Annual Quality Improvement Report on the Nursing Home Survey Process

Report to the Minnesota Legislature

Minnesota Department of Health

Federal Fiscal Year 2007
Released April 2008

MINNESOTA MDH DEPARTMENT OF HEALTH

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Executive Summary

The Minnesota Department of Health (MDH) Division of Compliance Monitoring, Licensing and Certification Program licenses and inspects hospitals, nursing homes and other health care providers. MDH also certifies health care facilities and other providers who take part in the federal Medicare and Medicaid programs, as part of a federally funded process known as "survey and certification." MDH employs surveyors who perform annual certification inspections known as "surveys" to evaluate the degree to which nursing homes that are Medicare and/or Medicaid certified are in compliance with a detailed set of federal regulations known as the "Conditions of Participation." These regulations also require nursing homes to comply with applicable state and local laws. When surveyors find a nursing home practice that is out of compliance with a federal regulatory requirement, the survey team issues a "deficiency" and the nursing home then is required to correct the practice to come into compliance with regulatory requirements.

This is the fourth Annual Quality Improvement Report on the Nursing Home Survey Process. Previous reports which explain the Minnesota Department of Health's licensing and certification process for nursing homes and activities undertaken during the last five years to improve the accuracy and consistency of the survey process can be found on the Department's website (See Appendix E for a link to the 2004, 2005 and 2006 Report).

This report describes activities initiated during the past year, focusing on the Federal Fiscal Year (FFY) 2007, which ran from 10-1-06 through 9-30-07.

As noted in last year's Legislative Report, the following three special focus areas were identified as areas for continuing improvements in the nursing home survey process during FFY 2007:

A. Monitor and Evaluate the Revised Post Certification Revisit Process. MDH has been monitoring the on-site follow up inspection patterns for randomly selected providers to determine the effectiveness of the new policy in maintaining compliance with federal and state resident nursing home health and safety requirements. Data to date shows that providers selected for the random on-site PCR inspection appear to be correcting citations at nearly the same rate as the year prior to the implementation of the follow-up policy. MDH is also looking at complaint data to see if complaint substantiation patterns are different between providers selected for random on-site inspections and those not receiving on-site follow-up. Data to date shows that the complaint substantiation rate for random by Plan of Correction (POC) for providers is 4.5% higher than the random on-site inspection group. MDH will continue to review substantiation rates.

B. Culture Change. MDH continued to be an active member of the Culture Change Coalition and helped provide educational opportunities on resident –centered care for surveyors, providers, consumers and policy makers. In August of 2007, Pioneer Network, a national not-for-profit organization that serves the culture change movement, held their national conference in Minnesota. MDH will continue to

promote culture change and offer joint training on innovations in culture change and regulatory compliance.

C. Continue Efforts to Improve Consistency. MDH continued to track and analyze survey team performance across the state, discuss results with L&C management, and develop plans to reduce variations. Training and guidance tools were also developed and offered to surveyors and providers on revised CMS guidelines issued in 2007, and new protocols were implemented. A major focus of the L&C Program this year has been planning for the implementation of the revised federal survey process or Quality Indicator Survey process (QIS). MDH was the first state, beyond the six demonstration states, that was chosen by CMS to expand QIS statewide. The Department has been working with stakeholders on plans for this three year roll–out of QIS in Minnesota. Plans include communicating with providers and stakeholders on QIS implementation, training groups of surveyors, conducting mock surveys, and implementing QIS on a regional basis. The Department anticipates that within three years, all surveyors will have been trained in QIS and the QIS process will be the only annual nursing facility survey process used in Minnesota.

This report also contains information on: compliance with time lines for delivering statements of deficiencies and for completing revisits after a nursing home has implemented corrective actions; and the independent dispute resolution process.

During 2008, the Department's primary focus will be the implementation of QIS. As mentioned above, this will be done over a three year period of time. This will include training of additional survey staff, implementing QIS in other regions of the state, analyzing survey process variations and developing a plan to reduce variations, and holding discussions with stakeholders on the best way to use the broad set of data that will now be available through the QIS process. Additionally, the Department will be working with stakeholders to examine state survey regulations and practices that are not currently part of QIS and determine how they will continue to be met. In the near future, CMS plans to release QIS protocols for complaint investigations, and MDH will need to discuss and develop plans for the roll-out of that protocol as well.

Introduction

This report fulfills the legislative requirement for providing an annual nursing home survey and certification quality improvement report. A copy of Minnesota Session Laws 2004, Chapter 247 which requires this report submission is attached as Appendix A.

The nursing home survey and certification program is a federal regulatory program funded by the Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services. CMS contracts with each state to administer the survey and certification program. This report is the fourth annual report on the nursing home survey process, and is based on analysis of data representing status of the program during Federal Fiscal Year (FFY) 2007, which ran from October 1, 2006 through September 30, 2007.[1]

The report is organized into three parts. Part I provides the data and other information required to be included in the annual report. Part II includes a summary of some of the activities implemented to improve the nursing home survey process. Part III identifies areas that MDH intends to focus on in the future.

[1] As noted, in a few instances, the report contains data outside of this reporting period.

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 CMS 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 Centers for Medicare and Medicaid Services (CMS) Online Survey Certification and Reporting System (OSCAR), a federal database of federal survey data, and Paradise, a state database of state and federal survey data. Tables identify data from the most recent nursing home survey in the database.[2]

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 federal regulations, which are contained in 42 Code of

[2] Data from each survey is entered into the OSCAR database following completion of the survey. The time required for data entry creates a time lag between completion of the survey and data entering the OSCAR database of approximately 45 days.

Federal Regulations (CFR) 483.1 to 483.75. These regulations also require nursing homes to comply with applicable state and local laws. When surveyors find a nursing home practice that is out of compliance with a federal regulatory requirement, the survey team issues a "deficiency" and the nursing home is then required to correct the practice to come into compliance with regulatory requirements. The Statement of Deficiencies, which includes all findings of noncompliance, is written on Federal Form Number CMS 2567 (2567). The 2567 statement identifies each area of noncompliance by referencing a specific deficiency ("tag") number.

Health tags have the prefix F (e.g., F-309). The tag numbers are contained in the nursing home regulations issued by CMS. The 2567 restates the regulatory language and specifies the survey findings that support the regulation not in compliance.

The federal health regulations cover 15 major areas including resident rights, quality of life, quality of care, and physical environment. The 2567 also identifies the scope and severity of the deficient practice. CMS has developed a scope and severity grid which allows for the classification of deficiencies based on the extensiveness of the deficient practice and the degree of harm presented to residents. Scope ranges from isolated findings to widespread findings of a deficient practice. Severity ranges from finding there is a potential for minimal harm if the deficient practice is not corrected, to findings of immediate jeopardy to resident health or safety. The CMS Scope and Severity Matrix is attached as Appendix B. The grid identifies 12 levels, labeled A through L, of deficiencies based on a combination of scope and severity score for a deficient practice.

MDH is required to follow the survey process and survey protocols issued by CMS.[3] These provisions are detailed and address specific procedures that must be completed during each survey, including: entrance interview, selection of resident sample for review, interviews with residents, facility staff, and family members, observations of care received by residents, medical record reviews and more detailed observations of the facility environment. Survey team members also review facility records, policies and procedures and other data. Included in the protocols are interpretive guidelines that serve as, and also provide surveyors with, specific survey protocols such as investigative protocols, definitions of regulatory terms, and interview probes that surveyors can use during surveys to evaluate compliance with regulations.

Once the survey is complete, MDH holds an exit conference with the nursing home to review preliminary findings and provide them with draft statements of deficiencies. A final 2567 is prepared and sent after the supervisory review is complete.

Deficiency Citations[4]

Variation between the states has been identified in the past and has been the subject of reports from the Government Accountability Office and the Office of the Inspector General of the federal Department of Health and Human Services. CMS has been reviewing this issue and has

[3] Survey protocols are in Appendix PP of the CMS State Operations Manual. See Appendix C of this report for links to Federal regulations, manuals, and program transmittals.
[4] This analysis and discussion is based only on health survey tags. An additional set of regulations, the Life Safety Code, is discussed later in the report.

identified 12 tags that had significant variation among states. CMS has revised clinical guidance, investigative protocols and interpretive guidelines for several of these identified tags and others are in progress. As new guidelines are issued, MDH works with their collaborative joint training group to develop training and guidance tools for surveyors and facility staff on these revised guidelines and implement new protocols. MDH's activities on CMS guidelines issued in 2007 are discussed in Section II of this report.

Minnesota Compared to National Data and Region V in Deficiency Citations

For the "current survey cycle"[5] ending on 10/25/07, Minnesota's average deficiencies per health survey was 9.9. The average deficiencies per health survey for all states in Region V was 6.1.

Table I, A-1: Average Deficiencies Per Health Survey, CMS Region V Current Survey Federal Oscar Data System, 10/25/07

State	Surveys	Tags from Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Illinois	824	4,118	5.0	3.0
Indiana	513	3,857	7.5	7.0
Michigan	425	3,569	8.4	8.0
Minnesota	394	3,898	9.9	9.0
Ohio	1,088	4,938	4.5	3.0
Wisconsin	396	1,777	4.5	4.0
Total	3,640	22,157	6.1	5.0

The national average deficiencies per health survey was 7.0 and Minnesota ranked ninth. A table of average number of health deficiencies per survey for the U.S. is attached as Appendix D. The Department continues to monitor the average deficiencies issued per health survey by MDH in comparison with other states. Between 2006 and 2007, the average number of citations issued per survey in Minnesota, CMS Region V, and nationally have all increased. The national average increased the most, by .5 deficiencies per survey.

Minnesota Compared to Region V in Scope and Severity of Deficiency Citations

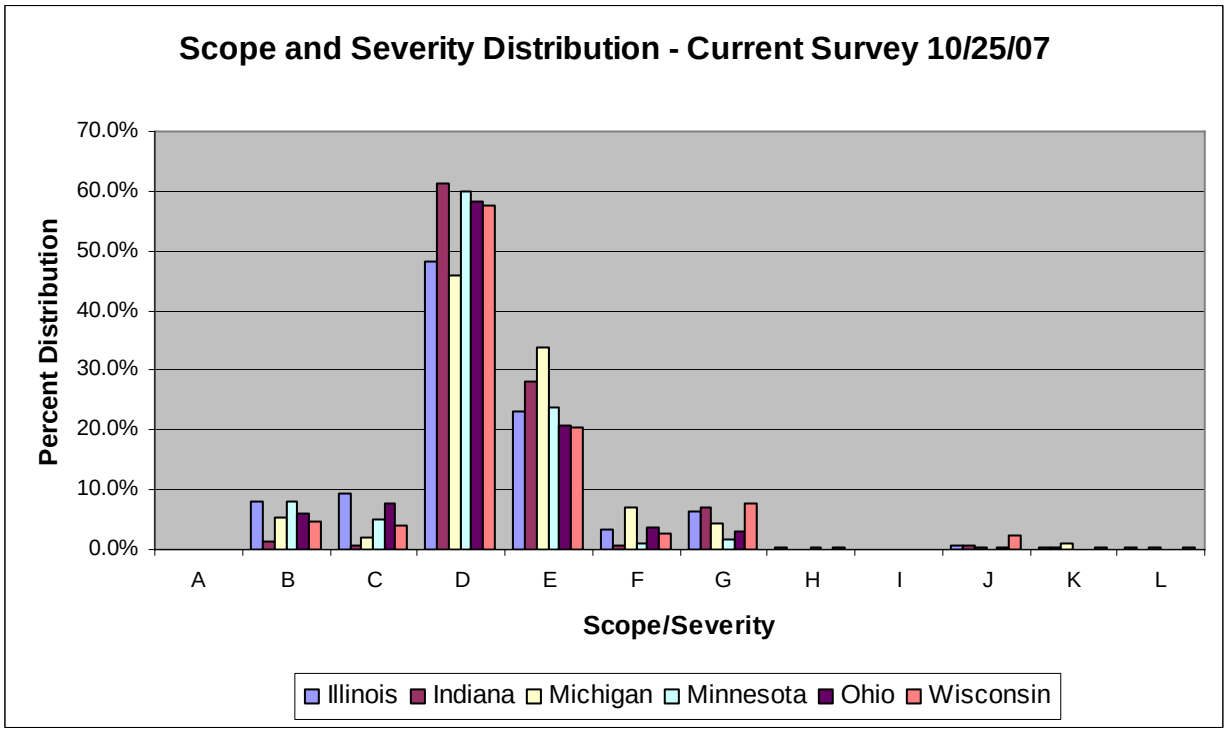
In Minnesota, the greatest number and percent of tags issued continue to be at scope and severity levels D and E, comparable to other states in Region V. Minnesota had fewer tags written at scope and severity G and above, compared to other states in Region V. Overall, the numbers of tags written at the most serious levels are small, compared to lower level tags in all states in Region V.

[5] "Current Survey Cycle" includes the most recent survey of each facility.

Table I, A-2: Number of Tags Issued in Each Scope and Severity, CMS Region V Current Survey, Federal OSCAR Data System, 10/25/07

State	A	B	C	D	E	F	G	H	I	J	K	L	Total
Illinois	0	326	391	1,981	946	141	264	11	1	30	16	11	4,118
Indiana	0	53	23	2,368	1,086	20	271	3	0	21	12	0	3,857
Michigan	0	197	75	1,635	1,205	248	151	5	1	12	31	9	3,569
Minnesota	0	311	194	2,340	931	39	70	12	0	1	0	0	3,898
Ohio	0	301	380	2,878	1,033	187	146	3	0	9	1	0	4,938
Wisconsin	0	81	69	1,024	366	46	135	7	0	39	6	4	1,777
Total	0	1,269	1,132	12,226	5,567	681	1,037	41	2	112	66	24	22,157

Graph I, 1: Scope and Severity Distribution Current Survey 10/25/07



It is significant to note that although maximum total deficiencies are higher than other states in Region V, they are similar to those states in that the vast majority of tags issued are at the D&E scope and severity level (60% were at D and 24% were at E).

Variation of Deficiency Citations within Survey Districts in Minnesota

Minnesota's survey teams work out of seven district offices, with four metro teams housed in one of them and two teams working out of the St. Cloud district office. One of the teams

working out of St. Cloud is a statewide team that surveys ongoing as a "mix max"[6]. MDH has looked at the average number of deficiencies issued by survey team on a monthly basis since FFY 2005, and shares this information with nursing home provider organizations. MDH also analyzes the median number of deficiencies by survey team on a monthly basis. Monthly reports also compare the average and median numbers of deficiencies issued by "Mix/Max" teams.

Since FFY 2004, MDH has undertaken a number of initiatives to address variation in deficiency citations between survey districts. These initiatives are described in previous Reports to the Legislature (See Appendix E for a link to the 2004, 2005 and 2006 Report). Continuation of these activities and development of additional initiatives to address the issue of consistency of the survey process are discussed later in this report.

One of the goals listed in the survey programs Quality Improvement Plan is to analyze variations and develop methods to reduce variations of +/- 2 from the statewide median by using a Plan Do Study Act (PDSA)[7] approach to quality improvement. See Appendix F for the 2008 Quality Improvement Plan for Survey Agency.

For data reported in 2006 and 2007, "current survey cycles", two districts were outside (above) the target range in 2006 (Table I, A-3) and two districts were outside (above) the target range in 2007 (Table I, A-4). It is important to note that in 2006, districts marked Statewide Team and Mix/Max were not included in calculating the mean and median, due to the small number of surveys performed. In 2007, the Statewide Team was not included for the same reason.

Table I, A-3: Average and Median Deficiencies Per Health Survey, Minnesota Survey Districts, 10/1/05 through 9/30/06, MDH Paradise Data System, 10-01-06

State	Surveys	Tags from Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Bemidji	42	409	9.7	9.0
Duluth	37	444	12.0	11.0
Fergus Falls	41	356	8.7	8.0
Mankato	65	490	7.5	7.0
Metro A	33	311	9.4	10.0
Metro B	24	282	11.8	12.0
Metro C	32	333	10.4	9.0
Metro D	31	320	10.3	9.0
Rochester	41	482	11.8	12.0
St Cloud	37	335	9.1	9.0
Statewide Team	6	68	11.3	11.5
Mix/Max	12	158	13.2	13.0
Total	401	3,988	9.9	9.0

[6] "Mix/Max" or mixed teams are teams that have approximately half the survey team from each of two survey teams.

[7] Plan- Do- Study- Act or PSDA is a model of continuous quality improvement. It guides organizations through the steps of information gathering and analysis to identify opportunities for improvement; planning an improvement; doing the improvement; studying the results with additional and ongoing data collection and analysis; acting on the results of the additional data collection to maintain, modify, or change the improvement.

Table I, A-4: Average and Median Deficiencies Per Health Survey, Minnesota Survey Districts, 10/1/06 through 9/30/07, MDH Paradise Data System, 10/01/07

State	Surveys	Tags from Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Bemidji	39	357	9.2	8.0
Duluth	34	395	11.6	11.0
Fergus Falls	35	318	9.1	8.0
Mankato	68	582	8.6	8.0
Metro A	29	288	9.9	8.0
Metro B	24	309	12.9	13.0
Metro C	27	215	8.0	7.0
Metro D	22	263	12.0	11.0
Rochester	34	408	12.0	12.0
St Cloud	44	404	9.2	9.0
Statewide Team	6	75	12.5	14.0
Mix/Max	33	398	12.1	11.0
Total	395	4,012	10.2	9.0

Data in Tables A-4 and A-5 (above) reflect a 3% increase in average number of deficiencies and no change in median number of deficiencies statewide from FFY 2006 through FFY 2007. The 2005 to 2006 report years depicted a 23.8% increase in average deficiencies per survey. The year to year fluctuation in mean and median seen over the past several years has appeared to have subsided. Both the average number of deficiencies and the average median has remained fairly stable between 2006 and 2007. MDH staff believe the reason for the fluctuations between 2005 and 2006 was due in part to the change in the "cross-referencing" policy which will be discussed in Section I. B of this report. In addition, last year's report indicated some of the fluctuation between 2005 and 2006 could also have been due, in part, to the increase in pressure ulcer and urinary incontinence deficiency tags. CMS issued revised guidelines and MDH conducted training and began surveying under the new guidelines in May, 2005. Those guidelines have now been fully implemented and the process appears to have stabilized.

The range in citation variance between the high and low survey district averages has continued to remain fairly constant over the past year. In FFY 2006, the district mean citations issued ranged from a low of 7.5 and high of 12.0. In FFY 2007, the district mean range was a low of 8.0 and a high of 12.9. This reflected a .2 decrease in the range between the highest citing district and the lowest citing district.

The range in citation variance between the high and low survey district median has increased over the past year. In FFY 2006 the district median citations ranged from a low of 7.0 and high of 12.0. The current district median range is a low of 7 and high of 13. This reflects a one deficiency increase in the range between the highest citing district and the lowest citing district. MDH will continue to review both survey team average and median as a measure to monitor survey process variance.

Prior to 2006, the Duluth district has been uniquely identified as the highest deficiency citing district in the state. Currently, Duluth, Metro B, Metro D, and Rochester districts along with Mix/Max teams have average citation patterns near 12 to 13 average deficiencies per survey. MDH continues to conduct monthly review of variabilities and evaluate where there are differences in teams.

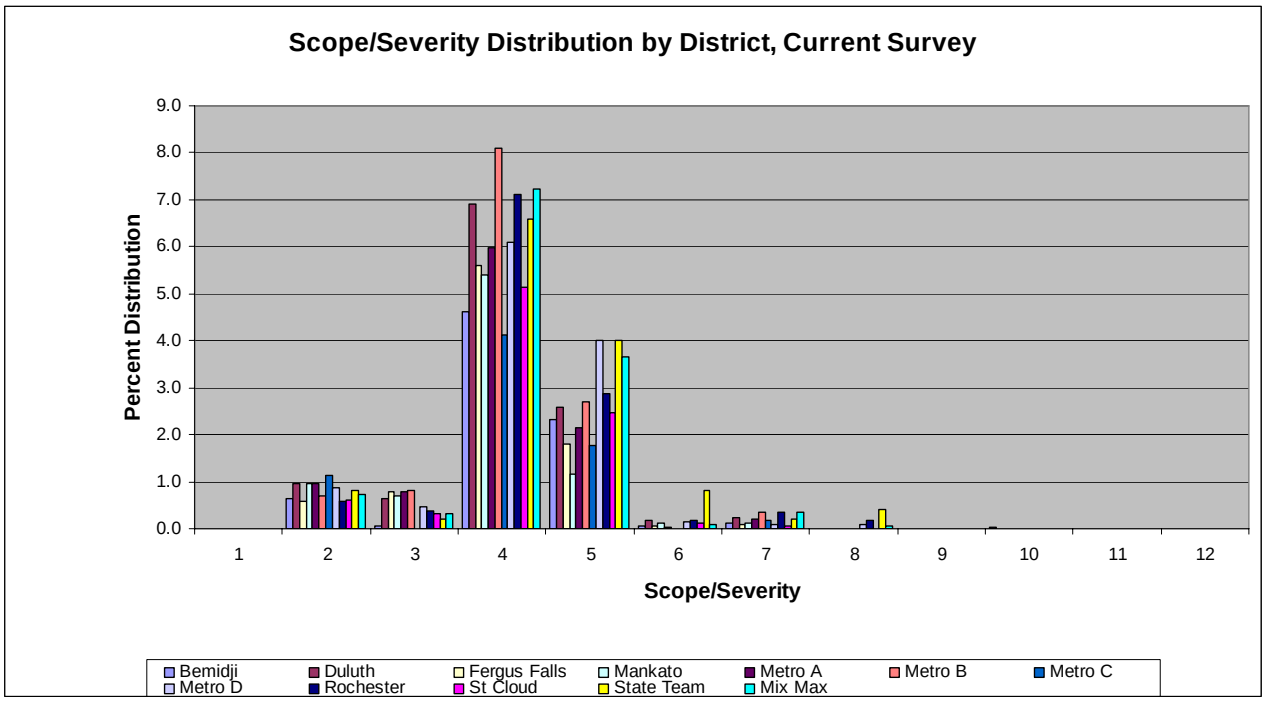
Scope and Severity of Deficiency Citations within Minnesota Survey Districts

Statewide, approximately 83.9% of health deficiencies cited are of D and E scope and severity. This indicates no actual harm with a potential for more than minimal harm that is not immediate jeopardy. This scope and severity pattern is fairly consistent with past years. As the number of citations increases, there tends to be a greater rate at which D and E level deficiencies are cited. Rates for scope and severity citations G and above are very consistent with last year's rate. Deficiencies with a scope and severity level of G or above constitute only 2.1% of deficiencies written statewide. This is only a .1% difference from last year (2.0%). The range of deficiency citations at a level G, range from a low of .8% in Metro B to 3.0% in Rochester.

Table I, A-5: Minnesota Survey Districts, Average Tags per Survey in Each Scope and Severity Current survey, Federal OSCAR Data System, 10/25/07

District	Surveys	A	B	C	D	E	F	G	H	I	J	K	L	Total
Bemidji	36	0.0	0.6	0.1	4.6	2.3	0.1	0.1	0.0	0.0	0.0	0.0	0.0	7.8
Duluth	36	0.0	0.9	0.6	6.9	2.6	0.2	0.2	0.0	0.0	0.0	0.0	0.0	11.5
Fergus Falls	37	0.0	0.6	0.8	5.6	1.8	0.1	0.1	0.0	0.0	0.0	0.0	0.0	8.9
Mankato	68	0.0	1.0	0.7	5.4	1.2	0.1	0.1	0.0	0.0	0.0	0.0	0.0	8.4
Metro A	31	0.0	1.0	0.8	6.0	2.2	0.0	0.2	0.0	0.0	0.0	0.0	0.0	10.1
Metro B	23	0.0	0.7	0.8	8.1	2.7	0.0	0.3	0.0	0.0	0.0	0.0	0.0	12.7
Metro C	25	0.0	1.1	0.0	4.1	1.8	0.0	0.2	0.0	0.0	0.0	0.0	0.0	7.2
Metro D	22	0.0	0.9	0.5	6.1	4.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	11.7
Rochester	37	0.0	0.6	0.4	7.1	2.9	0.2	0.4	0.2	0.0	0.0	0.0	0.0	11.6
St Cloud	42	0.0	0.6	0.3	5.1	2.5	0.1	0.1	0.0	0.0	0.0	0.0	0.0	8.8
State Team	5	0.0	0.8	0.2	6.6	4.0	0.8	0.2	0.4	0.0	0.0	0.0	0.0	13.0
Mix Max	32	0.0	0.7	0.3	7.2	3.7	0.1	0.3	0.1	0.0	0.0	0.0	0.0	12.4
Total	394	0.0	0.8	0.5	5.9	2.4	0.1	0.2	0.0	0.0	0.0	0.0	0.0	9.9

Graph I, 2 - Federal OSCAR Data System, 10/25/07



Life Safety Code Enforcement

The federal government has adopted National Fire Protection Association Standard 101 (Life Safety Code, 2000 edition) as the minimum standard for fire and life safety in all certified health care facilities. Life Safety Code (LSC) surveys are conducted by the Department of Public Safety, State Fire Marshal (SFM) Division, under contract with MDH. LSC deficiencies are designated as "K" tags.

The average number of deficiencies per LSC survey nationally during FFY 2007 was 3.9 and the average in Minnesota was 5.8; Minnesota ranked eleventh. Within CMS Region V, the average number of deficiencies per LSC survey was 5.0, and Minnesota ranked third. A table of average number of LSC deficiencies per survey for the U.S. is attached as Appendix G.

Table I, A-6: Average Deficiencies per LSC Survey, CMS Region V, OSCAR 10/25/07

State	Surveys	Tags from Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Illinois	824	4,921	6.0	5.0
Indiana	513	1,805	3.5	3.0
Michigan	425	3,803	8.9	8.0
Minnesota	394	2,299	5.8	5.0
Ohio	1,088	3,844	3.5	3.0
Wisconsin	396	1,466	3.7	4.0
Total	3,640	18,138	5.0	4.0

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

The issuance of independent but associated tags as required by CMS, or "cross-referencing", has been explained in previous Legislative Reports (See Appendix E for a link to the 2004, 2005 and 2006 Report). Minnesota's rate of "cross referencing" remains considerably higher than other states, despite the fact that the Department was given assurance by CMS that they are issuing tags correctly.

In 2007 Minnesota's rate for citing at least one tag from each of the outcome and process tags listed above, was 72.6%. The state of Connecticut was the next highest at 47.9%. The national average was 17.6%. See Appendix H for a table of national data on cross-referencing.

MDH continues to monitor the "cross referencing" rates within Minnesota and by other states, but believes that implementation of the Quality Indicator Survey Process (QIS), a revised federal survey process for nursing homes, may narrow the gap in variation between states. QIS is discussed in Section II of this report.

C. Number and Outcomes of Informal Dispute Resolutions

Federal regulations require 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 State statutory provisions for these two processes are found under Minnesota Statutes, Section 144A.10, subdivisions 15 and 16. IDR and IIDR decisions made by MDH are subject to CMS oversight.[8]

IDR

The IDR is performed by an MDH employee who has not previously been involved in the survey. For surveys with exit dates during FFY 2007, 15 IDRs were requested. A total of 31 tags were disputed. Of the disputed tags, the reviewer's decision was to change the scope and severity for 0 tags, and to delete 3 tags, for a total of 3 tags (10%) changed or deleted. Although CMS has the option of reviewing these decisions, in practice the MDH decision has remained in place, and MDH issues a revised 2567 as soon as its decision process is complete.

[8] State Operations Manual, Chapter 08, State Performance Standards, Section 7212C: Mandatory Elements of IDR. See Appendix C for a link to the State Operations Manual.

IIDR

IIDR involves a recommendation by an Administrative Law Judge (ALJ) from the Minnesota Office of Administrative Hearings (OAH). The ALJ's recommendation is advisory to the Commissioner, who reviews the case and can accept or modify the ALJ's recommendation.

Since the inception of the process in 2003, 100 IIDR requests have been made. In FFY07, there were 14 requests involving 31 tags. Of the 14 requests, 9 were withdrawn by the facility prior to the IIDR review, and those 9 included 22 tags. Table I, C-1 summarizes the tags that went forward with an IIDR in FFY2007.

Table I, C-1: Summary of IIDR Results, FFY07

Number of tags in dispute: 9

ALJ recommended action:	Number of tags:
Uphold tags as written	4
Uphold scope and severity, but delete some findings	2
Total tags upheld	**6**
Dismiss	3
Adjust scope and severity	0
Total tags adjusted or dismissed	**3**

Commissioner's decision:	Number of tags:
Uphold tags as written	5
Uphold scope and severity, but delete some findings	2
Total tags upheld	**7**
Dismiss tags	2
Adjust scope and severity	0
Adjust scope	0
Total number of tags adjusted or dismissed	**2**

Since CMS conducted ALJ training in April of 2006, CMS has not requested to review any files for IIDR decisions rendered by the ALJs and the commissioner. Therefore all decisions made by the commissioner have been "final".

MDH reimburses OAH for costs associated with review of IIDR cases. Facilities reimburse MDH for the proportion of costs that are attributable to disputed tags on which MDH prevails. The costs for 2007 were approximately $15,359 with MDH paying approximately $4,134 and nursing homes paying approximately $11,223 (Table I, C-2).

Table I, C-2: OAH Costs Paid by Nursing Homes and MDH through January 31, 2008

OAH Cost Apportionment	Number of Nursing Homes	Number of Tags	Cost Amount
Nursing Home paid 100% of costs	3	5	$10,411.00
Nursing Home split costs with MDH:	1	2	$ 1,624.00
Costs split – portion paid by NH		1	$ 812.00
Costs split – portion paid by MDH		1	$ 812.00
MDH Paid 100% of costs	1	2	$ 3,332.00

MDH uses a trained surveyor to review submitted materials and present MDH's position at the IIDRs. The IIDR process has required a considerable investment of staff time. Table I, C-3 presents a summary of supervisor and surveyor time spent on IIDRs compared to IDRs during FFY 2006. The IIDR process was contemplated as an "independent" but informal review of the disputed tags. Most nursing homes elect to use legal counsel in preparation of the IIDR materials and for representation at the IIDR review. MDH does not use legal counsel in the IIDR process. The IIDR process has increasingly become less informal over time and in many respects functions as a formal hearing. The amount of staff time devoted to preparation for IIDRs is substantial. In FFY07 a significant number of IIDRs withdrew prior to the actual IIDR review, after preparation by MDH of materials in support of the deficiencies. MDH is unable to recoup staff time and expense related to this work, and in a time of diminishing resources this is an area where benefit vs. cost might be reviewed.

Table I, C-3: Staff Time in Hours Spent on IDR and IIDR -- FY 2007

Process	Number of Reviews	Total Supervisor & Surveyor Time	Average Supervisor & Surveyor Time per Review
IIDR	12	232.25	19.3
IDR	15	106.00	7.1

MDH has used the information gained from the IIDR process to improve the survey process with respect to both identifying and documenting deficient practices. This information is shared with program management, supervisors and investigators. MDH also shares a status log of IIDRs with the two nursing home trade associations on a monthly basis, and with the LTC Issues Committee at its quarterly meetings.

D. Number and Outcomes of Appeals

The appeals process is a federal process. Nursing homes communicate directly with the CMS Region V Office in Chicago.

MDH is aware of only one nursing home that initiated an appeal at the federal level during FFY 2007.

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. If necessary, a post certification revisit (PCR) is conducted to determine whether the deficiency has been corrected. Minnesota Statutes, Section 144A.101, subdivision 5, (Appendix A) 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 communication, if the highest scope and severity score does not exceed level E. MDH performs an onsite revisit for levels D and E in situations where the determination of whether a deficient practice has been corrected is based on observation. (See Section II A. of this report for information on the Post Certification Revisit Process) B and C level deficiencies do not require a revisit.

For facilities surveyed during FFY 2007, there were 43 facilities with surveys with category 2 or 3 remedies imposed. One hundred eight revisits were conducted at these 43 facilities. Sixteen of these facilities had a total of 23 revisits which were completed subsequent to the facility being notified of a category 2 or 3 remedy. Of these:

- 85 revisits (79%) were completed within the 15 calendar days after the facility's identified date of correction.[9]

- 23 revisits (21%) for 16 facilities were not completed within the 15 calendar days after the facility's identified date of correction. Of these 23 revisits not completed within the 15 calendar days after the facility's identified date of correction:

    - A. Eight facilities did not suffer financial loss due to their failure to correct and the time of the visits.
    - B. Three of the facilities did suffer financial loss caused by a delay in providing an acceptable plan of correction which impeded MDH's ability to conduct a revisit within 15 days of the facility's identified correction date.
    - C. Four of the facilities did suffer financial loss caused by their failure to correct as opposed to the timing of MDH revisits.

[9] When a facility returns a PoC, the facility must identify a date by which corrections will be completed.

- D. One of the facilities did suffer financial loss caused by their failure to correct and the timeliness of MDH revisits.

Summary: The number of facilities having category 2 or 3 remedies decreased from 60 in FFY 2006 to 43 in FFY 2007(a 28% decrease). This resulted in a required 108 revisits. The survey workload resources were managed so that revisits were conducted in a manner as not to cause the facilities financial loss due to the timing of revisits by MDH in 99% of the cases.

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

A description of activities that MDH conducts on a regular basis to ensure the accuracy, integrity and consistency of the survey process can be found in previous annual quality improvement reports to the legislature (See Appendix E for a link to the 2004, 2005 and 2006 Report). Throughout FFY 07' the Licensing and Certification Program continued efforts to give surveyors the tools/training necessary to conduct their work. These include, but are not limited to the following:

- Supervisors reviewed all deficiencies before final 2567s were issued.
- Assistant Program Managers reviewed all deficiencies at level G and above before final 2567s were issued.
- Assistant Program Managers reviewed all F329 Unnecessary Medication deficiencies from the April 17, 2007 implementation date through December 2007.
- Monthly statewide L&C management team meetings including all supervisors, program management and division management, were held. The meetings were used to discuss and reach consensus on clarification of survey procedures. The monthly minutes are distributed shortly after the monthly L&C management team meetings and are used as a written communication tool with all survey staff.
- Quarterly statewide surveyor, supervisor and management videoconferences were conducted and used as a communication and training forum.
- The "Quick Tag Reference Guide" was recently updated to reflect changes made in 2007.
- The Clinical Web Window was expanded to include training materials for revised guidelines issued in 2007 and provide clarification on such issues as requirements for comprehensive resident assessments and coordination of hospice and nursing home services, as well as other important topics.

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 (the 2567) within 15 working days of the exit conference (Appendix A).

Delivery of a draft statement of deficiencies at the time of the survey exit has been implemented. Managers review data periodically and follow-up with supervisors who have problems complying with the timelines. In FFY 2007, four hundred and two (402) surveys were exited and the rough draft statement of deficiencies was left with the facility at the survey exit in three hundred ninety-one (391) instances. In cases the draft statement of deficiencies was not left with the facility, it was because of extended surveys requiring additional documentation time and travel efficiencies. The exit conferences were conducted by telephone at a later date after the surveyors left the facilities and draft statements of deficiencies were faxed to the facilities at that time of the exit conference.

Of the 402 surveys exited during FFY 2007, 391 or 97.26% met the 15 day requirement for delivering final 2567s. Eleven (11) or 2.74% of the surveys exceeded the 15 day requirement. Ten were related to surveys which required extra review due to complexity of deficiencies issued and/or the above average number of deficiencies issued. One was delayed as the review was sent to another supervisor due to heavy work load and the review was delayed due to mail delivery.

H. Other Survey Statistics Relevant to Improving the Survey Process.

Research on Deficiency Variability

Last year MDH reported analyzing over 64,000 surveys conducted nationally to evaluate patterns in nursing home survey deficiency citation variability between teams locally, by state, CMS region and nationally. MDH researchers were able to determine significant variability in citation patterns, but were unable to determine cause. Researchers' hypothesized that three primary factors might be responsible. They are:

- Residents characteristics
- Facility characteristics
- Survey team and surveyor characteristics.

MDH has communicated an interest in pursuing the research further, but the study's current applicability and future continuation is uncertain. Minnesota is now a QIS state. QIS introduces a significant change in the survey process. Future operational and research resources will need to be evaluated within the context need based on the QIS process.

Government Performance and Results Act (GPRA) Goals

As mentioned in previous Legislative Reports, CMS establishes annual quality improvement or GPRA goals for nursing facilities. These goals (national target FFY 2007) include achieving a nationwide pressure ulcer rate of 8.0% and a physical restraint rate of 5.9%. Table I, H-1 describes Minnesota's progress in meeting these goals.

Table I, H-1: GPRA Goal Rates for CMS Region V and Minnesota National Target Period for the Quarter Ending September 30, 2007

Goal Type	National Goal	CMS Region V Goal	Minnesota Rate 3rd quarter 2007
Pressure Ulcers	8.0%	7.4%	5.4%
Physical Restraints	5.9%	4.5%	2.4%

While over all Minnesota has met and exceeded the national goals, there are a significant number of individual nursing homes that still have higher rates than the regional or national goals require. During 2007, the MDH worked closely with Stratis Health and the provider associations to develop a plan to improve pressure ulcer rates and physical restraint rates in those nursing homes with scores above the GPRA goal. Part of the plan includes the provider associations initiating contact with the identified facilities to address the problem. MDH's goal is to have all nursing facilities meet or exceed GPRA goals related to pressure ulcer and physical restraints. The Department will continue to monitor progress and work with providers in achieving these goals.

II. Summary of Improvements Made to Date on the Nursing Home Survey Process: Areas of Special Focus for 2007.

The 2006 Report to the Legislature listed the following three areas of special focus for 2007:

A. Monitor and Evaluate the Revised Post Certification Revisit Process
B. Culture Change
C. Continue Efforts to Improve Consistency

A. Monitor and Evaluate the Revised Post Certification Revisit Process

On November 3, 2006 MDH revised its process for performing post certification revisits (PCR) for nursing facility surveys (Appendix I). PCR follow-up surveys are conducted to assure providers have corrected deficiencies found during an annual survey.

Prior to November 3, 2006, nursing homes who were issued a deficiency at a "D" level scope and severity or above received an automatic PCR follow-up inspection. If corrections were not made, citations were re-issued and another PCR visit was scheduled.

As of November 3, 2006, the date the revised PCR process went into effect, survey follow-up visits were prioritized according to the severity of the citations issued. Any survey with

deficiencies indicating substandard quality of care or immediate jeopardy to resident health or safety, or patterns of harm will still receive a mandatory PCR inspection. Surveys resulting in lower scope and severity deficiencies will be randomly selected for follow-up visits. Those providers not selected for a random on-site PCR, are required to complete the necessary plans of correction and assure MDH survey staff corrections are made. Under the revised PCR process, approximately 25% (100% pre-policy) of the providers with scope and severity deficiency citations of D or above received an on-site follow-up inspection.

MDH is currently monitoring the on-site follow up inspection patterns for randomly selected providers to determine the effectiveness of the new policy in maintaining compliance with federal and state resident nursing home health and safety requirements. MDH has established two preliminary measures it will use to monitor the policies outcome.

1. **Do providers selected for random on-site inspections have deficiencies corrected at the time of the follow-up inspection?**

   Seventy-five percent of all providers in the random selection process do not receive a follow up inspection under the revised policy. MDH will be monitoring on-site PCR visit surveys to verify that correction patterns are not changing. If correction rates worsen, MDH can alter or eliminate the random follow-up process.

   - During FFY 06, from October 1, 2005 through September 30, 2006, 325 surveys would have met the agencies random selection process. Of those 325, 62 or 19.1% did not have deficiencies adequately corrected and required multiple PCR visits.
   - During the period from November 3, 2006 through November 30, 2007, 75 surveys received a random on-site PCR inspection. Of those 75, 15 or 20.0% did not have deficiencies adequately corrected on the first follow-up inspection and required additional revisits from MDH. .
   - Correction rates requiring additional follow-up inspections are consistent, within 1% between the two periods for providers meeting the random selection criteria.

   Providers selected for the random on-site PCR inspection appear to be correcting citations at nearly the same rate as the year prior to the implementation of the follow-up policy. There were 207 surveys randomly selected for state survey agency plan of correction desk review to verify compliance with no on-site follow-up visit. MDH is estimating that approximately 41 (20%) of those provider surveys would not have had survey deficiency citations corrected sufficiently and would have required a second follow-up visit had an original on-site follow-up inspection been conducted.

2. **Are complaint substantiation patterns different between providers selected for random on-site inspections and those not receiving on-site follow-up inspections?**

   MDH will begin tracking the complaint substantiation levels for providers meeting the random PCR follow-up process. The table below is for complaints resolved between November 2006 and October 2007; the complaint substantiation rate for

PCR by Plan of Correction (POC) providers is 4.5% higher than the random on-site inspection group. MDH will continue to review substantiation rates.

Table II, A-1: Complaint Substantiation Rates, Nov. 2006 and Oct. 2007

Follow-up Type	Surveys	Total Complaints	Substantiated	Substantiation Rate
Random on-site inspection	75	136	12	8.8%
Random by POC, non on-site	207	315	42	13.3%

Federal fiscal year 2008 will be the second year of the random PCR policy. During the coming year MDH will begin to monitor the degree to which the random on-site and the random desk review group differ in the issuance of the same deficiency tag to the same provider for two consecutive annual survey cycles. Greater rates for repeated citation of the same deficiency in the non on-site group may indicate higher rates of uncorrected problems carrying forward into the next year.

B. Culture Change

MDH strongly supports a person-centered and directed model of care across all long term care settings and has been an active member of the Culture Change Coalition since its inception. This group of long-term care stakeholders meets regularly to discuss ways to advance resident-centered care.

In March of 2007 MDH co-sponsored a Culture Change Coalition Summit titled "Promoting Culture Change through Consumer and Policy Maker Involvement". Whereas the first summit (Regulation and Culture Change: How They Work Together, October 2006) targeted providers and survey staff, this summit targeted consumers, policy makers and long term care advocates.

In August of 2007 Pioneer Network, a national not-for- profit organization that serves the culture change movement, held their 7th national conference in Minnesota. Well over 1000 people attended this three day event, including MDH's Compliance Monitoring Division Director and a survey supervisor.

In October of 2007 staff from MDH's Licensing and Certification Program and Office of Health Facilities Complaints held their annual meeting and an expert in culture change presented at that meeting.

Additionally, the Department recently developed a Nursing Home Technology Pilot Grant Program, which uses one-time civil money penalty dollars to fund pilot projects that use new technology to improve resident quality of care and quality of life. Project proposals that furthered resident centered or resident directed care were given extra points in the review criteria. This ended up being a determining factor when it came down to awarding one like project over another.

The Department will continue to promote culture change and provide educational opportunities for providers, surveyors, and stakeholders on innovations in cultural change and regulatory compliance.

C. Continue Efforts to Improve Consistency

Regular Review and Analysis of Data

As mentioned in previous Legislative Reports, MDH has been evaluating survey and survey team performance across the state for the past several years. Deficiency data and information from survey teams following surveys is analyzed monthly by L&C Management to identify variations in the application of the survey process and to provide training and guidance to surveyors. MDH's progress on improving consistency is discussed in Section 1. A. of this report.

CMS Revised Guidance and MDH Training and Guidance for Surveyors and Providers

CMS continues to issue revised clinical guidelines, investigative protocols and guidance for surveyors on a number of tags they identified as having significant variation among states. In 2007, CMS issued revised guidance on the following: F 329 Unnecessary Medications, F 425 Pharmacy Services, F 428 Medication Regimen Review, and F 431 Labeling of Drugs and Biologicals; F 373 Paid Feeding Assistants; and, F 323 Accidents and Supervision. MDH, together with the collaborative joint training group, has developed training programs and tools on these new guidelines. Appendix J includes a chart that summarizes these training initiatives for 2007.

Future revised guidelines that CMS plans to issue include F 309 End of Life Issues and Pain Management; F 371Safe Food Handling; F 325 Nutritional Parameters; F 223-226 Abuse; and, F 441 Infection Control. As new guidelines are issued by CMS, MDH and the collaborative joint stakeholders group will continue to develop training and guidance tools and implement new protocols. MDH has and will continue to experiment with various training methods (e.g. face to face, telephone conferences, tool kits) to determine the most appropriate and effective technique for educating surveyors, providers, advocates and others on future guidelines.

Besides providing training on revised guidelines, MDH published two documents that clarify the requirements for comprehensive resident assessments and coordination of hospice and nursing home services. This was in response to concerns raised by providers. Both of these documents can be found on the Department's Clinical Web Window at http://www.health.state.mn.us/divs/fpc/cww/cwwindex.html.

Life Safety Code Training

In 2007, MDH provided Life Safety Code training on maintaining a fire-safe environment in health care facilities in three locations around the state. Training included information on

required maintenance and inspection of sprinkler systems and generator sets. Besides these formal training sessions, MDH has also spent a considerable amount of time this year in discussions with providers, CMS Region V staff, the State Fire Marshall and others to clarify requirements regarding medical gas in use/liquid oxygen, remote monitoring panel for generators, sprinklers in elevator shafts, portable heaters, state smoking ban legislation and magnetic locks on doors of egress. In 2008 MDH plans to provide training on protecting means of egress.

Dental Care Video

The Department is in the process of creating a training video on providing proper oral health care to residents in nursing homes, using civil money penalty funds. MDH is working with the University Of Minnesota School Of Dentistry Oral Health for Seniors Program and various long term care stakeholders on this video. It is expected to be released in 2008.

Communications for Survey Improvement – Duluth (CSI-Duluth)

CSI-Duluth, a regional stakeholder group formed in the northeast district of the state, continues to meet on a monthly basis and conduct regional training for surveyors and providers. In September 2007, CSI-Duluth provided training on behaviors. In 2008, CSI-Duluth plans to provide training on root cause analysis as a strategy for preventing/reducing incidents of illness or injury. CMS-Duluth will be a pilot study for root-cause analysis training, as previously this training has only been done with hospital. More information about CSI-Duluth activity is available on the Committee's website. See Appendix E for a link to CSI-Duluth's website.

Quality Indicator Survey Process

As mentioned in last year's Legislative Report, MDH applied to CMS to be the next state to expand the Quality Indicator Survey (QIS) Process, beyond the six demonstration states. QIS is a revised federal survey process for nursing homes that uses new technology to improve the accuracy, consistency and efficiency of the survey process. Strengths of the QIS process include increased resident sample size, more in-depth interviews and investigations, improved documentation of survey findings through automation, and the ability of the state to focus limited survey resources on those nursing homes with the greatest quality of care concerns. See Appendix K for a CMS fact sheet on the QIS Demonstration Project.

In May of 2007, Minnesota received notice from CMS that they that they were the only state, out of 13 states that applied, which was approved to go forwarded with QIS expansion (See CMS letter of approval in Appendix K). The Department has been preparing for QIS roll-out and has been working with all involved parties. Plans for the roll-out include the following:

- Communications with Providers and Stakeholders on the QIS Roll-Out - - MDH formed a QIS Communications Subcommittee, from members of the Long Term Care Issues Committee, to help with provider communications on the QIS Roll-Out.

- Surveyor Training -- CMS has hired Nursing Home Quality in Colorado (Dr. Andrew Kramer an expert in QIS), as the contractor for QIS training. Extensive training of a core group of MDH surveyors and supervisors/program managers from around the state and two CMS Regional Office staff will begin on January 7, 2008.

  A 90 minute overview of QIS will be provided by CMS Central Office, Nursing Home Quality, and MDH for all survey staff, providers, and other stakeholders via a telephone conference call the morning of January 7, 2008.

  During the second week of January, one to three mock surveys will be conducted. MDH will be seeking out volunteer facilities who are in the metro area, have been recently surveyed, and are in substantial compliance for these mock surveys. If, during a mock QIS, the survey team finds a situation of harm or an immediate jeopardy, the Office of Health Facilities Complaints will be contacted and the QIS will be aborted.

  Following the mock surveys, six surveys of record will be conducted. Once these surveys of record have been conducted, MDH will then move into the train-the-trainer phase of the roll-out, and will begin surveying nursing facilities using QIS on a regional basis. MDH anticipates that the next group of surveyors trained will occur sometime in the spring of 2008. It is MDH's goal that once surveyors have been fully trained in QIS, they will only do QIS surveys and that they will not revert back to surveying under the traditional survey process.

The Department anticipates that within three years all survey staff will have been trained in QIS and the QIS process will be the only annual nursing facility survey process used in Minnesota.

Recruitment and Retention of Quality Survey Staff

The MDH Licensing and Certification Program has been doing work force planning for the past four 4 years. The need arose when it became apparent to L&C management that approximately half of the survey staff would be eligible for retirement within the next five to 10 years. Two years ago, CMS appropriated MDH money for transition planning in preparation for retirements. Money was used to cross-train Program Assurance staff to complete nursing home enforcement packages, conduct the Rochester/Mankato Pilot Project (discussed in 2006 Legislative Report), allow the L&C assistant program manager to take advantage of the post retirement option and work part time as a Transition Supervisor II for one year, as well as other work force planning initiatives. CMS has since cut MDH's funding for workforce activity. However, the Department, as a whole, has taken on work force planning and intends to survey MDH staff on reasons why they choose to remain employed at MDH, amongst other things. This information will prove useful in the recruiting candidates to fill positions that will be vacant in the next 5-10 years due to staff retirements.

III. Areas of Special Focus for 2008

A major focus for the Department over the next three years will be statewide implementation of the revised federal survey process or **Q**uality **I**ndicator **S**urvey (QIS) Process. This will include training of additional survey staff on QIS and use of QIS improvement tools; implementing QIS in other regions of the state; and, analyzing survey process variations and developing a plan to reduce variations. The QIS process will provide the Department with a broader set of data than what is currently available and the Department will need to work with providers and other stakeholders to determine how best to use that data.

The Department will also work with stakeholders to examine state survey regulations and practices that are not currently part of QIS (e.g. meeting with family councils, Verify Clarify) and determine how they will continue to be met.

CMS will is in the process of developing QIS protocols for complaints. Once that protocol is released, MDH will need to develop a plan for roll-out of QIS complaint investigations.

V. Appendices

APPENDIX A.	Minnesota Session Laws 2004 – Chapter 247
APPENDIX B.	Assessment Factors used to Determine the Seriousness of Deficiencies Matrix
APPENDIX C.	How to Access CMS Regulations, Manuals, Updates, and Quality Initiative Information
APPENDIX D.	Average Deficiencies per Health Survey, National Data
APPENDIX E.	How to Access MDH Facilities Compliance Monitoring Information
APPENDIX F.	2008 Quality Improvement Plan for Survey Agency
APPENDIX G.	Average Deficiencies per Life Safety Code Survey, National Data
APPENDIX H.	Cross Referencing National Data (10-25-07)
APPENDIX I.	Nursing Home Post Certification Revisit Process
APPENDIX J.	MDH Collaborative Joint Training Activities on CMS Revised Guidelines FFY 2007
APPENDIX K.	CMS Quality Indicator Survey Process Demonstration Project Fact Sheet CMS Letter to MDH on QIS Application Acceptance

APPENDIX A

Minnesota Session Laws 2004 - Chapter 247

Key: (1)~~Language to be deleted~~ (2)New language

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

ASSESSMENT FACTORS USED TO DETERMINE THE SERIOUSNESS OF DEFICIENCIES MATRIX

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 Not on CMS-52567	B PoC	C PoC
Isolated	Pattern	Widespread	

Substandard quality of care is any deficiency in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25, Quality of Care, that constitutes immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.
Substantial compliance

Source: State Operations Manual, Chapter 7 - Enforcement and Survey Process for Skilled Nursing Facilities and Nursing Facilities, (Rev. 1, 05-21-04)
http://www.cms.hhs.gov/manuals/downloads/som107c07.pdf

APPENDIX C

How to Access CMS Regulations, Manuals, Updates, and Quality Initiative Information

Federal regulations are available at the CMS Laws and Related Regulations web page,
http://www.cms.hhs.gov/home/regsguidance.asp
This is a federal web page and MDH does not control its content.

The State Operations Manual, which contains survey protocols and interpretive guidelines for surveyors, is available from the CMS manuals web page,
http://www.cms.hhs.gov/manuals/
The same page contains a links to the Program Transmittals, which transmit updates to the manuals.

CMS Nursing Home Quality Initiative information is available from this CMS web page,
http://www.cms.hhs.gov/NursingHomeQualityInits/

Stratis Health, Quality Improvement Organization web site
http://www.stratishealth.org/

CMS Survey & Certification Online Training website
http://www.cms.internetstreaming.com/
CMS webcast training sessions are available on this website for one year from the date of original broadcast.

Links to the CMS web site are also provided from MDH's Facilities Compliance Monitoring web page. (See Appendix E). Nursing homes are encouraged to check both the MDH Facilities Compliance Monitoring web page and the CMS web site weekly for updated information.

Nursing Home Quality website. This is the organization that CMS contracted with for Quality Indicator Survey Process (QIS) Training
http://www.nursinghomequality.com/index.html

APPENDIX D

Average Health Deficiencies per Nursing Home Survey, by State OSCAR data system 10/25/07

State	Surveys	Average Number of Health Deficiencies
Puerto Rico (PR)	8	22.3
Wyoming (WY)	37	13.6
Delaware (DE)	45	12.6
District of Columbia (DC)	20	12.2
California (CA)	1,184	12.1
Maryland (MD)	224	10.2
Arkansas (AZ)	240	10.1
Minnesota (MN)	394	9.9
Idaho (ID)	78	9.8
Colorado (CO)	210	9.8
Kansas (KS)	349	9.5
Arizona (AZ)	135	9.4
Connecticut (CT)	242	9.0
Oklahoma (OK)	339	8.7
Vermont (VT)	39	8.4
West Virginia (WV)	127	8.4
Michigan (MI)	425	8.4
Maine (ME)	111	8.3
Florida (FL)	681	8.2
Virginia (VA)	278	8.1
Missouri (MO)	510	7.6
Indiana (IN)	513	7.5
South Carolina (SC)	176	7.4
Louisiana (LA)	281	7.3
Nevada (NV)	48	7.3
New Mexico (NM)	71	7.1
Alabama (AL)	188	7.1
Montana (MT)	94	6.9
Alaska (AK)	15	6.7
Washington (WA)	243	6.7
Texas (TX)	1,155	6.6
Hawaii (HI)	48	6.5
Nebraska (NE)	223	6.4
Georgia (GA)	362	6.4
Guam (GU)	1	6.0
Utah (UT)	92	5.9
Tennessee (TN)	328	5.9
Massachusetts (MA)	448	5.3
New York (NY)	650	5.0
Illinois (IL)	824	5.0
Kentucky (KY)	293	4.9
Oregon (OR)	138	4.9
Iowa (IA)	439	4.8
Pennsylvania (PA)	724	4.8
North Carolina (NC)	420	4.7
South Dakota (SD)	110	4.7
North Dakota (ND)	83	4.7
New Jersey (NJ)	366	4.5
Ohio (OH)	1,088	4.5
Wisconsin (WI)	396	4.5
Mississippi (MS)	202	3.9
New Hampshire (NH)	81	3.7
Rhode Island (RI)	86	2.9
Virgin Islands (VI)	1	1.0
Total	11,436	7.0

APPENDIX E How to Access MDH Facilities Compliance Monitoring Information

Annual Quality Improvement Report on the Nursing Home Survey Process
and Progress Reports on Other Legislatively Directed Activities, 2004, 2005 and 2006
http://www.health.state.mn.us/divs/fpc/legislativerpts.html

Minnesota Health Care Facilities Home
http://www.health.state.mn.us/divs/fpc/fpc.html

Compliance Monitoring Division Resident and Provider Information
http://www.health.state.mn.us/divs/fpc/consinfo.html

Compliance Monitoring Division Bulletins, Reports, Manuals, Forms
Includes link to Information Bulletins
http://www.health.state.mn.us/divs/fpc/proinfo.html
Providers are encouraged to sign up for e-mail notification of MDH Information Bulletins and CMS Program Transmittals.

Compliance Monitoring Division Clinical Web Window
http://www.health.state.mn.us/divs/fpc/cww/cwwindex.html

Nursing and Boarding Care Home Inspections:
Information for Residents, Families and Visitors
http://www.health.state.mn.us/divs/fpc/nursingpamplet.htm

Nursing and Boarding Care Home Survey Inspection Findings
http://www.health.state.mn.us/divs/fpc/directory/surveyfindings.htm

Long Term Care Issues Ad Hoc Committee home page
http://www.health.state.mn.us/ltc/

Communications for Survey Improvement Duluth (CSI-Duluth)
http://www.health.state.mn.us/ltc/csiduluth/index.html

APPENDIX F

2008 Quality Improvement Plan for Survey Agency Working Document

Mission of Minnesota Department of Health:
Keeping All Minnesotans Healthy

Vision of Licensing and Certification (L&C) Program:
Quality and Compassionate Care Every Time

Mission of Licensing and Certification Program:

To protect and improve the health, safety, comfort and well-being of individuals receiving services from federally certified and state licensed health care providers, and to monitor the quality of nursing assistant training programs.

This mission is accomplished through:

1. Issuance and renewal of licenses and certification/recertification activities for providers;
2. Surveying providers and enforcing compliance with federal and state statutes, regulations and guidelines;
3. Educating stakeholders via information sharing and training; and,
4. Oversight of the nursing assistant registry and nursing assistant training programs.

Purpose of the Ongoing L& C Quality Improvement Plan:

To ensure that activities carried out by L&C staff are performed accurately and in accordance with established state and federal requirements to protect health, well- being, safety and comfort; to identify areas for improvement in performance and in systems; and to make those improvements.

The 2008 Quality Improvement Plan includes 4 goals:

1. Promote Nursing Home Culture Change and regulatory compliance, working jointly with stakeholders.
2. All nursing facilities in Minnesota will meet or exceed the national Government Performance and Results Act*(GPRA) goals related to pressure ulcer and physical restraint reduction.
3. Improve consistency and accuracy across survey teams through implementation of the Federal Nursing Home Quality Indicator Survey (QIS) Process.
4. Improve communication and promote knowledge of the survey process.

❖ The Government Performance and Results Act (GPRA) of 1993, is to improve public confidence in the Federal Government by systematically holding Federal agencies accountable for achieving program results made public through annual performance goals, based on

strategic goals and linked to budget. Two of CMS goals for FY 2008 for nursing facilities include achieving nationwide Pressure Ulcers (PU) 8.5% and Physical Restraints: 6.1%.

- See http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSOPA01302008.pdf

Goal: Promote Nursing Home Culture Change and regulatory compliance, working jointly with stakeholders.

- Culture Change is an ongoing transformation in the physical, organizational, and psycho-social-spiritual environments that is based on person centered values. Culture Change restores control to elders and those who work closest to them.

- Participate in the Minnesota Culture Chance Coalition.
- Improve quality of life for long-term care residents by promoting awareness and understanding of culture change with stakeholders.
- Promote surveyors' and providers' mutual understanding about how regulations support culture change in nursing facilities and visa versa through ongoing dialogue and educational programs.

Goal: All nursing facilities in Minnesota will meet or exceed the national GPRA goals related to pressure ulcer and physical restraint reduction.

- Support ongoing efforts of stakeholders to follow-up with those facilities which exceed GPRA goals.
- Work with stakeholders to track the progress in meeting GPRA goals.

Goal: Improve and maintain consistency and accuracy across survey teams through implementation of the Federal Quality Indicator survey (QIS) process.

Objective: Educate surveyor agency staff about Federal QIS Nursing Home survey process, and implement consistent with Federal guidelines, use QIS tools for quality improvement.

- Orient MDH staff to QIS survey process over a three-year period.
- Orient MDH staff and understand how to use QIS survey process improvement tools.
- Use Mix/Max survey teams to capture observations and insights on survey process variances, and communicate information back to surveyors.

Objective: Analyze variations and develop methods to reduce variation using a Plan, Do Study, Act (PDSA) approach to quality improvement.

- Expand understanding about variances in survey data by conducting research that analyzes relationships between deficiencies issued, facility characteristics and MDS resident characteristics.

- Use PSDA approach for quality improvement to analyze variance(s) of greater than +/- 2 tags from the statewide median for tags issued per survey by team.
- Use PSDA approach for quality improvement to analyze variance(s) of greater than +/- 20% from the statewide average for tags issues by survey team.

Objective: Identify and correct known, suspected or potential problems with the survey process and identify opportunities for quality improvement.

- Use QIS survey process improvement tools.
- Use Mix/Max survey teams, unit supervisors and managers, surveyor trainers and federal oversight surveys to capture observations and insights on survey process variances, and communicate information back to surveyors.
- Review all deficiencies prior to being finalized and issued.
- Communicate areas for improvement through surveyor-training tools, quality tag and survey task guides, and QIS available resources.

Objective: Value all members of the Licensing and Certification Program and administrative staff individually. Attract and retain a professional survey and administrative staff workforce. Develop a succession plan for staff as retirements take place.

- Maintain and implement a positive work environment that supports survey agency staff in their positions. Communicate together as a statewide team.
- Attract competent and knowledgeable individuals.
- Use available options to plan for succession of staff.
- Provide effective staff orientation using knowledgeable surveyor trainers.
- Solicit ideas from survey agency staff for quality improvement.

Objective: MDH will meet CMS Performance Standards

Goal: Improving communication and promoting knowledge of the survey process.

- Participate in Long Term Care Ad Hoc Committee with representatives from providers, advocates, families and the quality improvement organization. Solicit feedback from participants.
- Meet regularly with provider associations, MNDONA, Stratis Health, and resident advocates.
- Participate in Duluth joint stakeholder work group.
- Work jointly with stakeholders to plan regulatory related educational programs, and technical assistance around common clinical and regulatory change topics.
- Continue to implement transparency in sharing information via MDH and CMS website.

Objective: Simplify and streamline the process of soliciting feedback on surveys.

- Simplify the questionnaire format.
- Improve the online approach to soliciting survey feedback.

APPENDIX G

Average LSC Deficiencies per Nursing Home Survey, by State, OSCAR data system 10/25/07

State	Surveys	Average Number of Health Deficiencies
Alabama (AL)	188	**3.8**
Alaska (AK)	15	**10.5**
Arizona (AZ)	135	**4.7**
Arkansas (AZ)	240	**1.4**
California (CA)	1,184	**5.5**
Colorado (CO)	210	**7.1**
Connecticut (CT)	242	**2.2**
Delaware (DE)	45	**3.8**
District of Columbia (DC)	20	**1.8**
Florida (FL)	681	**1.5**
Georgia (GA)	362	**2.6**
Guam (GU)	1	**3.0**
Hawaii (HI)	48	**0.4**
Idaho (ID)	78	**2.5**
Illinois (IL)	824	**6.0**
Indiana (IN)	513	**3.5**
Iowa (IA)	439	**5.9**
Kansas (KS)	349	**9.9**
Kentucky (KY)	293	**1.0**
Louisiana (LA)	281	**2.8**
Maine (ME)	111	**1.2**
Maryland (MD)	224	**2.4**
Massachusetts (MA)	448	**1.8**
Michigan (MI)	425	**8.9**
Minnesota (MN)	394	**5.8**
Mississippi (MS)	202	**1.0**
Missouri (MO)	510	**4.4**
Montana (MT)	94	**7.4**

State	Surveys	Average Number of Health Deficiencies
Nebraska (NE)	223	**2.2**
Nevada (NV)	48	**5.8**
New Hampshire (NH)	81	**2.2**
New Jersey (NJ)	366	**1.3**
New Mexico (NM)	71	**4.5**
New York (NY)	650	**2.7**
North Carolina (NC)	420	**3.2**
North Dakota (ND)	83	**4.9**
Ohio (OH)	1,088	**3.5**
Oklahoma (OK)	339	**3.2**
Oregon (OR)	138	**4.4**
Pennsylvania (PA)	724	**6.1**
Puerto Rico (PR)	8	**8.1**
Rhode Island (RI)	86	**0.3**
South Carolina (SC)	176	**1.1**
South Dakota (SD)	110	**3.1**
Tennessee (TN)	328	**3.4**
Texas (TX)	1,155	**4.8**
Utah (UT)	92	**4.1**
Vermont (VT)	39	**1.6**
Virgin Islands (VI)	1	**2.0**
Virginia (VA)	278	**3.4**
Washington (WA)	243	**2.9**
West Virginia (WV)	127	**2.6**
Wisconsin (WI)	396	**3.7**
Wyoming (WY)	37	**7.5**
Total	8,556	**3.9**

APPENDIX H

Cross-referencing how often when outcome tag (F0309, F0312, F0314, F0316) is cited is a process tag (F0280, F0282, F0272, F0276) also cited in states. Most Recent Inspections retrieved from the Federal OSCAR Database on 10/25/07

State	Inspections	Tags From each Group	Percentage
Alabama (AL)	188	43	22.9%
Alaska (AK)	15	1	6.7%
Arizona (AZ)	135	22	16.3%
Arkansas (AZ)	240	109	45.4%
California (CA)	1,184	281	23.7%
Colorado (CO)	210	36	17.1%
Connecticut (CT)	242	116	47.9%
Delaware (DE)	45	10	22.2%
District of Columbia (DC)	20	9	45.0%
Florida (FL)	681	95	14.0%
Georgia (GA)	362	93	25.7%
Guam (GU)	1	0	0.0%
Hawaii (HI)	48	4	8.3%
Idaho (ID)	78	31	39.7%
Illinois (IL)	824	78	9.5%
Indiana (IN)	513	148	28.8%
Iowa (IA)	439	50	11.4%
Kansas (KS)	349	92	26.4%
Kentucky (KY)	293	42	14.3%
Louisiana (LA)	281	60	21.4%
Maine (ME)	111	27	24.3%
Maryland (MD)	224	19	8.5%
Massachusetts (MA)	448	74	16.5%
Michigan (MI)	425	24	5.6%
Minnesota (MN)	394	286	72.6%
Mississippi (MS)	202	2	1.0%
Missouri (MO)	510	82	16.1%
Montana (MT)	94	12	12.8%
Nebraska (NE)	223	28	12.6%
Nevada (NV)	48	4	8.3%
New Hampshire (NH)	81	10	12.3%
New Jersey (NJ)	366	18	4.9%
New Mexico (NM)	71	13	18.3%
New York (NY)	650	56	8.6%
North Carolina (NC)	420	24	5.7%
North Dakota (ND)	83	3	3.6%
Ohio (OH)	1,088	110	10.1%
Oklahoma (OK)	339	88	26.0%
Oregon (OR)	138	33	23.9%

Pennsylvania (PA)	724	58	8.0%
Puerto Rico (PR)	8	3	37.5%
Rhode Island (RI)	86	12	14.0%
South Carolina (SC)	176	38	21.6%
South Dakota (SD)	110	7	6.4%
Tennessee (TN)	328	73	22.3%
Texas (TX)	1,155	126	10.9%
Utah (UT)	92	6	6.5%
Vermont (VT)	39	15	38.5%
Virgin Islands (VI)	1	0	0.0%
Virginia (VA)	278	100	36.0%
Washington (WA)	243	33	13.6%
West Virginia (WV)	127	11	8.7%
Wisconsin (WI)	396	67	16.9%
Wyoming (WY)	37	17	45.9%
Total	15,863	2,799	17.6%

APPENDIX I

Nursing Home Post Certification Revisit Process

The Minnesota Department of Health (MDH) is expanding their method of compliance verification. MDH will continue to use onsite post certification revisits as one method of verification, but on a less frequent basis. Below is the new post certification revisit process, effective for all nursing home surveys exited after November 3, 2006. This process is consistent with current federal policy and it is enhanced by the inclusion of random visits. The policy applies to all nursing home health and Life Safety Code deficiencies.

I. Mandatory Onsite Revisits

Onsite revisits will occur when any of the following situations apply:

A. when a facility has a deficiency finding of G and above on current survey;

B. when a facility has a deficiency finding of Substandard Quality of Care on current survey;

C. when a facility has been selected by CMS as a Special Focus Facility; or,

D. when a facility's prior survey or complaint investigation resulted in a deficiency finding of Substandard Quality of Care or immediate jeopardy.

II. Random Onsite Revisits

In addition to the mandatory revisits described above, MDH will conduct revisits to a percentage of facilities chosen at random. These random visits will provide the survey agency with an onsite sample to validate that Plans of Corrections are being implemented as written.

III. Verification of Compliance by Signature

The nursing home Plan of Correction (POC) is the facility's plan to be in compliance and is approved by MDH. The facility's signature on the Plan of Correction will be considered verification that compliance has been achieved as of the latest date specified on the POC and MDH may validate this verification by conducting an onsite revisit.

IV. Effective Date

This policy applies to all surveys exited after November 3, 2006.

V. Evaluation of Policy Change

This policy will be monitored and evaluated over the next year.

APPENDIX J

MDH Collaborative Joint Training Activities on CMS Revised Guidelines - FY 2007

Deficiency Tag #	Revised/New Guideline Deficiency Description	CMS Date Issued	Joint Training/Tools	MDH Implementation Date / Information Bulletin #	On Line CMS Training Available 24 hrs./day for 12+ months
F 329 F 425 F 428 F 431	Unnecessary Drugs and Pharmacy Services Medication Regimen Labeling of Drugs and Biologicals	Sept. 2006	CMS Webcast Dec. 15, 2006. Clinical Tool Kit. Joint Training Sessions are scheduled for Jan. and Feb. 2007. Sept. 2007 Statewide Phone Conf. Oct. 2007 MN Med. Dir. Assoc. Educational Sessions	April 15, 2007	X
F 323 (formerly F323 and F324)	Accidents and Supervision	July 2007	Two Joint Training Sessions held on Sept. 17, 2007 via Web Ex. Follow-up statewide conference calls scheduled for Feb. 11, 2008 and June 23, 2008.	October 1, 2007	
F 373	Paid Feeding Assistants	Aug. 2007	No need for training. MDH had policy and program in effect since 2003.	Aug. 17, 2007	

Future CMS Guidelines to be Issued:

F 309	End of Life Issues and Pain Management
F 371	Safe Food Handling
F 325	Nutritional Parameters
F 223-226	Abuse

CMS Quality Indicator Survey Demonstration Project

Overview of the QIS Process and Demonstration

QIS Survey Overview

The Quality Indicator Survey (QIS) is a revised long-term care survey process that was developed under Centers for Medicare & Medicaid Services (CMS) oversight through a multi-year contract. The QIS was designed as a staged process for use by surveyors to systematically and objectively review all regulatory areas and subsequently focus on selected areas for further review.

The QIS provides a structure for an initial review of larger samples of residents based on the MDS, observations, interviews, and medical record reviews. Utilizing onsite automation, survey findings from the first stage are combined to provide rates on a comprehensive set of Quality of Care Indicators (QCIs) covering all resident- and facility-level federal regulations for nursing homes. The second stage then provides surveyors the opportunity to focus survey resources on further investigation of care areas where concerns exist. Although the survey process has been revised under the QIS, the federal regulations and interpretive guidance remain unchanged.

The QIS was designed to achieve several objectives:

- Improve consistency and accuracy of quality of care and quality of life problem identification using a more structured process;
- Comprehensively review the full range of regulatory care areas within current survey resources;
- Enhance documentation by organizing survey findings through automation; and
- Focus survey resources on facilities with the largest number of quality concerns.

Initial testing of the QIS process has revealed that it yields increased consistency and improved documentation of survey findings. Given the promising results of these tests, CMS now wishes to evaluate the QIS on a larger scale using surveys of record through a demonstration, with an independent evaluation.

QIS Demonstration Overview

For the purposes of the QIS Demonstration, CMS has designated the QIS as a standard survey. Some facilities in Demonstration states will be surveyed using the QIS as the survey of record; however, most facilities in these states will be surveyed using the current survey process, now known as the traditional survey.

The demonstration and evaluation of the QIS will be conducted in five states: California, Connecticut, Kansas, Louisiana, and Ohio. These five states were selected from among twenty-five volunteering states based on several criteria, including: geographic balance; representation of rural areas; citation history; use of technology; and average survey time. One state was selected based on its primarily rural population.

Throughout the Demonstration, the QIS surveys will be observed by contractors whose role will be to evaluate the QIS and make recommendations to continuously improve the QIS process. The evaluation findings will ultimately be used by CMS in determining whether to replace the traditional survey with the QIS on a national scale.

Participating states will be trained on the use of the QIS protocols and software in two phases, the first beginning in September 2005 and second beginning in February 2006. Connecticut, Kansas, and Ohio will participate in the first phase, and California and Louisiana will take part in the second phase. The training approach will be evaluated and refined between the first and second phases.

Training will be comprised of classroom training, training surveys, and surveys of record during which training staff will be present. During the initial QIS surveys in each state, training contractor staff will be present to provide guidance on the use of the QIS protocols. Later on, evaluation contractor staff will accompany some survey teams to evaluate the QIS process.

In summary, the QIS Demonstration has several objectives: determine consistency of QIS when implemented in five states as surveys of record; assess time required to conduct QIS; continuously improve upon QIS process; and test training approaches that may be used for widespread training.

Description of the QIS

The QIS process utilizes customized software, called the "QIS Data Collection Tool" (QIS DCT), to guide surveyors through a structured, two-staged investigation. Figure 1 on the following page provides a step-by-step overview of the QIS process. The process begins with offsite preparation activities (similar to those completed during the traditional federal long-term care survey process), which include preparation of team assignments and review of available information regarding prior deficiencies, complaints, ombudsman information, and existing waivers/variances. Unlike the traditional survey process, the QIS does not require surveyors to review the Quality Measure/Quality Indicator (QM/QI) and OSCAR 4 reports or preselect potential residents for review prior to the survey. MDS data are also requested and loaded offsite into sur-

Continued on page 2

DESCRIPTION OF THE QIS—CONTINUED

veyors' computers and are used to calculate the MDS-based QCIs and create the resident pool from which the Stage I samples are randomly selected.

Following the offsite activities, and upon entry into the facility, a formal entrance conference is held during which necessary information is requested from the facility. Concurrent to the entrance conference, an abbreviated tour of the facility is conducted to provide an orientation to the resident population, staff, and facility layout. Unlike the traditional survey process, the purpose of the tour under the QIS process is not to select a sample of residents for review nor to gather detailed information regarding specific concerns.

Three distinct Stage I samples are selected. These include: 1) the MDS sample (which is drawn offsite); 2) the Census sample; and 3) the Admission sample. The MDS sample includes facility-reported information for all residents who had an MDS assessment at any time within the past six months (except discharge or re-entry assessments). The Census sample includes 40 randomly selected residents in the facility at the time of the onsite visit, and the Admission sample includes 30 recent admissions (emphasizing SNF post-acute patients and long-stay admissions on critical issues such as rehospitalization, death, or functional loss). In addition to these three samples, other residents can be sampled at the surveyors' discretion (referred to as the Surveyor-initiated sample).

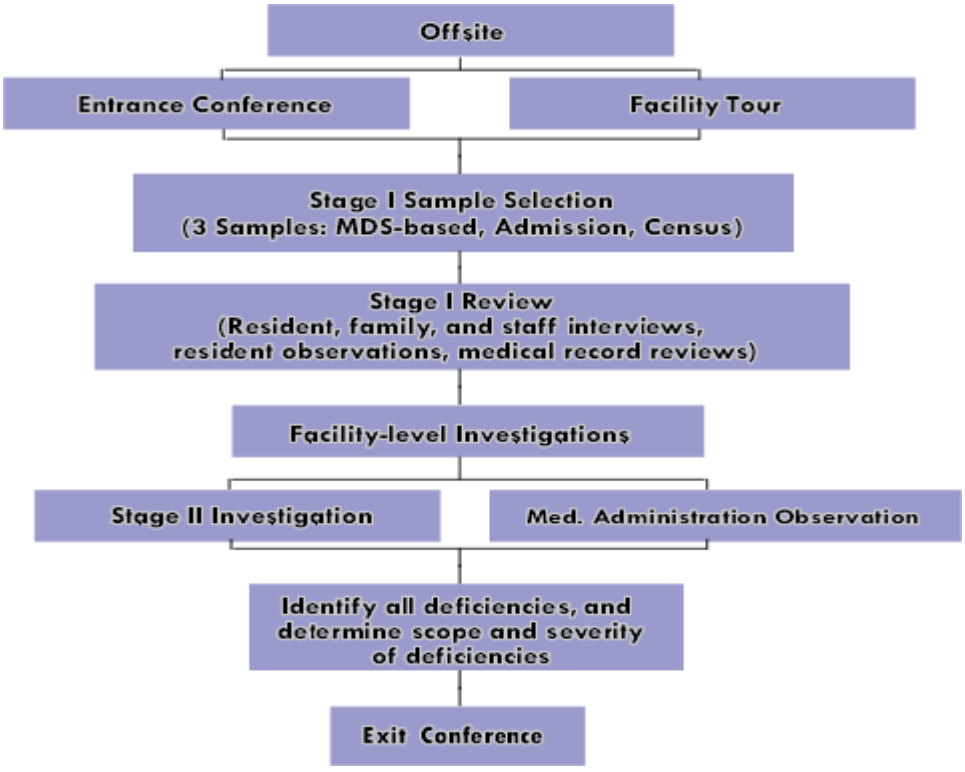
Stage I involves a preliminary investigation of both the Census and Admission samples, covering all regulatory areas. This review is through staff, resident, and family interviews, resident observations, and medical record reviews. Concurrent with the resident-level tasks, facility-level investigations are initiated, which include a Resident Council interview, observations of dining and kitchen, and reviews of the facility's infection control practices, demand billing process, and quality assessment and assurance program. (Additional facility-level investigations, including abuse prohibition, environment, nursing service sufficient staff, resident funds, and admission, transfer, discharge are completed only if triggered during Stage I.) These onsite data are used together with MDS data to construct resident-centered outcome and process indicators, called Quality of Care Indicators (QCIs).

Upon completion of Stage I, the QIS DCT is used to calculate the QCI results, which identify Care Areas that will require further investigation during Stage II. When the rate of a QCI exceeds a specified national benchmark or "threshold," that QCI identifies or "triggers" a Care Area for Stage II investigation. The results of Stage I provide the team with a list of the potential facility and resident care problems and preliminary information on each, but a complete Stage II investigation is required to determine whether deficient practices exist.

Stage II involves a more in-depth resident-level investigation of Care Areas identified at the conclusion of Stage I. Investigations follow a set of investigative protocols that assist the surveyor in completing an organized and systematic review of the triggered Care Areas. The protocols consist of probes that guide the surveyor through the investigation and assist in determining whether the facility is in compliance with the associated regulations (i.e., whether the "critical elements" of care are in place). Once the surveyor completes each investigation and determines whether each of the critical elements was met, all findings are entered into the QIS DCT. For each unmet critical element, the QIS DCT displays possible F tags for citation and requires the surveyor to enter relevant findings and assign an appropriate severity level. Concurrent to the Stage II investigation, medication administration is observed for ten residents selected

Continued on page 3

FIGURE 1: OVERVIEW OF THE QIS PROCESS



DESCRIPTION OF THE QIS—CONTINUED

for review during Stage II. If no Care Areas are triggered during Stage I, certain facility-level investigations must still be completed.

After all facility-level and Stage II resident-level investigations have been completed, the team analyzes the results to determine whether deficient practices exist. An exit conference is then conducted, during which the facility is informed of the survey findings.

DIFFERENCES BETWEEN THE QIS AND TRADITIONAL SURVEY PROCESS

TRADITIONAL SURVEY PROCESS

Information requested of facility upon survey entrance

- Quality Measure/Quality Indicator Report
- Roster Sample Matrix Form (CMS 802)

Tour

Gather information about concerns that have been pre-selected, new concerns, and other candidates for the sample. Determine whether residents pre-selected for the Phase I sample are still present in the facility.

Sample selection

- Residents selected offsite based on facility's QIs of concern. Sample size is determined by facility census.
- Determine whether any pre-selected concerns should be dropped and whether any pre-selected residents should be substituted based on review of Roster/Sample Matrix and findings from the tour.
- Determine which pre-selected Phase I sample residents are interviewable and number of reviews to complete based on census.
- Select residents for review type.

Survey structure

Phase I involves both comprehensive and focused reviews. Phase II involves focused and closed record reviews.

Review process

Surveyors complete the Resident Review, which includes selected investigative protocols for key regulatory tags.

Automation

At this point, most data collection is done on paper; computers are used only for the Statement of Deficiencies.

Group interview

Meeting with the Resident Group or Council (includes review of resident council minutes to identify concerns).

QIS PROCESS

Information requested of facility upon survey entrance

- Alphabetical list of residents and their room numbers.
- List of new admissions and discharges over last 30 days.

Tour

Initial brief review to gain information about the resident population, staff, and facility layout. The purpose is not to select a sample of residents for review nor to gather detailed information regarding specific concerns.

Sample selection

Four samples selected by the QIS DCT, including:

- MDS Offsite sample – residents with an MDS within 180 days prior to survey.
- Random Admission sample – 30 residents admitted more than 30 days prior to survey who had an MDS within 180 days prior to survey.
- Random Census sample – 40 residents currently in facility selected through offsite and onsite activities.
- Surveyor-initiated sample – residents selected at surveyor's discretion.

Survey structure

Stage I involves a preliminary investigation of all regulatory areas in Admission, Census, and Surveyor-initiated samples; Stage II involves further investigation of triggered Care Areas in Stage II sample chosen based on Stage I findings.

Review process

Follow consistent protocols for making observations, conducting interviews, and reviewing charts in Stage I; also includes specific structure for Stage II review and documentation.

Automation

Each team member uses tablet PCs throughout to record findings that are synthesized and organized by computer.

Group interview

Group interview replaced by Resident Council President/ Representative interview, supplemented by individual resident interviews.

HISTORY AND DEVELOPMENT OF THE QIS

The University of Colorado's Division of Health Care Policy and Research and the University of Wisconsin-Madison's Center for Health Systems Research and Analysis developed the QIS with information systems support provided by Maverick Systems, Inc., and Alpine Technologies through a contract from CMS for which RTI International was the prime contractor.

The QIS process, tools, software, and training materials have undergone extensive revisions and refinements over the years through pilot, feasibility, alpha, and beta tests led by teams of researchers, state surveyors, and CMS staff in numerous facilities throughout the country. The QIS Demonstration will enable CMS to further refine and improve upon the QIS process before determining whether to proceed with national implementation.

Under the QIS Demonstration, the University of Colorado will be responsible for providing surveyor training and technical support, with additional technical support provided by subcontractors Alpine Technologies and Iowa Foundation for Medical Care. The demonstration evaluation will be conducted by Abt Associates, Inc., and the UCLA Borun Center for Gerontological Research, with assistance from the University of Colorado. Remtech Services, Inc., is participating in the development of training methods.

During the Demonstration, a CMS team will provide oversight and guidance on all aspects of the QIS Demonstration implementation, evaluation design and performance, and refinements to the QIS process, as well as communication with participating states, their stakeholders, and other interested parties.

Questions regarding the QIS Demonstration Project may be directed to Fred Gladden at 410-786-3033 or FGladden@cms.hhs.gov.

Quality Indicator Survey Demonstration Project
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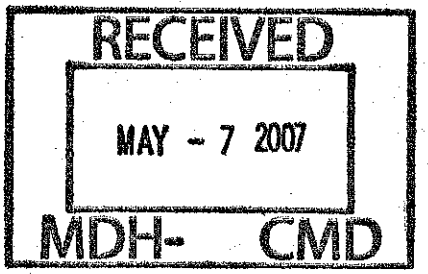
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

MAY 4 2007



Ms. Darcy Miner
Director
Compliance Monitoring Division
Minnesota Department of Health
85 E 7th Place
PO Box 64882
St. Paul, Minnesota 55164-0882

Dear Ms. Miner:

Thank you for your letter to me on April 5, 2007 asking about the status of the State's application for selection to implement the Quality Indicator Survey (QIS) process and expressing your continued commitment to implementation of the QIS in Minnesota. Through S&C-07-09 we invited State survey agencies that are not currently participating in the QIS demonstration to apply for selection for future statewide implementation of the QIS.

While congratulations were expressed during the recent Leadership Summit on being selected as the first new State to move forward with QIS implementation, I want to take this opportunity to formally acknowledge the exceptional work of you and your staff in developing a logical, comprehensive, and realistic plan for QIS implementation. The survey and certification team evaluating Minnesota's application described it as impressive, thoughtful, and detailed. The personnel proposed in the application are seasoned and the State support you have garnered is impressive. Also, we want to acknowledge your expression of willingness to work with CMS and its contractors in developing a new surveyor orientation model that includes the QIS process. This information has been shared internally and, while we do not interpret this as a condition of participating in QIS implementation, we plan to discuss this with you at a future date.

We are moving forward with the QIS process because, like you, we believe that the QIS has the potential to improve survey accuracy, consistency, and efficiency. A strong Federal survey and certification process protects the residents we serve. We recognize your commitment to strengthening the process and we thank you very much. We look forward to successful QIS implementation in Minnesota!

Sincerely,

Angela Brice-Smith for

Thomas E. Hamilton
Director