope and Severity Distribution
Current surveys - Last survey performed, OSCAR data system extracted on 12-9-04

Current Surveys

	Number of tags issued in each scope and severity during the time period.												
District	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**Total**
Bemidji	0	21	11	218	139	2	17	0	0	0	0	0	408
Duluth	0	21	13	283	122	9	18	0	0	1	0	0	467
Fergus Falls	0	36	21	219	80	10	4	2	0	0	0	0	372
Mankato	0	50	20	262	80	8	5	0	0	0	0	0	425
Metro A	0	25	16	242	114	6	3	0	0	0	0	0	406
Metro B	0	14	12	134	40	16	3	0	0	0	0	0	219
Metro C	0	17	26	194	88	14	4	0	0	0	2	0	345
Metro D	0	25	19	109	40	3	1	0	0	0	0	0	197
Rochester	0	30	9	222	131	5	13	0	0	0	2	0	412
St Cloud	0	30	14	186	71	2	7	0	0	0	0	0	310
Total	0	269	161	2,069	905	75	75	2	0	1	4	0	3,561

Current Surveys

	Percent of tags issued in each scope and severity during the time period.												
District	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**Total**
Bemidji	0.0%	5.1%	2.7%	53.4%	34.1%	0.5%	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Duluth	0.0%	4.5%	2.8%	60.6%	26.1%	1.9%	3.9%	0.0%	0.0%	0.2%	0.0%	0.0%	100.0%
Fergus Falls	0.0%	9.7%	5.6%	58.9%	21.5%	2.7%	1.1%	0.5%	0.0%	0.0%	0.0%	0.0%	100.0%
Mankato	0.0%	11.8%	4.7%	61.6%	18.8%	1.9%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Metro A	0.0%	6.2%	3.9%	59.6%	28.1%	1.5%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Metro B	0.0%	6.4%	5.5%	61.2%	18.3%	7.3%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Metro C	0.0%	4.9%	7.5%	56.2%	25.5%	4.1%	1.2%	0.0%	0.0%	0.0%	0.6%	0.0%	100.0%
Metro D	0.0%	12.7%	9.6%	55.3%	20.3%	1.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Rochester	0.0%	7.3%	2.2%	53.9%	31.8%	1.2%	3.2%	0.0%	0.0%	0.0%	0.5%	0.0%	100.0%
St Cloud	0.0%	9.7%	4.5%	60.0%	22.9%	0.6%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Total	0.0%	7.6%	4.5%	58.1%	25.4%	2.1%	2.1%	0.1%	0.0%	0.0%	0.1%	0.0%	100.0%



B. Cross-Referencing of Citations by Region Within the State and Between States Within CMS Region V

During discussions relating to the variations in deficiency numbers, one issue - "cross referencing" – raised many comments and concerns. While the term is not technically correct, "cross-referencing" has been used to refer to situations when findings contained in one tag are also identified in another tag. The concern is that this could improperly inflate the number of deficiencies that are issued.

The "cross referencing" practice refers to situations when findings of noncompliance can be based on similar factual situations. For example, if the survey identifies a quality of care concern for a resident, such as improper positioning, the development of pressure sores, failure to meet the health needs of the resident, etc., a quality of care tag will be issued. These quality of care tags are tags F309 through F333. As part of the survey process, MDH surveyors are also expected to determine whether the poor outcome that was identified was based on the facility's failure to properly assess the resident's needs, to properly develop care plans to address those needs, or to implement the care plan and revise the plan as necessary. It is crucial for resident well being that these steps are taken and appropriately carried out. The federal regulations include provisions relating to assessment and care planning and the tags associated with these provisions are often referred to as the process tags. If, as part of the survey investigative process, it is determined that there was noncompliance in these areas, the process tag would be issued. In some cases, residents identified in the outcome tag could also be identified in the process tag if it was also determined that the facility did not adequately assess the resident or develop and implement the appropriate care plan. Similar findings would be included in each tag and often the language would be very similar. However, the tags are issued for two distinct findings of noncompliance- the poor outcome and the failure to properly assess and develop the care plan. The two tags would also require that the nursing home specifically develop a plan of correction for each finding of noncompliance – how the care issues will be addressed and how the failure to assess or develop the care plan will also be addressed. However, there are situations when both process tags and outcomes tags are issued which would not be considered as "cross-referencing". For example, if the outcome tag identified concerns with Residents A, B and C, and the process tags identified concerns with Residents D, E, and F, this would not be considered as "cross referencing". The policy discussed below does not impact this scenario.

Prior to June 21, 2004, MDH nursing home surveyors issued federal deficiencies for related findings under outcome and process (care planning and assessment) tags. Minnesota issued multiple tags for related deficiencies because this was consistent with CMS guidelines for issuing deficiencies. Providers raised concerns that this practice was duplicative and unnecessary and was not followed consistently by other states in CMS Region V and elsewhere.

A subcommittee of MDH's Long Term Care Issues Ad Hoc Committee was formed to look at survey related data. This subcommittee was chaired by Patsy Riley, the President and Chief Executive Officer of Stratis Health and members were selected from the Ad Hoc Committee. This subcommittee examined the survey data and made recommendations that are contained in their July 2004 final report. One of those recommendations was to continue to seek further clarification of the issue from CMS. In April 2004, Commissioner Mandernach, Patsy Riley and MDH staff met with federal officials and state agency representatives from the Region V states to discuss the findings relating to the wide variability of "cross-referencing". MDH noted that we had been informed that the process followed in the state was in accordance with federal policy and expectation; however, when data was reviewed it was very apparent that there was no consistent implementation of this policy within the region or nationally. MDH requested further clarification from CMS, but it has not been provided.

In June 2004, MDH developed a new policy on issuing deficiencies for related findings. Since MDH had not received any clarification on a national policy, it was felt that this was an appropriate step to take. This new policy was explained in a June 21, 2004 Information Bulletin to providers. The new policy states the following:

"The Minnesota Department of Health will identify deficient findings under assessment, care planning and outcome tags. If a related deficient practice is found under an assessment and/or care planning tag(s) AND outcome tag, MDH will cite the finding under the appropriate outcome tag and will NOT include that finding in an assessment and/or care planning deficiency. MDH will continue to issue assessment and or care/planning tags for findings where an outcome tag is not issued."

Please see Appendix C for an Information Bulletin that includes more information on this policy.

MDH is in the process of conducting a thorough evaluation of the "cross referencing" policy. MDH reviewed its plans for doing an evaluation with the Long-Term Care Issues Ad Hoc Committee at their October 7, 2004 meeting. The Committee was in agreement that the existing Survey Findings/Review Subcommittee should be reconvened to assist MDH in developing an evaluation protocol and analyzing information. Patsy Riley from Stratis Health, the Quality Improvement Organization, agreed to lead this effort. Other members would be added to the committee as needed. The subcommittee is planning to meet in February of 2005.

C. Number and Outcome of Independent Informal Dispute Resolutions

Federal law requires 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 statutory provisions for these two dispute resolution processes can be found under Minnesota Statutes, Section 144A.10, subdivisions 15 and 16.

The IDR is performed by an MDH employee who has not previously been involved in the survey.
An alternate review process called the Independent Informal Dispute Resolution Process (IIDR) for survey disputes was passed into law effective July 1, 2003 Minnesota Statutes, section 144A.10, subdivision 16). It provides for a review by an Administrative Law Judge (ALJ), from the Office of Administrative Hearings (OAH). The statute specifies that the findings of the ALJ will not be binding on the MDH. Decisions made by MDH must be in accordance with federal regulations and are not binding on CMS.

The Informal Independent Dispute Resolution process (IIDR) has been operational since July of 2004. Of the 18 pending cases, six withdrew the IIDR request prior to the review, and MDH rescinded one of the 18 prior to the ALJ review. As of December 15,2004, an additional 12 IIDRs have been requested, and of those three have withdrawn prior to scheduling a review with an ALJ and an additional two withdrew prior to the scheduled ALJ review. All current requested IIDRs are scheduled for timely ALJ review.

As of December 15, 2004, there have been 14 reviews conducted before an ALJ (one facility combined its two requests into one review) and 12 ALJ recommendations have been rendered with two pending. Prior to the reviews being conducted, facilities dropped some disputed tags and MDH modified a few tags. There were 36 tags in dispute for the 12 ALJ reviews completed. The ALJ's recommendations were to uphold 14 tags as written, adjust the scope and/or severity on 18 tags and dismiss four tags. The commissioner's decisions have been to uphold 16 tags valid as issued, change the scope and severity on 14 tags and dismiss 4 tags.

Twelve of the 14 facilities that have had an IIDR, have had counsel prepare and present their position at the review. MDH utilizes a survey team supervisor to review submitted materials and present MDH's position at the IIDRs. MDH intends to utilize information gained from the IIDR process to improve the survey process with respect to both identifying and documenting deficient practices. A status log of IIDRs is maintained by MDH and shared with, nursing home trade associations and the Ombudsman for Older Minnesotans on a regular basis.

D. Number and Outcomes of Appeals

The appeals process is an entirely federal process. All communications are between the nursing home and CMS Region V Office in Chicago.

MDH is currently aware of two nursing homes with active appeals at the federal level. Since 1996, CMS has indicated that there have been 41 appeal cases filed. CMS is preparing additional information on the status of these cases and it will be included in our next annual report.

E. Compliance with Timelines for Survey Revisits and Complaint Investigations

If a survey team finds deficiencies at the B through L level, the nursing home is required to submit a plan of correction (POC) to MDH. In most instances, a revisit is conducted to determine whether the deficiency has been corrected.

Minnesota Statutes, Section 144A.101, subdivision 5, requires the commissioner to conduct revisits within 15 calendar days of the date by which corrections will be completed, in cases when category 2 or 3 remedies are in place. The statute allows MDH to conduct revisits by phone or written communications, if the highest scope and severity score does not exceed level E.

As of December 15, 2004 there were 23 facilities with surveys or revisits exited after August 1, 2004 with Category II or III remedies imposed. Thirty revisits have been completed since August 1, 2004:

- 20 revisits were completed within 15 calendar days.

- 10 revisits were not completed within the 15 calendar days after the POC date of correction.

- Of these 10 revisits, 7 were not conducted timely due to circumstances beyond MDH control, (e.g. CMS approval required to do the revisit; or when the correction date on the POC is 15 days prior to its submission to MDH)

- The remaining 3 revisits were not conducted timely, due to MDH scheduling failures. However, none of these revisits resulted in the facilities having more penalties actually imposed than if the revisits were completed timely.

F. Techniques of Surveyors in Investigations, Communication, and Documentation to Identify and Support Citations

An extensive description of the activities taken by MDH and CMS to promote integrity throughout the survey process can be found on the MDH website for the Long Term Care Ad Hoc Committee at the following link: http://www.health.state.mn.us/ltc/quality.pdf or see Appendix D. that was distributed to the LTC Issues Ad Hoc Committee on January 15, 2004.

This document summarizes the federal oversight activities of MDH as well as the steps taken by MDH. Those steps include onsite survey mentoring and coaching, ongoing deficiency review, and internal communications with survey staff.

In addition, all new survey staff complete and extensive orientation program and are required to complete federally mandated training on the nursing home survey process.

Other initiatives relating to training and communication strategies will be discussed later in this report.

G. Compliance with Timelines for Providing Facilities with Completed Statements of Deficiencies

Minnesota Statutes, section 144A. 101, subdivision 2 requires the Commissioner to provide facilities with draft statements of deficiencies at the time of the survey exit and with completed Statements of Deficiencies within 15 working days of the exit process.

MDH enhanced an existing tracking system that monitored the timelines of survey package completion. An additional supervisor was assigned to process survey packages. The system automatically sends e-mails at various time frames to supervisors to alert them to send out the 2567 form and letters. This was not completely operational until early October as many changes were made to the process following trial and error testing. Memos were also updated for communication about draft deficiencies.

The system tracked surveys exited between August 1, 2004 and December 11, 2004. Of the 134 surveys tracked, only three exceeded the 15 day requirement (2.24% over 15 days). Two of these instances related to a supervisor out on personal emergency leave of absences. The third instance was related to a problem in the computer software used to automatically notify the person who is responsible for generating the letters after a survey is completed. As soon as the problem was identified, it was corrected.

H. Other Survey Statistics Relevant to Improving the Survey Process

MDH has not prepared additional information for this report. However, as evidenced by the MDH efforts to utilize the Internet for sharing survey and complaint findings directly with the public, MDH is continuing to identify information that could be routinely included on our websites. We will be working with stakeholders to determine what types of reports would be useful on an ongoing basis and which could then be added to the MDH website.

I. Identification of Inconsistencies and Patterns Across Regions of the State and Quality Improvement Recommendations and Action Plans to Address Problems Identified

As previously discussed above, MDH has identified a number of broad areas where there is significant variability in the issuance of survey deficiencies. Additional activity will need to be taken to delve deeper into the root causes of these differences. We will be continuing to work with stakeholders to discuss and address these issues. The Survey Findings Subcommittee has made a number of recommendations for further analysis of the survey data in the future. See Appendix E for information on how to obtain a copy of this report.

II. Progress Reports on Other Legislatively Directed Activities

The Laws of Minnesota 2004, Chapter 247, section 5 requires the Commissioner to include in this report a progress report and implementation plan for the following legislatively directed activities:

(1) an analysis of the frequency of defensive documentation and a plan, developed in consultation with the nursing home industry, consumers, unions representing nursing home employees, and advocates, to minimize defensive documentation;
(2) the nursing home providers work group established under Laws 2003, First Special Session, Chapter 14, article 13c, section 3; and,
(3) progress in implementing the independent informal dispute resolution process.

A. Analysis of the Frequency of and Plan to Minimize Defensive Documentation

A work group is in the process of being formed which will consist of the stakeholders identified in the law as well as representatives of the acute care industry, legal arena, Minnesota Board of Nursing, and Minnesota Department of Human Services. The work group will begin with a review of the work done by the Minnesota Health and Housing Alliance's Clinical Advisory Council. The Council has met six times over the past year on the defensive documentation issue and will be submitting a report with their recommendations to MHHA leadership in January 2005.

B. Progress of the Nursing Home Providers Work Group

Laws of Minnesota 2003, First Special Session, chapter 14, article 13C, section 3, requires the commissioner to establish a working group consisting of nursing home and boarding care home providers, representatives of nursing home residents, and other health care providers to review current licensure provisions and evaluate the continued appropriateness of these provisions

A work group has been formed and will hold their first meeting on December 21, 2004. MDH is developing a comparison list of areas to focus the work group's discussion.

C. Progress of the Independent Informal Dispute Resolution Process

The IIDR process has been fully implemented as previously discussed in this report.

III. Summary of Improvements Made to Date on the Nursing Home Survey Process

In addition to the information in Part I and II of this report, MDH has undertaken other initiatives to help improve the survey process. Some of these improvements were legislatively mandated and others were at MDH's own initiative or based on stakeholders' comments and perspectives.

Agency's Quality Improvement Program

Minnesota Statutes, Section 144A.10, subdivision 17 directs the Commissioner to establish a quality improvement program for the nursing home survey and complaint process, and to consult with consumers, consumer advocates, representatives of the nursing home industry and representatives of nursing home employees in implementation of the program.

It is important to note that MDH's Licensing and Certification Program has an established quality assurance plan. The quality assurance plan includes both federal and state training and oversight provisions. See Appendix D. MDH will continue to review and enhance the quality assurance program.

Additionally, in April of 2003, 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. A Long-Term Care Issues Ad Hoc Committee (Stakeholders' Group) comprised of a variety of stakeholders was formed and has met several times. In January 2004, two subcommittees were formed to work on more focused areas of the Ad Hoc Committee's discussions, the Survey Findings/Review Subcommittee and the Communications for Survey Improvement Subcommittee.

The Survey Findings/Review Subcommittee focused on issues relating to the number, type and severity of deficiencies issued by MDH. The goal of the subcommittee was to identify the underlying causes of increased number of deficiencies, develop a process for analyzing identified trends, and identify areas of focus that will enhance the quality of care in nursing homes, recognizing that compliance is the first step toward quality.

The Communications for Survey Improvement Subcommittee focused on ways to minimize tensions created by the survey process and the regulatory relationship. The group was charged with establishing productive and respectful communications and relationships among regulated facilities, residents and their families, and the department; findings ways to better integrate information from family members and facility staff into the survey findings; and, clarifying roles and responsibilities of MDH and provider staff in putting the group's recommendation into action.

The Survey Findings/Review Subcommittee and Communications for Survey Improvement Subcommittee made several recommendations that MDH has incorporated into their quality improvement plan. Please see Appendix E. for information on how to obtain a copy of these subcommittee reports.

MDH also contracted with the Management Analysis Division (MAD) of the Minnesota Department of Administration to examine and recommend improvements to the survey process. The review included interviews with more than 60 stakeholders; focus groups, consulting with representatives of the nursing home survey processes in six other states; observing three onsite inspections conducted by MDH; analyzing recent

trends in deficiency citations; reviewing selected literature from other state and federal sources; and, reviewing findings from the commissioner's ad hoc committee an it's subcommittees. Please see Appendix E. for information on how to obtain a copy of the MAD report.

After reviewing the recommendations from these reports, the Long-Term Care Issues Ad Hoc Committee prioritized the recommendations. Attached is a grid, which describes those priorities and MDH's progress towards implementing those priority recommendations. See Appendix F. which was reviewed by the Ad Hoc Committee last October. This grid is also available on MDH's website for the Ad Hoc Committee at: http://www.health.state.mn.us/ltc/index.html

One of the key recommendations was to continue the Long-Term Care Issues Ad Hoc Committee. MDH concurred with the recommendation and the Ad Hoc Committee is continuing to meet on a regular basis. One of the next tasks for this group will be to assist in the review of the Legislative Auditor's report, which also examined the survey process. This report is expected to be available in January 2005. Additionally, the Committee will monitor the progress made in implementing the priority recommendations mentioned above and included in the grid in Appendix F. A subcommittee of the stakeholders' group will continue to analyze survey related data.

In addition to the Ad Hoc Committee, and as a means of improving communications and working relationships in all regions of the state, MDH will be forming a similar stakeholders group in the Duluth area as part of a pilot study. MDH hopes that this regional pilot project will serve as a model for replicating the process throughout the state. The committee will focus on issues relevant to the Duluth region and the first meeting will be in January 2005.

The Long-Term Care Ad Hoc Committee will continue to be the mechanism for consultation with consumers, providers, advocates and others in the development and implementation of the quality improvement program.

Established a Quality Improvement Nurse Specialist Position

MDH has established several new positions to help with our quality improvement efforts. We are in the process of hiring a Quality Improvement Nurse Specialist who will work for the Director of the Health Policy, Information and Compliance Monitoring Division and will be responsible for quality improvement activities. This person will work closely with Stratis Health, the Quality Improvement Organization and members of the Long-Term Care Ad Hoc committee in the development of future quality improvement initiatives. Individuals from the Office of the Ombudsman for Older Minnesotans, ElderCare Rights Alliance, and staff from Care Providers of Minnesota and the Minnesota Health and Housing Alliance have been assisting MDH in the recruitment and applicant screening process.

Secured a .5 Research Position

MDH secured a .5 research position who will work with the Quality Improvement Nurse Specialist to develop reports regarding survey and deficiency trends, and work with stakeholders to provide support and education to the various parties on how to interpret survey findings. This individual will be a point of contact to ensure that advocates and stakeholders clearly understand survey issues and have access to factual descriptive information.

Expanded Survey Staff to Include Other Disciplines

MDH will also be creating a group that is comprised of various specialists, such as OT's, PT's, dieticians and pharmacists to provide additional expertise to the survey process. This staff will be housed in St. Cloud and will be considered a statewide resource with members assigned to survey with all other teams.

Family Council Interviews

Minnesota Statutes, section 144A.101, subdivision 6, requires family councils to be interviewed as part of the survey process and invited to participate in the exit conference.

While interviews with family members have always been a part of the survey process, there never was a requirement to formally meet with a facility's family council until this legislation was enacted. As a result, MDH convened a work group to develop an MDH Information Bulletin regarding this legislative requirement. The group, composed of representatives from the Minnesota Health and Housing Association, Care Providers of Minnesota, Ombudsman for Older Minnesotans, Association for Retired Persons (AARP), and ElderCare Rights Alliance provided valuable input to MDH. An Information Bulletin was issued on July 1, 2004 and a survey tool for interviewing members of the family council/group was developed and included with this bulletin. See Appendix G. All surveys conducted after August 1, 2004 where a family group/council existed included an invitation for the family group/council to participate in the survey process. In January 2005, the stakeholders group will reconvene to review the implementation of this activity.

As of October 12, 2004, there were 255 nursing homes that had existing family councils.

Implemented Technologically Related Quality Improvement Initiatives

As part of MDH's quality improvement initiatives, there have been a number of technological innovations implemented to assist providers and provide more information to consumers. Many of these innovations rely on provider access to the web for conducting business transactions. These innovations include, but are not limited to, providing a web site for clinical issues to be discussed, placing survey activity forms on the web, and providing expanded information about nursing home surveys and complaint investigations on the web. Appendix H lists and describes these technological innovations.

Expanded our Efforts to Train and Educate Nursing Home Providers

Minnesota Statutes, Section 144A.10, subd. 1a.was amended by modifying existing requirements that apply to the Commissioner of Health's role in training and educating providers about new regulations. These amendments require training of long-term care providers and state surveyors to be done jointly. It also requires the commissioner to consult with experts and make available training resources on current standards of practice and the use of technology.

MDH is working on a number of initiatives to educate providers about new regulations and current standards of practice, including the following:

- MDH issued Information Bulletin #04-5 detailing how to access CMS Training via Satellite Broadcast and Webcast. Nationally accepted clinical/professional standards and guidelines for surveyors and providers are accessible at these sites.

- MDH continues to consult with staff at Stratis Health, the Quality Improvement Organization for Minnesota, for the development of training programs. MDH is in the process of planning and implementing a joint training session for providers and survey staff on the recently updated federal protocols for pressure ulcers. In addition to staff from Stratis Health, MDH will be working with the various stakeholders to plan and offer these training programs.

- Provider Trainings - -MDH has committed to providing support for at least four provider training events per year. MDH is in the process of hiring outside consultants to assist with these training efforts. As time permits, MDH will continue to work with outside groups to provide assistance in their training programs.

- MDH In-service Training - -MDH has invited stakeholders to participate in the annual licensing and certification in-service training and new surveyor orientation.

- State Survey Agency/Quality Improvement Organization Work Group - - Minnesota is one of four states participating in a State Survey Agency/Quality Improvement Organization Work Group that will develop a model for an integrated approach to quality improvement in pressure ulcers and reducing unnecessary restraints. This is one of many CMS sponsored initiatives underway to encourage collaboration between State Survey Agencies and Quality Improvement Organizations and respond to providers need for additional and on-going clinical training to improve the care of nursing home residents.

IV. Areas of Special Focus for 2005

The following three areas will be given special attention during 2005:

1. **Improving Consistency Across Survey Teams.** MDH utilizes ten separate survey teams, four in the metro area and six in out state areas. Achieving maximum survey consistency across these teams has always been a challenge. The onsite supervisor mentoring/monitoring surveys conducted during 2004 (discussed in part I. F. of this report) were an important step in identifying areas of inconsistency related to the conduct of specific survey tasks. But it is unlikely that all of the observed variation is attributable to procedural inconsistency and we need to develop a much better understanding of other factors which may influence survey team behavior. In addition, we need to take full advantage of our survey database to track the number and types of deficiencies issued by each team over time. Trend analysis can be a useful tool in identifying differences and understanding their causes. MDH also needs to establish parameters for acceptable levels of variation and systems to address outlier situations as soon as they are detected.

2. **Improving Communication and an Understanding of the Survey Process.** The Long-Term Care Issues Ad Hoc Committee and its Communications Subcommittee have created an excellent foundation for MDH to build on during 2005. The participation of a broad stakeholder group, including MDH staff, providers (and provider organizations), advocacy organizations, employees and family members, has provided an important opportunity to share perspectives and identify common goals. But it is vitally important that this momentum not be lost and that we build on our early success in gaining better understandings and building trust. Therefore, MDH is committed to continuing its strong support for the Long-Term Care Issues Ad Hoc Committee, as well as its subcommittees, and in piloting this approach on a regional basis. We anticipate utilizing the experience gained in our Duluth regional pilot project (which will begin in January, 2005) to develop similar groups in the other MDH survey regions.

3. **Collaborating on Provider Quality Improvement Projects.** As the State Survey Agency, MDH's primary function is to monitor compliance with federal certification standards. CMS separately contracts with Stratis Health as the Quality Improvement Organization (QIO) for Minnesota. But it is essential that these functions be carried out in close collaboration in order to achieve the maximum benefit for residents in nursing homes across the state. During 2005, MDH will work to further strengthen its relationship with the QIO and to engage provider and advocacy organizations in mutual efforts to promote and support the adoption of clinical best practices in long-term care settings. Joint training opportunities will be sought to assure that state surveyors, providers and advocates share a common understanding of current best practices and how to achieve them.

Minnesota Session Laws

Minnesota Session Laws - 2004

Key: ~~language to be deleted~~...new language Change language enhancement display.

Legislative history and Authors

CHAPTER 247-H.F.No. 2246

An act relating to health; modifying the nursing facility survey process; establishing a quality improvement program; requiring annual quality improvement reports; requiring the commissioner of health to seek federal waivers and approvals; amending Minnesota Statutes 2002, sections 144A.10, subdivision 1a, by adding a subdivision; 256.01, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 144A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2002, section 144A.10, subdivision 1a, is amended to read:

Subd. 1a. [TRAINING AND EDUCATION FOR NURSING FACILITY PROVIDERS.] The commissioner of health must establish and implement a prescribed process and program for providing training and education to providers licensed by the Department of Health, ~~either by itself or~~ in conjunction with the industry trade associations, before using any new regulatory guideline, regulation, interpretation, program letter or memorandum, or any other materials used in surveyor training to survey licensed providers. The process should include, but is not limited to, the following key components:

(1) facilitate the implementation of immediate revisions to any course curriculum for nursing assistants which reflect any new standard of care practice that has been adopted or referenced by the Health Department concerning the issue in question;

(2) conduct training of long-term care providers and health department survey inspectors ~~either~~ jointly ~~or during the same time frame~~ on the department's new expectations; and

(3) ~~within available resources~~ the commissioner shall ~~cooperate in the development of clinical standards, work with vendors of supplies and services regarding hazards, and identify research of interest to the long-term care community~~ consult with experts in the field to develop or make available training resources on current standards of practice and the use of technology.

Sec. 2. Minnesota Statutes 2002, section 144A.10, is amended by adding a subdivision to read:

Subd. 17. [AGENCY QUALITY IMPROVEMENT PROGRAM; ANNUAL REPORT ON SURVEY PROCESS.] (a) The commissioner shall establish a quality improvement program for the nursing facility survey and complaint processes. The commissioner must regularly consult with consumers, consumer advocates, and representatives of the nursing home industry and representatives of nursing home employees in implementing the program. The commissioner,

through the quality improvement program, shall submit to the legislature an annual survey and certification quality improvement report, beginning December 15, 2004, and each December 15 thereafter.

(b) The report must include, but is not limited to, an analysis of:

(1) the number, scope, and severity of citations by region within the state;

(2) cross-referencing of citations by region within the state and between states within the Centers for Medicare and Medicaid Services region in which Minnesota is located;

(3) the number and outcomes of independent dispute resolutions;

(4) the number and outcomes of appeals;

(5) compliance with timelines for survey revisits and complaint investigations;

(6) techniques of surveyors in investigations, communication, and documentation to identify and support citations;

(7) compliance with timelines for providing facilities with completed statements of deficiencies; and

(8) other survey statistics relevant to improving the survey process.

(c) The report must also identify and explain inconsistencies and patterns across regions of the state, include analyses and recommendations for quality improvement areas identified by the commissioner, consumers, consumer advocates, and representatives of the nursing home industry and nursing home employees, and provide action plans to address problems that are identified.

Sec. 3. [144A.101] [PROCEDURES FOR FEDERALLY REQUIRED SURVEY PROCESS.]

Subdivision 1. [APPLICABILITY.] This section applies to survey certification and enforcement activities by the commissioner related to regular, expanded, or extended surveys under Code of Federal Regulations, title 42, part 488.

Subd. 2. [STATEMENT OF DEFICIENCIES.] The commissioner shall provide nursing facilities with draft statements of deficiencies at the time of the survey exit process and shall provide facilities with completed statements of deficiencies within 15 working days of the exit process.

Subd. 3. [SURVEYOR NOTES.] The commissioner, upon the request of a nursing facility, shall provide the facility with copies of formal surveyor notes taken during the survey, with the exception of interview forms, at the time of the exit conference or at the time the completed statement of deficiency is provided to the facility. The survey notes shall be redacted to protect the confidentiality of individuals providing information to the surveyors. A facility requesting formal surveyor notes must agree to pay the commissioner for the cost of copying and redacting.

Subd. 4. [POSTING OF STATEMENTS OF DEFICIENCIES.] The commissioner, when posting statements of a nursing facility's deficiencies on the agency Web site, must include in the posting the facility's response to the citations. The Web site must also include the dates upon which deficiencies are corrected and the date upon which a facility is considered to be in compliance with survey requirements. If deficiencies are under dispute, the commissioner must note this on the Web site using a method that clearly identifies for consumers which citations are under

dispute.

Subd. 5. [SURVEY REVISITS.] The commissioner shall conduct survey revisits within 15 calendar days of the date by which corrections will be completed, as specified by the provider in its plan of correction, in cases where category 2 or category 3 remedies are in place. The commissioner may conduct survey revisits by telephone or written communications for facilities at which the highest scope and severity score for a violation was level E or lower.

Subd. 6. [FAMILY COUNCILS.] Nursing facility family councils shall be interviewed as part of the survey process and invited to participate in the exit conference.

Sec. 4. Minnesota Statutes 2002, section 256.01, is amended by adding a subdivision to read:

Subd. 21. [INTERAGENCY AGREEMENT WITH DEPARTMENT OF HEALTH.] The commissioner of human services shall amend the interagency agreement with the commissioner of health to certify nursing facilities for participation in the medical assistance program, to require the commissioner of health, as a condition of the agreement, to comply beginning July 1, 2005, with action plans included in the annual survey and certification quality improvement report required under section 144A.10, subdivision 17.

Sec. 5. [PROGRESS REPORT.]

The commissioner of health shall include in the December 15, 2004, quality improvement report required under section 2 a progress report and implementation plan for the following legislatively directed activities:

(1) an analysis of the frequency of defensive documentation and a plan, developed in consultation with the nursing home industry, consumers, unions representing nursing home employees, and advocates, to minimize defensive documentation;

(2) the nursing home providers workgroup established under Laws 2003, First Special Session chapter 14, article 13c, section 3; and

(3) progress in implementing the independent informal dispute resolution process required under Minnesota Statutes, section 144A.10, subdivision 16.

Sec. 6. [RESUBMITTAL OF REQUESTS FOR FEDERAL WAIVERS AND APPROVALS.]

(a) The commissioner of health shall seek federal waivers, approvals, and law changes necessary to implement the alternative nursing home survey process established under Minnesota Statutes, section 144A.37.

(b) The commissioner of health shall seek changes in the federal policy that mandates the imposition of federal sanctions without providing an opportunity for a nursing facility to correct deficiencies, solely as the result of previous deficiencies issued to the nursing facility.

Presented to the governor May 18, 2004

Signed by the governor May 26, 2004, 9:00 p.m.

Appendix B

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. 2 Optional: Cat. 1
	Actual harm that is not immediate	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 Mgmt.
	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. 2 Optional: Cat. 1
	No actual harm with potential for minimal harm	A No PoC 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 (Cat.1)	**Category 2 (Cat.2)**	**Category 3 (Cat.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 Money Penalties: Up to $3,000 per day $1,000 - $10,000 per instance	Temp. Mgmt. Termination **Optional**: Civil Money Penalties 3,050-$10,000 per day $1,000 - $10,000 per instance

Denial of payment for new admissions must be imposed when a facility is not in substantial compliance within 3 months after being found out of compliance.

Denial of payment and State monitoring must be imposed when a facility has been found to have provided substandard quality of care on three consecutive standard surveys.

NOTE: Termination may be imposed by the State or CMS at any time.

Minnesota Department of Health
Protecting, maintaining and improving the health of all Minnesotans

June, 2004

Information Bulletin 04-9
NH-100

Federal SNF/NF Deficiencies Related to Outcome, Assessment and/or Care Planning Findings
Effective Date – June 21, 2004

Background:

The Minnesota Department of Health has identified deficient practices that create non-compliance with more than one federal regulation and issues federal deficiencies under each requirement.

Concerns have been raised that federal citations issued for related findings under both the outcome tag and the assessment and/or care planning related tags are duplicative and unnecessary.

Minnesota has identified that different state survey agencies issue different patterns of citations with some issuing only the outcome tag and others issuing outcome, assessment and/or care planning tags.

Policy

Nursing homes are expected to help residents attain and/or maintain their highest practicable physical, mental and psychosocial well-being.

The key to achieving this outcome is through individualized resident assessment, and individualized plan of care development and implementation.

The Minnesota Department of Health conducts surveys and/or complaint investigations consistent with federal guidelines for the purpose of determining a facility's compliance with federal standards. This involves reviewing all components of resident care implemented by a nursing facility including implementation of individualized assessment, care planning and interventions.

Issuance of Federal Deficiencies Related to Outcome, Assessment and/or Care Planning Tags

MDH will approach issuing federal deficiencies related to outcome, assessment and/or care planning tags as follows:

The Minnesota Department of Health will identify deficient findings under assessment, care planning and outcome tags. If a related deficient practice is found under an assessment and/or care planning tag(s) AND an outcome tag, MDH will cite the

finding under the appropriate outcome tag and will NOT include that finding in an assessment and/or care planning deficiency.

MDH will continue to issue assessment and/or care planning tags for findings where an outcome tag is not issued.

Evaluation of Policy

MDH will evaluate outcome(s) of this policy change in October, 2004.

If you have any questions regarding this Information Bulletin, please contact in writing:

Minnesota Department of Health
Health Policy, Information and Compliance Monitoring Division
Licensing and Certification Program
85 East Seventh Place, Suite 300
PO Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 215-8701

This document can be made available in alternative formats upon request. Call (651) 215-8701 or contact The Direct Connect MN Relay Service (MRS): (651) 297-5353 or (800) 627-3529.

For questions about this page, please contact our Facility & Provider Compliance Division: fpc-web@health.state.mn.us

See also > Facility & Provider Compliance Home

Updated (none)

APPENDIX D.

ACTIONS TO PROMOTE INTEGRITY THROUGH CONSISTENT IMPLEMENTATION OF THE SURVEY PROCESS

FEDERAL INITIATIVES TO ASSURE INTEGRITY

C Numerous training sessions for surveyors on the various survey processes, including nursing facilities, ESRD, hospitals, hospices, rural health clinics, ICFs/MR, home health agencies, life safety code, and CLIA. These training sessions, many of which are mandatory, provide a consistent interpretation of the regulations and related survey processes for surveyors nationwide.

All state agency staff surveying nursing homes must complete the federal Basic Long Term Care Training course and pass the Surveyor Minimum Qualifications Test (SMQT). All of our survey staff, except for those who were recently hired and are still in orientation, have attended the Long Term Course and have successfully completed the SMQT.

In addition, all survey staff attended the federal Basic ICF/MR training in March, 2003 and will be attending the federal Home Health Agency training course in April 2004. State agency staff representatives usually attend the majority of these federally sponsored training programs, and any resulting new information and clarifications are then distributed to all survey staff for implementation. The majority of federal training courses also include representatives from the various provider organizations.

C The Federal Oversight/Support Survey (FOSS) is another element of CMS involvement in assuring consistent application of the survey process, specifically in Long Term Care. This process involves Federal surveyors monitoring and evaluating the State agencies on-site survey performance by accompanying the state surveyors and rating their performance in several measures, including such items as concern identification, investigation, and deficiency determination. Verbal and written feedback from these FOSS surveys are reviewed with all survey staff. We have had at 6 FOSS surveys conducted by the RO since June 2003, and 2 more are planned for the end of January 2004.

In addition, Federal Regional Office (RO) staff conduct Federal Monitoring Surveys (look behind surveys). These surveys are conducted by RO staff within 60 days of the state agency survey and results are compared and the SA performance is evaluated. In the ICFs/MR, federally contracted surveyors conduct comparative surveys usually within 30 days of the SA survey. We have had 6 ICF/MR comparative surveys conducted sine June 2003. Again, the results of these surveys are provided to all survey staff in order to assure consistent application of the regulations and survey processes.

C The Central Office of CMS in Baltimore identified several specific regulatory requirements which appeared to have less consistent interpretations by survey staff across the nation, and convened workgroups in early 2002 to develop current clinical guidance,

investigative protocols and provide direction for making severity determinations. These workgroup panels included clinical experts, Central and Regional Office survey staff, and representatives from various state agencies. The topic areas currently in various stages of development and review, include pressure ulcers, incontinence, medical directors, psychosocial harm, dietary etc. Three different staff from the Minnesota survey agency are actively involved in 4 different panels.

The pressure ulcer guidance is nearing completion, has gone out for public comment twice, and should be ready for dissemination to providers and surveyors in the near future. CMS is currently planning training formats, including scripted training sessions to assure all survey staff receive the same training. The guidance for the other regulatory areas should follow soon thereafter.

STATEWIDE INITIATIVES FOR SURVEY INTEGRITY

- In September 2003, the Licensing and Certification Program formalized a Quality Assurance/Improvement plan for FY 04. This formalized plan was the result of information from a variety of sources, including information gleaned during on-site surveys by supervisory staff, survey statistics, surveyor comments from the "We care to listen memo, FOSS/FMS results, GAO reports, and the MDH Commissioner's Advisory Stakeholder's group. These Statewide activities include the following:

  - **Onsite Mentoring and Coaching Surveys**

Each survey team in the state will have at least 5 different supervisors/apm's on-site during a nursing home survey in FY 04. This will allow opportunities to examine our variability, consistency, and assure integrity in the survey process and its implementation. The focus of these surveys will be on investigation of findings. The onsite supervisor will discuss the team observations and identify areas for review and forward those areas for clarification as needed. Areas of both consistency and variability will be evaluated. Clarifications will be provided to all staff. In addition, each supervisor is responsible for going onsite with their own team members throughout the year to monitor implementation of the survey process and evaluate staff performance. Clarifications related to consistent implementation of the survey process will also be posted on the intranet website.

Since June 2003, our supervisors/apm's have been present on approximately 28 surveys across the state with teams from districts other than their own.

  - **Deficiency Review**

A program wide activity to improve deficiency writing and review was conducted for all state surveyors during the October 2003 In service. Both L&C and OHFC staff were involved in this activity. In addition, deficiencies identifying actual

harm and any enforcement actions will continue to be reviewed by the supervisor and APM. The majority of these will also be sent to the CMS RO for review as per the SOM. Deficiencies issued at the supervisory coaching and mentoring surveys will be reviewed by both the on-site supervisor and the team supervisor. All of these review activities will provide opportunities to look at consistency and variability across both L&C and OHFC activities, and across the state. Any survey involving immediate jeopardy is sent to all district offices and reviewed by survey staff.

C **Supervisor meetings/weekly telephone conferences**

Face-to-face supervisor meetings will continue to be conducted on an approximately monthly basis to provide an opportunity for supervisors from all district offices to discuss survey findings, identify clarifications needed, share information regarding on-site coaching and mentoring surveys, review current status of workload and discuss and resolve issues involving variability in implementation of the survey process. Information from the supervisors meeting is then shared with each team during their monthly staffing and scheduling meetings.

Weekly telephone calls are scheduled for most Monday mornings. All supervisors, program assurance staff, support staff, the assistant program managers, and representatives from both OHFC and the fire Marshall's office are included. This call is used to coordinate and monitor the status of the workload, provide a forum for communication between all involved staff and share any clarifications and information. The results of the supervisor onsite coaching and mentoring surveys are discussed and reviewed. Clarifications are then distributed to the surveyors by their supervisor.

C **Statewide surveyor calls**

At least four times per year, a 2-3 hour statewide telephone call is conducted with all surveyors and supervisory staff. These calls are used to provide clinical updates, interpretive guidance and survey process clarifications. Information from the onsite supervisory surveys, the FOSS and FMS surveys, the ICF/MR comparative surveys and best practice deficiencies will be discussed and reviewed

C **Statewide surveyors**

We currently have 5 surveyors with expertise in health care disciplines including dietary, social services, medical records, and sanitation who survey with each team at least once per year. They interact with surveyors across the entire state and provide feedback on survey consistency and variability which is reviewed at supervisory meetings and any needed clarifications are shared with survey staff.

DISTRICT OFFICE INITIATIVES

- **Monthly staff meetings**

Each team conducts monthly staff meetings to share any new information, clarifications and updates. In addition, each team may have specific initiatives they are pursuing, such as peer review or deficiencies written in past month, results of FOSS surveys in-depth review of a specific survey package, review of the IJ and substandard quality of care deficiencies issued by all teams, and review deficiencies issued by other teams. The monthly staff meetings are a time for assessing variability and discussing any differences in survey process or deficiency determination which may have been identified across the state.

- **Mixed team surveys**

Each team has several surveys throughout the year where members of their own team work together with surveyors from other teams. This provides us with input to evaluate survey integrity and variability as we compare notes and discuss both similarities and differences. Any differences are then presented and discussed at monthly supervisor meetings. Clarifications resulting from these surveys are then disseminated to all staff via either team meetings, statewide telephone calls, and placed on our MDH Intranet website..

- **Supervisors on-site**

Supervisors spend time on-site with their own team, mentoring and evaluating surveyor performance. They are also able to identify any survey process variability with their own teams and provide direct feedback and clarifications to the surveyors, as well as share observations with supervisor group. Supervisors have been on-site with their own teams numerous times since June 2003, (approximately 30 times). In addition, the supervisors have the opportunity to interact and communicate directly with providers in their district. This interaction also helps build stronger relationships with the provider community.

How to Access MDH Reports

The following reports can be obtained by accessing the Internet at www.health.state.mn.us/ltc

- Minnesota Department of Health, Survey Findings/Review Subcommittee Final Report, July 2004

- Minnesota Department of Health, Communications for Survey Improvement (CSI-MN) Subcommittee Final Report, June 30, 2004

A copy of the Minnesota Department of Health Nursing Home Licensing and Certification Report prepared by the Management Analysis Division (MAD Report), June 30, 2004, can be obtained by contacting Grace Thorpe, of the MDH Health Policy Information and Compliance Monitoring Division, at (651) 215-8758.

PRIORITIES FOR IMPLEMENTATION OF THE MAD REPORT RECOMMENDATIONS

Stakeholders's Recommendations	**MDH Priorities / Tasks:**	**Coordinated With Whom**	**Action Taken To Date**	**Target Completion Date**
*** Develop consistent behavior protocol for facility and staff and surveyors to use during the survey process. Specific items to include are noted in the Communications for Survey Improvement Recommendations.** (communication group)	Nurse Specialist will convene a subgroup of the Stakeholders' Group and division staff to develop protocols and strategies for improving communications during the survey process.	Stakeholders' Group Subcommittee	• Created a Nurse Specialist position as a Provider Liaison and division point person for these activities. In process of scheduling interviews and have identified top candidates. • RO approved $25,000 of federal dollars to continue communication efforts.	May 2005

Stakeholders's Recommendations	MDH Priorities / Tasks:	Coordinated With Whom	Action Taken To Date	Target Completion Date
Develop a process to communicate survey findings in a user-friendly format. **Includes expansion of survey teams to include other types of professional disciplines in the survey process.** (communication group)	• Expand survey team to include other professional disciplines.		• Established statewide survey staff that includes 2 RN's, 2 OTs, 1PT, 1 Pharmacist and 1 Dietician. Negotiating for additional office space in St. Cloud for these statewide staff. Posting and advertising positions.	Jan. 2005
Develop broad-based methods for communicating survey results, related actions and other important information. (communication group)	• Post survey findings and other information on web. • Nurse Specialist with Stakeholders' Group will develop a quality assurance, educational approach to communicating survey results. The group will address regulatory myths.	Stakeholders' Group	• Survey findings and information posted on web. • Complaint investigation findings will be posted on the web.	3/1/04 10/11/04 May 2005

Stakeholders's Recommendations	**MDH Priorities / Tasks:**	**Coordinated With Whom**	**Action Taken To Date**	**Target Completion Date**
Enhance the plan of correction. Includes training to entire stakeholder group and various other items to be considered and completed. (data group)			• Issued Informational Bulletin 04-09: Federal SNF/NF Deficiencies Related to Outcome, Assessment and/or Care Planning Findings Effective Date – June 21, 2004	June 21, 2004
			• Updated Information Bulletin 95-02: Developing Written Plans Of Correction	Aug., 2004
	• Prepare an analysis of deficiencies for July, August, and Sept.2004. Analysis will identify whether the number of def's. have stayed the same, increased, decreased, etc. under the new Information Bulletin 04-9.	Stakeholders' Data Group Stratis Health		Nov. 2004
	• MDH will convene meetings with Stakeholders' Group and Stratis Health to identify deficiency root-cause analysis, plan of correction process and quality assurance strategies for all deficiencies including those that relate to Information Bulletin 04-9.	Subgroup of Stakeholders' Group Stratis Health		Needs Discussion

Stakeholders's Recommendations	**MDH Priorities / Tasks:**	**Coordinated With Whom**	**Action Taken To Date**	**Target Completion Date**
**** Develop a "profile" to review and correlate deficiencies, complaints and enforcement. Includes suggested MDH and CMS actions**. (data group)	• Develop nursing home profiles.	Stakeholders' Group and Stratis Health	• MDH is in the process of securing research staff to assist in developing nursing home profiles. Staff will work in coordination with Stratis Health and the Stakeholders' Group	Nov. 2004 July 2005
***** Continue the advisory group. Composition could change but should retain all presently represented stakeholders.** (data group)	• Continue the advisory group.	Stakeholders' Group	• MDH Commissioner concurs with the recommendation to continue the advisory group. Members of the advisory group were asked to identify replacements or state whether they themselves wanted to continue and report back by next meeting. Review membership composition including adding residents to the group.	Jan. 2005
MDH should approach its nursing home and long-term care responsibilities from its broad public health mission. Specifically, MDH should:	• Prior to proceeding, MDH would like to incorporate the feedback from the Legislative Auditor's Report and the MAD Report Recommendations.	Stakeholders' Group		Dec. 2004

Stakeholders's Recommendations	**MDH Priorities / Tasks:**	**Coordinated With Whom**	**Action Taken To Date**	**Target Completion Date**
- develop and broadly communicate a clear statement of the values and principles that will guide its survey and other work in long term care. **- use its scientific research and analytical ability to assess long-term care needs and system capabilities** **- the Dept. should also use its assessment information to guide policy so that resources can be focused where they can have the greatest impact on long term care** (MAD report)	MDH has incorporated this recommendation with the communications/behavior recommendation above (see *). MDH has incorporated this recommendation with the "profile" recommendation above (see **). • MDH will convene meetings with the Stakeholders' Group and Stratis Health to discuss LTC policy. Information from these meetings will be shared with the DHS LTC Committee.	Stakeholders' Group, DHS		
Continue to convene the Ad Hoc Committee to advise the dept on matters pertaining to the survey process. Defines potential duties of the Committee. (MAD report)	Same as continue the advisory group recommendation above (see ***).			

Stakeholders's Recommendations	MDH Priorities / Tasks:	Coordinated With Whom	Action Taken To Date	Target Completion Date
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. Suggested specific things MDH should work in partnership with stakeholders on such as:	• Nurse Specialist will coordinate meetings with the Stakeholders' Group on developing and maintaining positive relationships.	Stakeholders' Group		July 2005
-hold regional mtgs. to discuss findings and recommendation of the communications subcommittee.	• Nurse Specialist will participate in Regional Meetings.	Stakeholders' Group		
-conduct joint training for surveyors and stakeholders on the survey process.	• Training will be jointly identified and MDH and providers will provide support for at least 4 provider training events per year. Plan for the next 12 months will be developed by Feb. 2005 Stakeholders' mtg.	Stakeholders' Group		Feb. 2005
-continue to promote active family and resident involvement in the survey process	• Promote the establishment of Family Councils		• Convened a Stakeholder workgroup. Family Council Bulletin issued 7/20/04. • Reconvene Stakeholder workgroup to evaluate progress to-date.	7/2004 Jan. 2005

Stakeholders's Recommendations	**MDH Priorities / Tasks:**	**Coordinated With Whom**	**Action Taken To Date**	**Target Completion Date**
- implement the recommendations regarding the establishment and use of consistent communication and behavioral protocols by both surveyors and staff in the survey process **- create a NH surveyor set of values and principles** (MAD report)	Same as the communications/behavior recommendations above (see *) Same as the communications/behavior recommendations mentioned above (see *).			
Develop and implement external reviews of deficiencies, to promote greater confidence that deficiencies indicate a problem that will likely have serious impact on the resident. (MAD report)	• This item needs further discussion.			
Establish a quality assurance and improvement coordinator position. Includes primary responsibilities of the position (MAD report)	Same as Nurse Specialist position identified in communications/behavior recommendation above (see*).			

Stakeholders's Recommendations	**MDH Priorities / Tasks:**	**Coordinated With Whom**	**Action Taken To Date**	**Target Completion Date**
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. Additional comments on "cross referencing and clarify and verify) (MAD report)	• L& C Managers and supervisors will work as a statewide team to administer the CMS programs as a statewide program consistently.		• MDH L&C Supervisors met 9/13-15/04 to clarify roles, responsibilities, authority, etc.. They identified areas to streamline to provide supervisors time to accomplish priority tasks (eg. Implementation of federal data base (AEM) allowed them to shift the drafting of NH enforcement letters from supervisors to LC staff. Scheduling and time keeping systems will be reviewed next). Additional follow-up needed.	On-going
	• Foster productive communications as a group of supervisors.		• Identified internally that there were problems with Clarify and Verify. Addressed issues with supervisors. Additional follow-up needed. Process needs to be evaluated and fine-tuned.	On-going
			• Developed recruitment and retention plan for management and supervisory staff and identified a need for 2 additional FTE's. Secured federal dollars for these positions as MDH will experience a 70% turnover within the next few years. In the process of filling positions.	Jan. 2005

Stakeholders's Recommendations	MDH Priorities / Tasks:	Coordinated With Whom	Action Taken To Date	Target Completion Date
Implement routine reviews of deficiency data as part of the monthly district office supervisor meetings. Specifically develop criteria for evaluating summary deficiency data and develop other measures relating to survey inconsistency, by district. (MAD report)	• Develop reports for supervisors and evaluate survey data.		• Research staff will develop reports for supervisors, and assist in evaluating data related to survey inconsistency. In process of securing research staff to support this activity.	Dec 2004

Minnesota Department of Health
Protecting, maintaining and improving the health of all Minnesotans

July, 2004

Information Bulletin 04-14
NH-105
BCH-24

Family Council/Groups

Purpose:

The purpose of this bulletin is to communicate information about:

- The involvement of family councils/groups in nursing homes and boarding care homes as outlined in state and federal requirements;
- The obligation of nursing homes and boarding care homes to establish resident and family councils; and
- The involvement of family council/groups in the nursing home survey process.

Because state and federal requirements address together in the same regulatory grouping both family groups and resident groups, both are included in this document.

This information bulletin applies to federal and state licensure requirements.

Obligation of Nursing Facilities to Establish Family Councils

Nursing facilities are required to make attempts to establish resident and family councils. This is reviewed during the nursing home licensure survey process.

Minnesota Statutes 144A.10 subdivision 8b states:

Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. A nursing home or boarding care home that is issued a notice of noncompliance with a correction order for violation of this subdivision shall be assessed a civil fine of $100 for each day of noncompliance.

Family Council/Group Involvement

Both federal and state requirements address the rights of residents and families to organize councils or groups and responsibilities of nursing facilities:

Minnesota Statutes 144.651 subdivision 27 under the patients and residents of health care facilities bill of rights states:

Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.

Federal Nursing Home regulations under CFR 483.15 states:

CFR 483.15(c) Participation in Resident and Family Groups: (1) A resident has the right to organize and participate in resident groups in the facility; (2) A resident's family has the right to meet in the facility with the families of other residents in the facility; (3) The facility must provide a resident or family group, if one exists, with private space; (4) Staff or visitors may attend meetings at the group's invitation; (5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;

CFR483.15(c)(6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

Resident and Family Advisory Council Education

Minnesota Statutes 144A.33 Subdivision 1 addresses resident and family advisory council education. In Minnesota this is implemented by the ElderCare Rights Alliance under contract with The Minnesota Board on Aging and administered by The Ombudsman for Older Minnesotans.

Educational program. Each resident and family council authorized under section 144.651 , subdivision 27, shall be educated and informed about the following: (1) care in the nursing home or board and care home; (2) resident rights and responsibilities;(3) resident and family council organization and maintenance;(4) laws and rules that apply to homes and residents;(5) human relations; and (6) resident and family self-help methods to increase quality of care and quality of life in a nursing home or board and care home.

Effective August 1, 2004: Family Council/Group Involvement in Nursing Home Survey Process

Minnesota Law, effective August 1, 2004, requires that nursing facility family councils be interviewed as part of the nursing home survey process and be invited to the exit conference.

Minnesota Statutes 144A.101 Subdivision 6 states: *Nursing facility family councils shall be interviewed as part of the survey process and invited to participate in the exit conference.*

Attached to this information bulletin is the Family Council/Group Interview tool. Effective August 1, 2004, Minnesota Department of Health (MDH) staff will use this tool during the nursing home survey process to interview members of the family council/group. Comments for improvement with this are welcome and will be evaluated.

Family Council/Group Resources:

Family members may have further questions or comments about participation in family groups. Below are resources:

- Your Nursing Home. MDH directory of providers includes nursing homes and may be accessed via MDH website at: http://www.health.state.mn.us/divs/fpc/directory/fpcdir.html ;
- Office of Ombudsman for Older Minnesotans at: http://www.health.state.mn.us/divs/fpc/consumerinfo/ombuds.htm ;
- ElderCare Rights Alliance at: www.eldercarerights.org .

If you have any questions regarding this Information Bulletin, please contact in writing:

Minnesota Department of Health
Facility and Provider Compliance Division
Licensing and Certification Program
85 East Seventh Place, Suite 300
PO Box 64900, St. Paul, Minnesota 55164-0900
Telephone: (651) 215-8701

This document can be made available in alternative formats upon request. Call (651) 215-8701 or contact The Direct Connect MN Relay Service (MRS): (651) 297-5353 or (800) 627-3529

For questions about this page, please contact our Facility & Provider Compliance Division: fpc-web@health.state.mn.us

See also > Facility & Provider Compliance Home

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Comments and Questions | Phone Number, Address and Directions | Privacy Statement and Disclaimer

Updated (none)

APPENDIX H.

TECHNOLOGICAL INNOVATIONS TO ASSIST PROVIDERS

- **Development of a Clinical Web Window**

A Clinical Web Window was developed and placed on the Web February 9, 2004. The "Window" provides an easily accessible place where clinical issues can be presented on a regular basis. MDH hopes that this will contribute to high quality care in the Long Term Care (LTC) continuum, and will provide a forum for discussion of the regulatory approach to clinical issues, and when possible, alert practitioners to clinical issues that may receive increased attention during surveys. Contributors to this website will include MDH staff, and when available or needed, practitioners with special interest or expertise.

- **Nursing Assistant Registry Updates Via the Web**

This project was designed to allow access to the Nursing Assistant Registry (NAR) by providers in order to update the NAR information on-line, as opposed to being sent the information in paper form for hand editing. The project was completed July 8, 2004, and providers can now verify that a NA is on the registry via the web.

- **Training Videos on Internet**

MDH is currently, testing the ability to provide short videos on the Internet. MDH hopes that by providing short videos on the web, it will minimize the cost and time involved in making copies, mailing videos, etc. to all providers. The first pilot project was to include placing the video titled "The Federal Nursing Home Survey Process - The Role of the Nursing Assistant" on the Web. However, when it became clear that the video was too lengthy to put on the Web, MDH decided to send DVD's and VHS copies to administrators and training site coordinators in all nursing homes and board and care homes in Minnesota. This experience not withstanding, MDH anticipates that the Internet will prove to be an efficient and effective vehicle for the distribution of training videos in the future.

- **L&C Facility Questionnaire Via the Web**

A questionnaire was developed which allows providers to comment on the survey process. An internal work group developed a draft questionnaire first for comment. Once the form was finalized, it was distributed to the facility administrator during the survey process. As feedback was minimal, survey supervisors began conducting follow-up calls to the facility administrator for feedback on the survey process. MDH reviews these questionnaires and acts upon pertinent information. A summary of comments is currently being compiled.

Approximately 350 nursing home survey responses were reviewed for this legislative report. Most respondents indicated that the most recent survey was positive, a learning process, and that surveyors were knowledgeable, approachable, and professional in their interactions with staff and residents. There were some comments about staff feeling overwhelmed and intimidated by the survey process. A few respondents expressed concerns regarding deficiencies issued, and some noted that they believed the survey process was "non-forgiving." Respondents indicated that they felt they could contact the MDH if they had concerns, and most indicated in their response that they had no concerns with their most recent survey. If concerns are

noted, the supervisor speaks with the surveyors involved to resolve the concerns. Overall, the majority of comments indicated that communication between surveyors and staff has improved, and that surveyors were non-threatening and performed a thorough job.

- **Expanded Information About Nursing Home Surveys and Complaint Investigations Now Available on the Web**

MDH began placing expanded information about nursing home surveys on the Web on March 1, 2004. Form #2567 which includes the deficiency information and the facilities Plan of Correction (POC) is posted on this website for all facilities that have been surveyed since October 2002.

In addition to survey information on the Web, MDH placed the complaint investigation reports on the web on October 13, 2004. The complaints reports are for nursing homes, board and care homes, home care providers, home health agencies, hospice facilities and services, hospitals, facilities that offer housing with services, and supervised living facilities. Reports posted on the site date back to January 2003. The Web site allows the user to search for complaint information by date, provider type, provider name, and the county or city where the provider is located. The site includes information for both substantiated and unsubstantiated complaints, as well as cases where the complaint investigation was inconclusive. Information available on the site also includes the number of complaints filed against a provider, as well as the documentation developed in support of investigative findings.

- **Facility Licensure/Registration Renewals Via the Web**

MDH has developed a pilot project for Housing With Services providers as they submit a registration for their annual renewal. There is not a federal certification component with this group of providers and they will complete their annual renewal via the web. However, payments will still need to be mailed to MDH. This project will be expanded as MDH gains experience with each provider group.

- **Case Mix Facility Options Via the Web**

Facilities will be able to designate whether they or Case Mix Review will print the Case Mix determination letters. These resident letters indicate the case mix classification that will be used for payment of the nursing home case received. This feature was implemented effective July 1, 2004.

- **671/672 Forms on the Web**

Instead of providers trying to complete these forms (facility staffing and resident census) manually during the on-site survey, they will be given a web site so that this data can be entered. The site will have the necessary edit checks to ensure the information is accurate. Currently, extensive follow-up is required by L&C staff with facility staff to ensure the information is accurate. This step will be eliminated and providers will have more time to enter the information. Note: Extended October 1, 2004 implementation date to obtain additional provider feedback and evaluation. System was implemented on November 1, 2004 and providers are continuing to give MDH comments. The system is being enhanced as comments are received.