Annual Quality Improvement Report on the Nursing Home Survey Process

Report to the Minnesota Legislature

Minnesota Department of Health

Federal Fiscal Year 2008
Released June 2009

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 fifth 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, 2006 and 2007 Reports).

This report describes activities initiated during the past year, focusing on the Federal Fiscal Year (FFY) 2008, which ran from 10-1-07 through 9-30-08.

As noted in last year's Legislative Report, MDH's Licensing and Certification Program's special focus area for 2008 was Implementation of the Quality Indicator Survey Process (QIS), a new federal survey process for nursing homes. This is the first in what is expected to be a three year project. As of January 15, 2009, three survey teams have been trained in QIS, and only 97 surveys out of a total of 393 surveys, or approximately 25%, were conducted using the QIS process. The majority of the surveys were conducted using the traditional survey process.

MDH is just now starting to receive data reports from CMS on QIS surveys and working with CMS QIS experts on how to interpret that data and use it to its fullest extent. Data that MDH has collected and analyzed manually does not show a large increase in average number of deficiencies issued under the QIS survey process compared to that of the traditional survey process. Additionally, a review of deficiency tags shows deficiency tags issued under QIS to be fairly consistent with those issued under the traditional survey process with the exception of a few that do not overlap between the two processes.

Comments received from providers and surveyors about QIS have been very positive. Minnesota's implementation of QIS received national attention when Minnesota was awarded the Association of Health Facility Survey Agency (AHFSA) Promising Practice Award in October 2008. Since that award, several states have contacted Minnesota for advice on training implementing QIS statewide. MDH will continue to implement QIS statewide and collect and analyze survey data.

MDH continued to monitor survey deficiencies and make comparisons with other states. Data analyzed, shows that Minnesota continues to be high in average number of deficiencies issued compared to other states in CMS Region V and nationally, except in the area of complaints and Life Safety Code deficiencies. MDH believes that once other states begin to implement QIS, this gap will narrow. MDH also continued to monitor deficiency variations between survey districts within the state. This was one of MDH's primary special focus areas reported on in previous Legislative Reports. However over the last few years MDH has successfully taken steps to narrow this gap and discovered that through the implementation of the QIS process, which changes the make-up of the team (mix-max teams), it is becoming almost impossible to determine which team conducted the survey. This is making it increasingly difficult to report on any variation by team. Therefore, MDH has stopped reviewing survey team average and median deficiencies as a measure for monitoring survey process variation, until all surveyors are trained and conducting surveys under the QIS process.

This past year, the Department also continued work on other improvements to the survey process including providing joint training to surveyors and providers on revised guidelines issued by CMS, Life Safety Code regulations, culture change, and root cause analysis.

Additionally the Department collected and analyzed data on its revised post certification revisit policy that went into effect in November of 2006 to determine the effectiveness of that policy in assuring that deficiencies are corrected.

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 2009, the Department's primary focus will be continued statewide implementation of QIS. 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 reviewing and analyzing QIS data. Areas will be examined and a plan for follow-up will be developed as appropriate. 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.

MDH will also continue to monitor the revised PCR policy, and determine what, if any, changes need to be made to that policy, as well as plan for the replacement of the federal Minimum Data Set (MDS) 2.0 with MDS 3.0 which has an implementation date of October 1, 2010.

The Department is pleased with the quality improvement activities it has undertaken these past five years and received national recognition this year when it was awarded the CMS Survey and Certification Leadership Award for MDH's internal and external quality improvement efforts and stakeholder communication. MDH will not only continue, but, strengthen its quality improvement activities in the coming years.

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 fifth 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) 2008, which ran from October 1, 2007 through September 30, 2008.[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) Certification and Survey Provider Enhanced Reporting (CASPER) System, 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 CASPER 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 CASPER 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 of deficiencies, labeled A through L, 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 the following: 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 MDH 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

[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.

federal Department of Health and Human Services. CMS has been reviewing this issue and has 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 2008 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 02/26/09, Minnesota's average deficiencies per health survey was 10.0. The average deficiencies per health survey for all states in Region V was 6.8

Table 1, A-1: Average Deficiencies per Health Survey, CMS Region V Current Survey

State	Surveys	Tags from Each Group	Average Defs. Per Survey
Illinois	794	4,787	6.0
Indiana	511	4,109	8.0
Michigan	425	3,474	8.2
Minnesota	388	3,866	10.0
Ohio	957	5,456	5.7
Wisconsin	393	2,061	5.2
Total	3,468	23,753	6.8

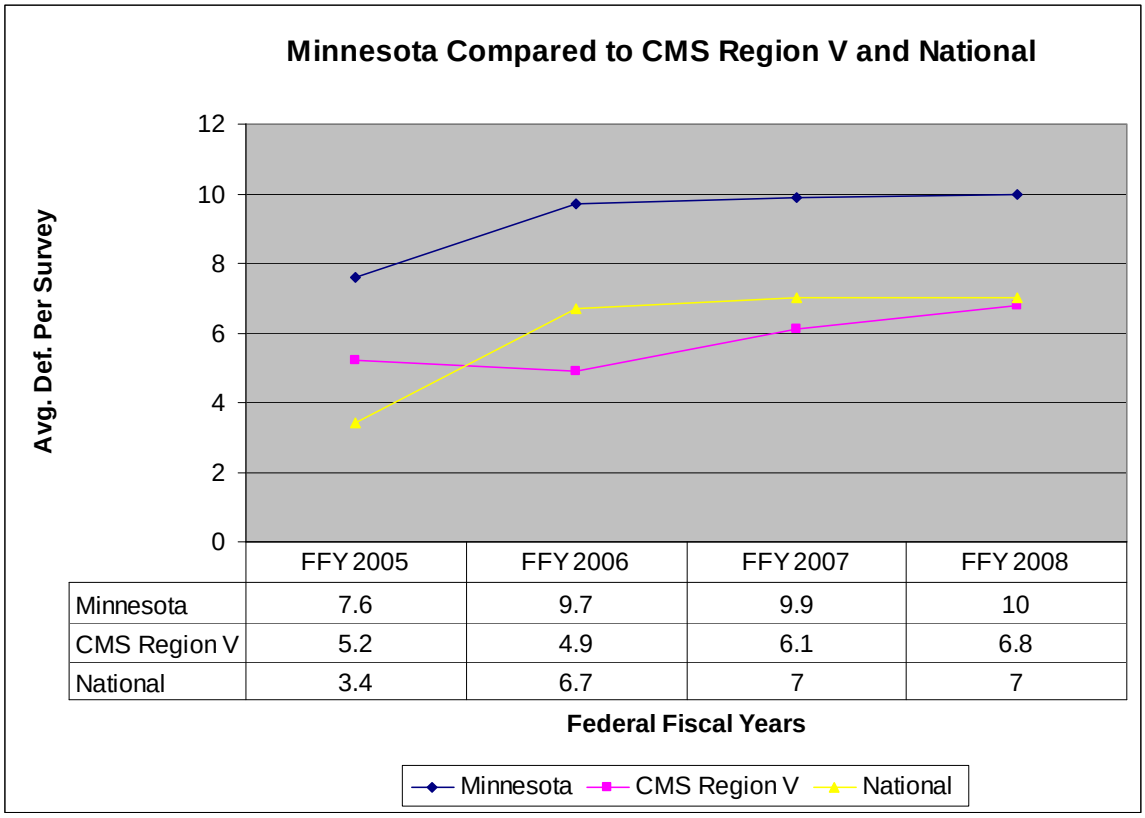
Source: Federal CASPER Data System, 02/26/09

Regionally, both the average number of deficiency per survey and total number of deficiencies have grown between 2007 and 2008. The average deficiencies per survey increased by 11.5%, from 6.1 in 2007 to 6.8 in 2008. This ranged from a high of 10.0 average deficiencies per survey in Minnesota to a low of 5.2 average deficiencies per survey in Wisconsin. At the same time, the total number of deficiencies grew by 7.2%, from 22,157 in 2007 to 23,753 in 2008, with the highest range of 5,456 survey deficiencies in Ohio to a lowest range of 2,061 deficiencies in Wisconsin. Tables I, A-1 above show the six states in CMS Region V with their respective average deficiency rates.

The national average deficiencies per health survey was 7.0 and Minnesota ranked tenth. 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. The graph below (Graph I, A-1) shows the average number of deficiencies per health survey from 2005-2008 for Minnesota, CMS Region V, and Nationally.

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

Graph I, A-1 Minnesota Compared to CMS Region V and National FFY 2005-2008



	FFY 2005	FFY 2006	FFY 2007	FFY 2008
Minnesota	7.6	9.7	9.9	10
CMS Region V	5.2	4.9	6.1	6.8
National	3.4	6.7	7	7

Source: Federal CASPER Data System

In terms of average deficiency per health survey, from FFY 2005 – 2008 average number of deficiencies for Minnesota increased slightly each year. Nationally, the average number of deficiencies also showed similar slight increases in average deficiencies per survey between FFY 2006 and FFY 2007, except between 2007 and 2008 where the average number of deficiencies remained the same or showed no increase at all. Regional average number of deficiencies experienced a slight decrease between 2005 and 2006, and kept increasing through FFY 2008.

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

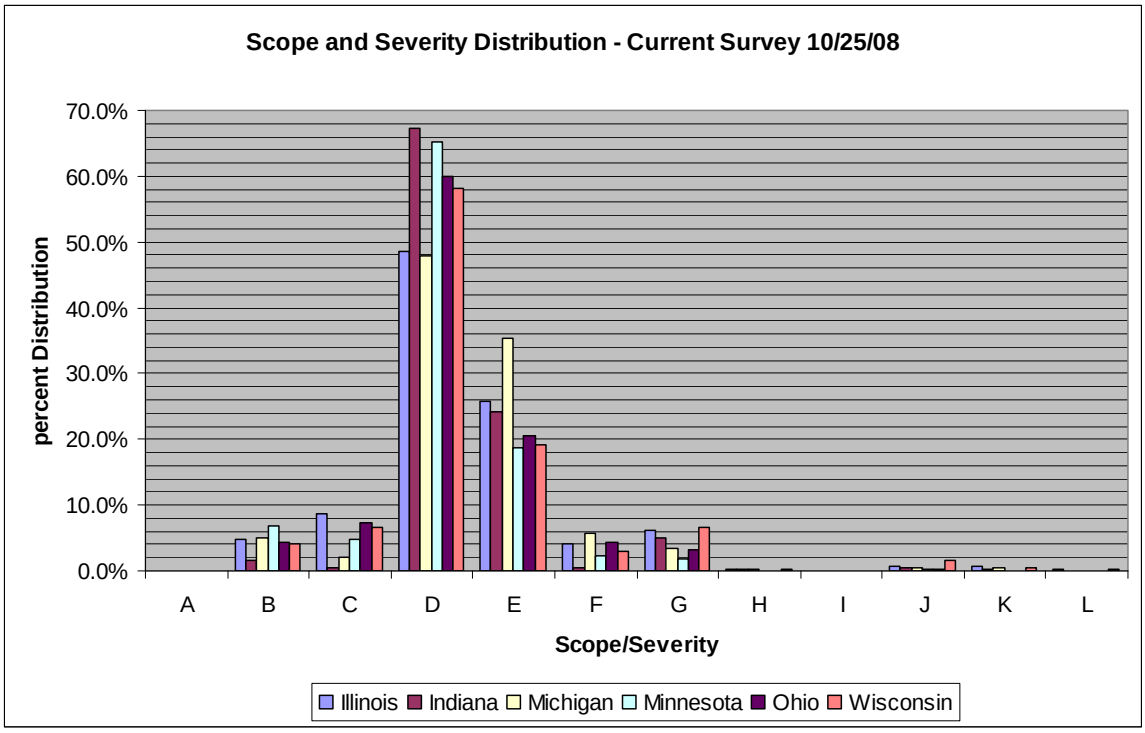
In Minnesota, the greatest number and percent of tags issued continue to be at scope and severity levels D and E, which is comparable to other states in Region V (Table I, A-2). Minnesota had fewer tags written at scope and severity G and above, compared to other states in Region V. Overall, the numbers of tags written at the most serious levels are small, compared to lower level tags in all states in Region V.

Table I, A-2: Number of Tags Issued in Each Scope and Severity, CMS Region V Current Survey

State	A	B	C	D	E	F	G	H	I	J	K	L	Total
Illinois	0	227	410	2,328	1,231	201	299	12	0	35	35	9	4,787
Indiana	0	70	20	2,762	996	18	204	12	0	21	6	0	4,109
Michigan	0	176	69	1,661	1,224	195	115	5	0	14	13	2	3,474
Minnesota	0	262	185	2,518	725	86	72	2	0	12	4	0	3,866
Ohio	0	239	393	3,276	1,123	236	172	0	0	12	5	0	5,456
Wisconsin	0	86	134	1,199	396	60	134	4	0	32	9	7	2,061
Total	0	1,060	1,211	13,744	5,695	796	996	35	0	126	72	18	23,753

Source: Federal CASPER Data System, 02/26/09

Graph I, A-2: Scope and Severity Distribution Current Survey 10/25/08



Source: Federal CASPER Data System

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 (65% were at D and 19% were at E). See Graph I, A-2 above.

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

Since FFY 2005, MDH has looked at average and median number of deficiencies issued by survey team on a monthly basis and has shared this information with nursing home provider organizations. MDH has also undertaken a number of initiatives to address variation in deficiency citations between survey districts. These data and initiatives are discussed in previous Legislative Reports (See Appendix E for a link to the 2004, 2005, 2006, and 2007 Legislative Reports)

While the Department recognizes that reporting survey deficiency data by region within the state is a requirement in the Annual Legislative Report, and has reported this data in previous Legislative Reports, the Department has undergone several changes to the survey process this year which makes it difficult to continue to report this data in a meaningful way. One of the major changes this year is the Department's implementation of a new federal survey process called the Quality Indicator Survey (QIS) Process. Statewide implementation of QIS is expected to take three years and 2008was the first year of implementation. Training began in early January 2008 and the first QIS mock survey was conducted end of January 2008. Not all surveyors are trained in QIS and not all surveys are being conducted using the QIS process. In fact, approximately three-fourths of the total number of surveys are being conducted under the traditional survey process. Additionally, the teams that are surveying under QIS are made up of surveyors from different districts. The mixing up of teams (mix-max teams) is one of the quality assurance strategies under the QIS process. As a result, it is becoming more difficult for MDH to determine which team conducted the survey, and report on the number, scope and severity of citations within the state and identify variations. Therefore, MDH has stopped reviewing the survey team average and median deficiencies as a measure of monitoring survey process variance, until all surveyors are trained in QIS and all surveys are being conducted using the QIS process. At that time, the concept of "team arrangements" will be more relevant and meaningful to track.

It is important to note that one of the strengths of the QIS process and one of the reasons Minnesota requested to be one of the first states to implement QIS beyond the six demonstrations states, was to improve accuracy and consistency of the survey process. This is just one of the objectives that QIS was designed to achieve. Other objectives include the following, as described in CMS'updated QIS brochure (See Appendix F):

- Enable timely and effective feedback on survey processes for surveyors and managers;
- Systematically review requirements and objectively investigate all triggered regulatory areas within current survey resources;
- Provide tools for continuous improvement;
- Enhanced documentation by organizing survey findings through automation; and,
- Focus survey resources on facilities (and areas within facilities) with the largest number of quality concerns.

More information about QIS, including MDH's progress with implementing QIS statewide and analyzing deficiency data, is discussed in Section II of this report.

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's 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 2008 was 4.3 and the average in Minnesota was 3.3; Minnesota ranked 29th. Within CMS Region V, the average number of deficiencies per LSC survey was 5.5, and Minnesota had the fewest number of deficiencies issued at 3.3 (Table I, A-3 below). A table of average number of LSC deficiencies per survey for the U.S. is attached as Appendix G.

Table I, A-3: Average Deficiencies per LSC Survey, CMS Region V

State	Surveys	Tags from Each Group	Average Defs. Per Survey
Illinois	794	5,273	6.6
Indiana	511	3,061	6.0
Michigan	425	2,666	6.3
Minnesota	388	1,285	3.3
Ohio	957	4,751	5.0
Wisconsin	393	2,023	5.1
Total	3,468	19,059	5.5

Source: Federal CASPER Data System, 02/26/09

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, 2006, and 2007 Reports). Briefly, it means that a deficiency practice is sited in two or more related tags, usually a "process" tag and an "outcome" tag. 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.

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 which was designed to improve the accuracy and consistency of the survey process, will likely narrow the gap in variation between states once it is fully implemented in all 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.[6]

IDR

The IDR is performed by an MDH supervisor who has not previously been involved in the survey. For surveys with exit dates during FFY 2008, 12 IDRs were requested. A total of 24 tags were disputed. Of the disputed tags, the reviewer's decision was to change the scope and severity for 1 tag, and to delete 8 tags, for a total of 9 tags (38%) 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.

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, 111 IIDR requests have been made through FFY 2008. In FFY 08, there were 14 requests involving 30 tags. Of the 14 requests, 5 were withdrawn by the facility prior to the IIDR review, and those 5 included 14 tags. Table I, C-1 summarizes the tags that went forward with an IIDR in FFY 2008.

Table I, C-1: Summary of IIDR Results, FFY08

Number of tags in dispute: 9		
ALJ recommended action:		Number of tags:
Uphold tags as written		5
Uphold scope and severity, but delete some findings		0
Total tags upheld	**5**	
Dismiss		1
Adjust scope and severity		3
Total tags adjusted or dismissed	**4**	
Commissioner's decision:		Number of tags:
Uphold tags as written		5
Uphold scope and severity, but delete some findings		1
Total tags upheld	**6**	
Dismiss tags		1
Adjust scope and severity		2
Adjust scope		0
Total number of tags adjusted or dismissed	**3**	

[6] 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.

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 2008 were approximately $27,210 with MDH paying approximately $9,500 and nursing homes paying approximately $17,710 (Table I, C-2).

Table I, C-2: OAH Costs Paid by Nursing Homes and MDH through FFY 08

OAH Cost Apportionment	Number of Nursing Homes	Number of Tags	Cost Amount
Nursing Home paid 100% of costs	4	5	$17,710.00
Nursing Home split costs with MDH:	0	0	$ 0
Costs split – portion paid by NH	0	0	$ 0
Costs split – portion paid by MDH	0	0	$ 0
MDH Paid 100% of costs	2	4	$ 9,500.00

Source: Office of Administrative Hearing Invoices

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 2008. 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. 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.

In FFY 08, the Centers for Medicare and Medicaid Services (CMS) reminded states of its guidance on the Release of Federal Documents by the State Survey Agencies, Administrative Information Bulletin 07-06, issued January 12, 2007 (See Appendix H for a copy of this bulletin). Per that Administration Memo, much of the information and many of the documents routinely used in the IIDR process require a Freedom of Information Act (FOIA) request. There have been a number of FOIA requests by nursing homes; that has delayed scheduling IIDRs while MDH awaits CMS responses to those requests. Three IIDR requests from FFY 08 are delaying scheduling an IIDR pending notification from CMS on their FOIA requests.

Table I, C-3: Staff Time in Hours Spent on IDR and IIDR -- FY 2008

Process	Number of Reviews	Total Supervisor & Surveyor Time	Average Supervisor & Surveyor Time (hrs.) per Review
IIDR	9	221.5	9
IDR	15	117	15

Source: Paradise Data System

MDH has used the information gained from the IIDR process, as well as the IDR 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 two nursing homes that initiated an appeal at the federal level during FFY 2008.

E. Compliance with Timelines for Survey Revisits and Complaint Investigations

If a survey team finds deficiencies at the B through L level, the nursing facility 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, Subd. 5 requires the Commissioner to conduct revisits within 15 calendar days of the date by which corrections will be completed, in cases where 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. B and C level deficiencies do not require a revisit.

For facilities surveyed during FFY 2008, there were 46 facilities with surveys where category 2 or 3 remedies were imposed. One hundred eighteen (118) revisits were conducted at these 46 facilities. Nineteen of these facilities had a total of 28 revisits which were completed more than 15 days after the date of the facility's alleged compliance date. Seventeen of these facilities had a total of 40 visits which were completed subsequent to the facility being notified of a category 2 or 3 remedy. Of the 118 revisits:

- 90 revisits (79%) were completed within 15 calendar days after the facility's alleged compliance date.

- 28 revisits (21%) for 19 facilities were not completed within the 15 calendar days after the facility's alleged compliance date. Ten of these were L & C revisits, 2 were OHFC revisits and 16 were LSC revisits. Of these 28 revisits not completed within the 15 calendar days after the facility's alleged compliance date, in no case did the date of the revisit result in additional category 2 or 3 remedies and/or increased financial burden to the facility.

The number of facilities having category 2 and/or 3 remedies increased from 42 in FFY 2007 to 46 in FFY 2008 (an 11% increase). This resulted in the required 118 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.

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, 2006 and 2007 Reports). These activities are also described in MDH's Licensing and Certification (L&C) Program's Quality Assurance Plan (Appendix I). Throughout FFY 08 the L&C 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.
- 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 updated to reflect changes made in 2008.
- The Clinical Web Window was expanded to include training materials on Abuse Prevention and Reporting and the revised federal guidelines issued in 2008 regarding Nutrition and Food Sanitary Conditions (F 325 and F371).

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

Minnesota Statutes, Section 144A.101, Subd. 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 CMS-2567) within 15 working days of the exit conference.

Delivery of a draft statement of deficiencies at the time of the survey exit has been implemented. Three hundred ninety-four (394) surveys were exited during FFY 2008 and the rough draft statement of deficiencies was left with the facility at the survey exit in all 394 instances.

Of the 394 surveys exited during FFY 2008, greater than 99% met the 15 day requirement for delivering the final CMS-2567. Of the three surveys that exceeded the 15 day requirement for delivering the final CMS-2567, one delay was related to issues involving training for the new QIS survey process, and included computer problems and deficiencies requiring extra proofing and editing. One delay was related to shifting of deficiency review responsibilities to substitute staff to cover for a vacant supervisory position in the District Office. One delay was related to a unit supervisor being out of state at a week long training session, deficiencies being received late for review and computer problems.

H. Other Survey Statistics Relevant to Improving the Survey 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 2008) include achieving a nationwide pressure ulcer rate of 8.0% or below and a physical restraint rate of 5.9% or below. Tables I, H-1 and I, H-2 describe Minnesota's progress in meeting these goals.

Table I, H-1: GPRA Goal Rates for CMS Region V and Minnesota National Target Period for CY 08 4th Quarter, Ending December 31, 2007

Goal Type	National Goal	CMS Region V Goal	Minnesota's Rate 4th Qtr. 2008	# of NHs in MN Above National Goal	# of NH in MN Above CMS Reg. V Goal
Pressure Ulcers	8.0%	7.4%	5.9%	72 (out of 393 NHs)	96 (out of 393 NHs)
Physical Restraints	5.9%	4.5%	2.3%	47 (out of 393 NHs)	83 (out of 393 NHs)

Source: CMS PDQ Data

Table I, H-2: GPRA Goal Rates for CMS Region V and Minnesota National Target Period for CY 08 4th Quarter, Ending December 31, 2008

Goal Type	National Goal	CMS Region V Goal	Minnesota's Rate 4th Qtr. 2008	# of NHs in MN Above National Goal	# of NH in MN Above CMS Reg. V Goal
Pressure Ulcers	8.0%	7.4%	5.1%	71 (out of 387 NHs)	97 (out of 387 NHs)
Physical Restraints	5.9%	4.5%	2.0%	30 (out of 387 NHs)	58 (out of 387 NHs)

Source: CMS PDQ Data

While overall Minnesota continues to meet and exceed the national goals, there are a significant number of individual nursing homes that still have higher rates than the regional or national goals require. 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 its providers and stakeholders in achieving these goals.

MDH and Stratis Health, the Quality Improvement Organization, have been working closely with the provider associations by sharing GPRA rates so provider associations can assist their members in reaching these goals. Related to the pressure ulcer goal, MDH and Stratis Health together established a committee of stakeholders to promote collaborative efforts to reduce the prevalence of pressure ulcers across a continuum of health care settings. The committee plans to identify and learn from Minnesota communities and system models that have worked effectively across settings on pressure ulcers and other health care issues.

II. Summary of Improvements Made to Date on the Nursing Home Survey Process: Areas of Special Focus for 2008.

A. Statewide Implementation of the Quality Indicator Survey (QIS) Process

As stated in the 2007 Report to the Legislature, implementation of the revised federal survey process or Quality Indicator Survey (QIS) process was MDH's Licensing and Certification Program's primary focus for 2008. Minnesota was chosen by CMS to be the first state to expand QIS beyond the six demonstrations states. Full implementation is expected to take three years.

QIS uses new technology to improve the accuracy, consistency and efficiency of the survey process. Strengths of this new 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 F for a CMS fact sheet on QIS).

Training of Survey Staff

Training on QIS began on January 7, 2008 with CMS' contracted QIS training staff (Nursing Home Quality) providing an extensive training to a core group of MDH surveyors (St. Cloud Team), survey supervisors, program managers and computer staff. Two federal surveyors and one federal IT staff also attended this training. Training included one week of classroom training followed by a mock survey and six surveys of record (two of the six were compliance surveys) per team (participants were divided up into 3 teams). This comprehensive training extended over a two month period of time.

Providers and other stakeholders were invited to participate via conference call during the first 1½ hours of the training, where an overview of the QIS process was given.

Since that core group of surveyors was trained, three other groups were trained using the core group as trainers. The Bemidji and one Metro Team B staff was trained in April 2008. The Mankato Team, the rest of the St. Cloud Team and two surveyors from the Metro area were trained in October 2008. A fourth group (rest of the Metro Area surveyors) was trained in February 2009. It should be noted that all new hires are also being trained in QIS, as opposed to the traditional survey process. The three remaining survey teams (Duluth, Fergus Falls and Rochester) will be trained in 2010. It is MDH's goal that once surveyors have been fully trained in QIS, they will only do QIS surveys and they will not revert back to surveying under the traditional survey process. The Department anticipates that by the end of January 2011, 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.

Communications with Providers

MDH has had regular communications with providers on the status of QIS implementation and issues surrounding QIS, through its statewide provider and surveyor telephone conferences and other meetings with providers and stakeholders. On June 23, 2008, a statewide surveyor and provider phone conference was held to give an update on implementation of QIS and discuss other regulatory issues. MDH learned through that phone conference that investigations were an area that needed additional training. During the week of July 14, 2008 staff from Nursing Home Quality (CMS' QIS trainers) came to Minnesota to provide additional training to surveyors on the new investigative protocol using the QIS tool. Additional provider and surveyor telephone conferences were scheduled for January 26, March 30 and June 15 of 2009. MDH has also provided other QIS information to providers, including posting links to CMS'QIS Resource Manual and Electronic Forms and Worksheets on the Compliance Monitoring Division web site under the Information Bulletin section (See Appendix C and E for links to the web sites containing these QIS resources).

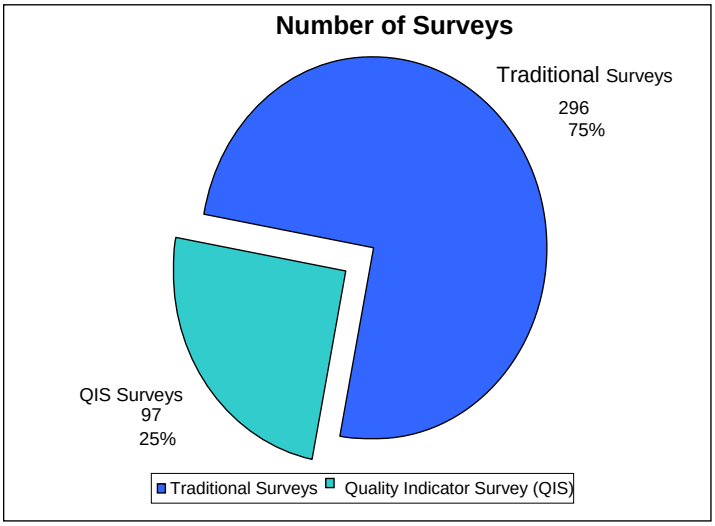
Evaluation of QIS and QIS Survey Deficiency Data

As mentioned previously, this is the first year of a three year statewide implementation plan for QIS. The majority of 2008 was focused on learning about the QIS process, training surveyors, working out issues between the two processes, etc. MDH is just now starting to receive QIS data reports from CMS, and survey supervisors and managers have been working with Nursing Home Quality to better understand that data and use it to the fullest extent. MDH will be working with survey staff in FFY 09' to educate them about QIS data reports. Areas that are determined to be

outliers will be examined and a plan for follow-up will be developed as appropriate. CMS is also working on modifying the Aspen Central Office data base, which will provide Minnesota comparison data with other QIS states. Additionally, federal survey staff will be visiting Minnesota during the last quarter of FFY 09' to conduct a focus survey of QIS, as part of the federal oversight process and evaluation of QIS. MDH expects to learn much from this federal survey and the data provided.

Meanwhile, MDH has conducted its own manual data review and analysis of QIS. Data from 01/1/08 – 01/14/09 showed that a total of 97 or approximately 25% of the 393 total surveys were conducted using the QIS process, and 296 or approximately 75% using the traditional survey process (Graph II, 1).

Graph II, A-1: Number of QIS vs. Traditional Surveys Conducted, Surveys Exited Between 01/01/08 and 01/14/09



Source: Paradise Data System

The total number of deficiencies issued per survey ranged from 0 to 27 and the average number of deficiencies was 11.23 (Table II, A-1). This reflects a 14.2% increase in average number of deficiencies under the QIS process compared to the traditional survey process.

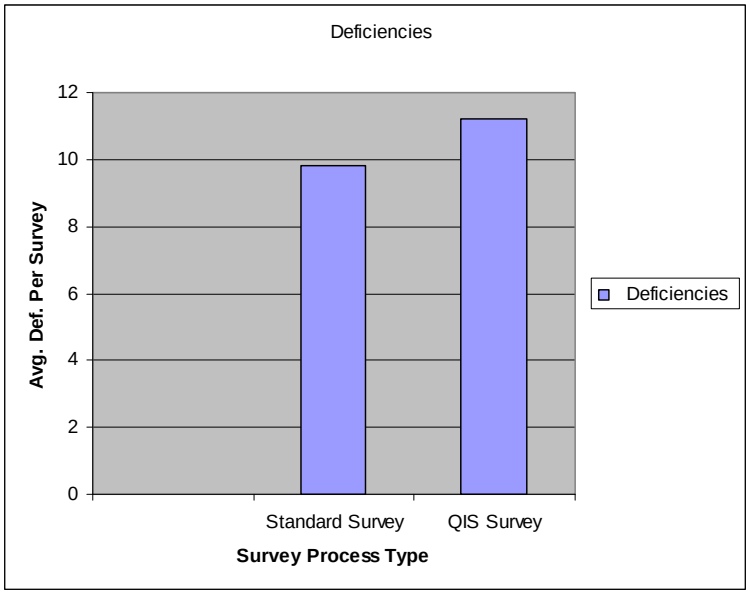
Table II, A-1: Average Deficiencies per Health Survey Traditional Survey Process vs. QIS Process, Surveys Exited Between 01/01/08 and 01/14/09

Survey Process Type	# of Surveys	Deficiencies	Avg. Def./Survey
Traditional Survey Process	296	2,910	9.83
Quality Indicator Survey (QIS)	97	1,089	11.23
Total	393	3,999	10.18

Source: Paradise Data System

Graph II, A-2 shows average deficiencies per health survey for both the traditional vs. the QIS surveys. For the surveys exited between 01/01/08 and 01/14/09, the QIS surveys have resulted in only 1.4 additional deficiencies. However, it is important to note that Minnesota only did 97 QIS surveys out of 393 total surveys. Only a small percentage of the total surveys were conducted using the QIS survey process (24.69%) compared to the traditional survey process (75.32%). Therefore, it is difficult to draw final conclusions when the two survey process types were not equally distributed or selected.

Graph II, A-2: Average Deficiencies per Health Survey Traditional Survey Process vs. QIS Process, Surveys Exited Between 01/01/08 and 01/14/09



Source: Paradise Data System

MDH does not expect to see a large increase in deficiencies with the QIS process, because Minnesota was already doing "cross-referencing" per federal requirements. "Cross-referencing", or the issuance of independent but associated tags ("process" and "outcome" tags) is embedded in the QIS process. Under the traditional survey process, data shows that some states are issuing "process" and "outcome" tags on a consistent basis, whereas other states are not. The issue of "cross referencing" has been explained in previous Legislative Reports (See Appendix E for a link to the 2004 – 2007 Reports).

In terms of the types of deficiency tags cited under QIS compared to the traditional survey process, manual review of tags identified several overlaps in tags issued under the traditional survey process compared to that of QIS (Table II, A-2). This indicates to the Department that surveyors, even under the traditional survey process, were looking at and identifying issues in the right areas.

Table II, A-2: Traditional Survey Deficiencies Compared to QIS Survey Deficiencies, 12/19/09 and 01/14/09

Top 10 Traditional Survey Deficiencies as of 01/14/09	Top 10 QIS Deficiencies as of 12/19/08
F329 Unnecessary Medication	F272 Comprehensive Assessment
F314 Pressure Ulcer Treatment/Prevention	F323 Accidents/Supervision
F282 Prov. Care According to Plan of Care	F329 Unnecessary Medications
F323 Accidents/Supervision	F282 Prov. Care According to Care Plan
F315 Urinary Incontinence	F428 Drug Regimen Review
F272 Comprehensive Assessment	F279 Comprehensive Care Plan
F279 Comprehensive Care Plan	F280 Care Plan Revision
F465 Environment	F371 Food Handling and Sanitation
F371 Food Handling and Sanitation	F315 Urinary Incontinence
F 274 Assessment after Significant Change	F314 Pressure Ulcer Treatment/Prevention

Source: Paradise Data System

Providers have expressed concern about higher scope and severity deficiencies issued under QIS. However, there is no data at this time to support that allegation. Data that MDH collects on IIDRs for FFY 08' shows that only two QIS surveys requested an IIDR.

Feedback from providers about QIS has been very positive overall. Providers have commented that facilities are being cited as they would have under the traditional survey process. Providers find the QIS process to be less intrusive for staff and residents because the survey process observations are collected over the entire survey, and not primarily in blocks of observation times during the first day which is the practice under the traditional survey process. In the early stages of implementing the QIS process, providers expressed concern about losing some of the state survey tasks (e.g.Verify Clarify, interviews with family council members) that are not part of the federal QIS process. However, MDH has since resolved those issues. For the Verify Clarify task, QIS provides ample opportunity for communication throughout the process, especially with licensed nursing staff. For the family council interview requirement, surveyors are asking licensed only nursing homes for family council contacts and related information in order to meet the state regulations. A few providers have expressed concern about the amount of nursing time that is involved in Stage I interviews. This appears to be more of an issue with the smaller facilities which may not have a lot of nursing staff to serve as a back-up for providing cares, etc. while other nursing staff is being interviewed.

From a surveyor's perspective, those surveyors who have been trained and surveying under the QIS process, like the new process. They find the QIS process to be more comprehensive and believe they are investigating areas and identifying issues they may not have under the traditional survey process (e.g. dental, rehabilitation, resident funds). Surveyors also like the fact that the QIS process involves more interviews of residents, and as a result they are doing a more thorough review of quality of life areas.

MDH will continue to seek feedback on QIS from providers, surveyors and other stakeholders and work to resolve issues that arise from the change in survey processes.

MDH as a QIS Resource for Other States

MDH's implementation of QIS received national recognition in October of 2008 when it was awarded the Association of Health Facility Survey Agency (AHFSA) Promising Practices Award for its proposal titled "Nursing Home Quality Indicator Survey (QIS): Plan to Reality, a Case Study – Best practices learned for future implementation by state survey agencies". Since that award, several states and a Canadian providence have contacted Minnesota for advice on training and implementing QIS.

B. Other Quality Improvement Activities

Monitor and Evaluate the Revised Post Certification Revisit Process

As explained in the 2007 Legislative Report, on November 3, 2006 MDH revised its process for performing post certification revisits (PCR) for nursing facility surveys (Appendix J). 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 a PCR follow-up inspection. If corrections were not made, citations were re-issued and another PCR visit was scheduled.

As of November 3, 2006, 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.

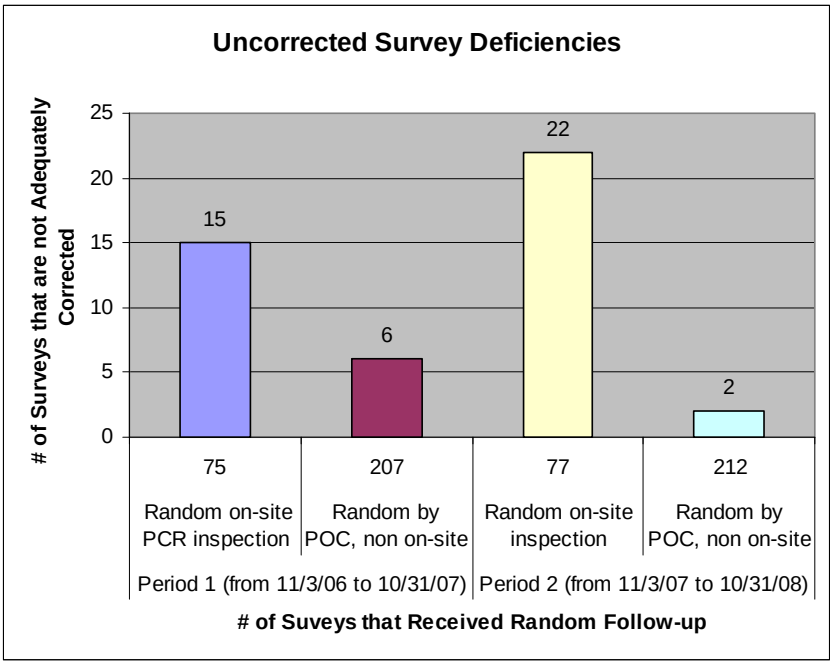
MDH is currently monitoring the on-site follow up inspection patterns for randomly selected providers to determine the effectiveness of the new policy in maintaining compliance with federal and state resident nursing home health and safety requirements. MDH has established two preliminary measures it 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 agency's random selection process. Of those 325, 62 or 19% did not have deficiencies adequately corrected and required multiple PCR visits.

- During the period from November 3, 2006 through October 31, 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.
- Between the period of November 1, 2007 and October 31, 2008, 77 surveys received a random on-site PCR inspection. Of those 77, 22 or 28.6% 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 were consistent, within 1% between FFY 06 and FFY 07 for providers meeting the random selection criteria. However correction rates requiring a follow-up inspection increased 8.6% from Period 1 (from November 3, 2006 to October 31, 2007) to period 2 (from November 3, 2007 to October 31, 2008).

Graph II, B-1, Uncorrected Survey Deficiencies, November 3, 2006 to October 31, 2008



Source: Paradise Data System

It appears that providers were correcting deficiencies for the first year that the revised policy went into effect. However during the second year (Period 2) some providers may not have followed through with correcting deficiencies. The Department will continue to monitor the correction rates over FFY 09 and discuss these changes with the provider association to determine if the PCR policy needs further revision or if the random follow-up process needs to be discontinued.

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. Table II, B-1 below is for complaints resolved between November 3, 2006 and October 31, 2007; the complaint substantiation rate for PCR by Plan of Correction (POC) providers is 4.5% higher than the random on-site inspection group.

Table II, B-1: Complaint Substantiation Rates, Nov. 3, 2006 to Oct. 31, 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%

Source: Paradise Data System

The table below is for complaints resolved between November 3, 2007 and October 31, 2008; the complaint substantiation rate for PCR by Plan of Correction (POC) providers is 0.3% lower than the random on-site inspection group.

Table II, B-2: Complaint Substantiation Rates, Nov. 3, 2007 to Oct. 31, 2008

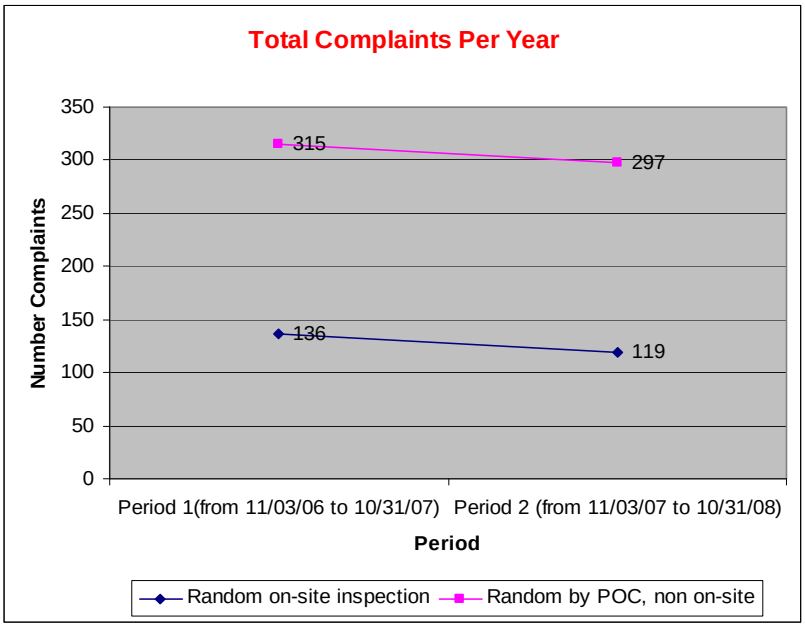
Follow-up Type	Surveys	Total Complaints	Substantiated	Substantiation Rate
Random on-site inspection	77	119	18	15.1%
Random by POC, non on-site	212	297	44	14.8%

Source: Paradise Data System

The number of substantiated complaints for the random on-site inspection increased 50%, from 12 (between Nov. 3, 2006 and Oct. 31, 2007) to 18 (between Nov. 3, 2007 and Oct. 31, 2008). For the random by POC non on-site group, number of substantiated complaints remained the same in 2008. Similarly, the substation rate for the random on-site inspection group increased (1.5%).

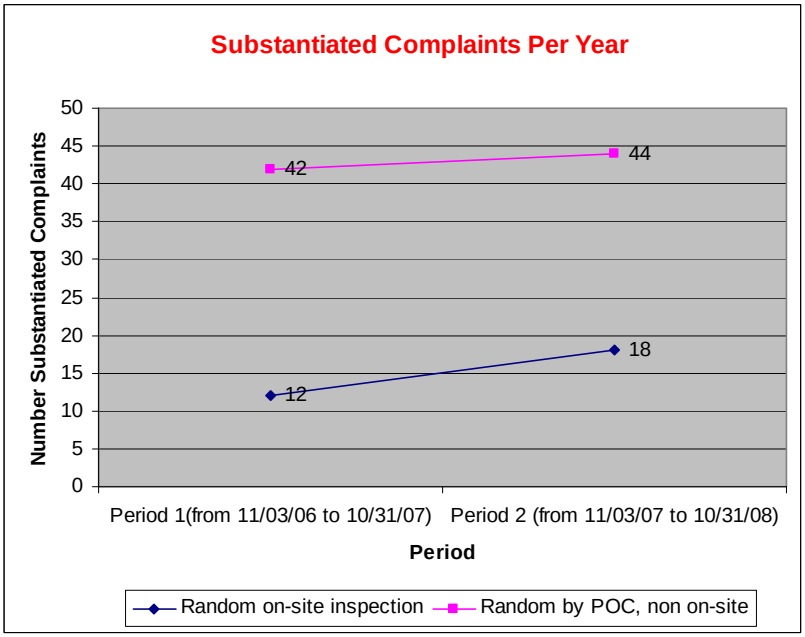
Looking exclusively at total complaints for the Random by POC, non on-site group, MDH received 5.7% percent less than the previous period. For Period 1 (November 3, 2006 to October 31, 2007) a total of 315 complaints were received for the Random by POC, on-onsite group compared to Period 2 (November 3, 2007 to October 31, 2008) where a total of 297 complaints were received.

Graph II, B-2: Complaint Totals, November 3, 2006 to October 31, 2008



Source: Paradise Data System

Graph II, B-3: Substantiated Complaints, Nov. 3, 2006 to Oct. 31, 2008



Source: Paradise Data System

In last year's Legislative Report, MDH indicated that they would begin monitoring 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. MDH was concerned that 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. MDH has not completed a thorough review and analysis of this data, and will report on the findings in the 2009 Legislative 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 FFY 2008, CMS issued revised guidance on F325 and F371 Nutrition and Sanitation. MDH, together with the collaborative joint training group, developed a three-hour joint provider and surveyor statewide video conference on these new guidelines which was held on October 3, 2008. Three follow-up phone conferences to discuss status of implementation and issues surrounding the new guidelines were scheduled for January 29, March 30, and June 15 of 2009.

Future revised guidelines that CMS plans to issue include F 309 End of Life Issues and Pain Management and F 223-226 Abuse. 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.

Besides providing training on CMS revised guidelines, MDH also conducted two training sessions in April of 2009 on abuse prevention and reporting, for providers, surveyors and complaint investigators. More information on this training can be found in MDH's Compliance Monitoring Division Information Bulletin 08-04 and on the Clinical Web Window (See Appendix E for a link to the Information Bulletins and Clinical Web Window web sites.)

Life Safety Code Training

During June 2008, MDH conducted a four-hour seminar on protecting the means of egress for approximately 300 long term care facility administrators and engineers in five locations throughout the state.

In addition to this training, MDH contracted with a retired State Fire Marshall Supervisor, on a Life Safety Code (LSC) documentation project. The project involved the development of narrative language, sample blank forms and sample completed forms for twelve major LSC topics (e.g. fire drills, emergency generator sets, fire alarm systems, etc.). These documents are available on MDH's Engineering Section web site at http://www.health.state.mn.us/divs/fpc/lifesafetycode.html . The documents should be helpful for providers, as MDH has found that a significant number of LSC deficiencies cited each year are related to non-existent, incomplete or incorrect documentation.

Dental Care Video

For the past 1½ years the Department has been developing a training video and workbook on providing proper oral health care to residents in nursing homes. MDH has been working with the University of Minnesota School of Dentistry Oral Health for Seniors Program and various long

term care stakeholders on this project. The video is being funded through the Civil Money Penalty Program and is expected to be released later in 2009.

Communications for Survey Improvement – Duluth (CSI-Duluth)

CSI-Duluth, a regional stakeholder group in the northeast district of the state, continues to meet on a regular basis to conduct regional training for surveyors and providers. In October and December of 2008 CSI-Duluth took part in a pilot study to provide root cause analysis training (RCA) to nursing homes in the region. Root cause analysis training is a structured, systematic, team-based and facilitated process to uncover the contributing factors behind adverse events or errors. This was considered a pilot study, because the RCA training that has been conducted to date has only been provided to hospitals. Approximately 185 people from 38 facilities in the northeast region of the state attended this two-part training. The first day of training focused on providing attendees with a basic understanding of how the RCA approach to investigations is different from the customary approach to investigation, and how it can positively impact their organization. The second day of training, attendees learned how to convene an RCA team, the types of questions to ask, how to facilitate an RCA, how to deal with challenging issues that might arise, how to get leadership buy-in, etc. MDH and Stratis Health will be following up with attendees to see what steps they have taken to get leadership buy-in, train staff, or implement RCA in their facilities. All materials from the training are posted on MDH's Clinical Web Site for providers statewide to access. Discussions are also occurring about possibly creating a library that includes forms, data collection and analysis tools that staff could access, and also about the possibility of doing a metro area RCA training.

More information about CSI-Duluth activity is available on the Committee's website. See Appendix E for a link to CSI-Duluth's website.

Culture Change

MDH continues to support 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 October of 2008 providers and advocates of long term care services, MDH surveyors and complaint investigators, staff from the State Fire Marshall's Office as well as others gathered for a half day session to discuss how regulations and culture change fit together to improve care and life for older adults in long term care facilities and programs. This was the third educational session sponsored by the Minnesota Culture Change Coalition.

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.

III. Areas of Special Focus for 2009

Continue Statewide Implementation of the Quality Indicator Survey (QIS) Process

A major focus for the Department over the next two years will be continued statewide implementation of the revised federal survey process or Quality Indicator Survey (QIS) Process. This will include training of additional survey staff (Duluth, Fergus Falls and Rochester teams), on QIS and use of QIS improvement tools; implementing QIS in other regions of the state; and, reviewing and analyzing QIS data. As mentioned previously, MDH is just beginning to receive QIS data from CMS and survey supervisors and managers are working with Nursing Home Quality, CMS' contracted QIS expert and trainer, to better understand the data and use it to its fullest extent. Throughout 2009, the Licensing and Certification Program management will be working with survey staff to educate them on the QIS data reports. Areas that are determined to be outliers will be examined and a plan for follow-up will be developed as appropriate. MDH will also review data from CMS that compares Minnesota to other QIS states, as soon as that data becomes available on CMS' Aspen Central Data Base. The QIS process will provide the Department with a broader set of data than what is currently available and the Department will integrate this into its ongoing quality improvement activities.

Implementation of Minimum Data Set 3.0

Federal regulations require all certified nursing and boarding care homes to use a standardized assessment instrument when completing comprehensive assessments of resident's needs. The same instrument, the Minimum Data Set (MDS), is used by the federal and state government for payment purposes and for quality indicators. The current version, MDS 2.0, will be replaced by MDS 3.0 on October 1, 2010. CMS has released a timeline form the implementation of this document. The timeline is available at:
http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp .

The Licensing and Certification section of MDH has already been working with providers, DHS, and the Case Mix Review section in order to provide a seamless transition to MDS 3.0. This work will continue and intensify throughout 2009 and 2010 in order to provide training and both clinical and technical support for all stakeholders.

Continue Monitoring and Evaluating the Post Certification Revisit Process

MDH will continue to monitor the correction rates and complaint substantiation levels for providers and discuss with provider associations to determine if the Post Certification Revisit (PCR) policy needs further revision or if the random follow-up process needs to be discontinued to assure that deficiencies are being corrected.

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.	CMS' Updated Brochure Describing Quality Indicator Survey (QIS), May 16, 2008
APPENDIX G.	Average Deficiencies per Life Safety Code Survey, National Data
APPENDIX H.	Release of Federal Documents by the State Survey Agencies, Administrative Information Bulletin 07-06, issued January 12, 2007
APPENDIX I.	2009 Quality Improvement Plan for Survey Agency
APPENDIX J.	Nursing Home Post Certification Revisit Process

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, Quality Indicator Survey Process and other 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://surveyortraining.cms.hhs.gov/
CMS webcast training sessions are available on this website for one year from the date of original broadcast.

Nursing Home Quality Indicator Survey (QIS) Process Resources

Updated Brochure Describing the QIS Survey Process
http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter08-21.pdf

Nursing Home Quality Indicator Survey (QIS) – Resource Manual
http://www.uchsc.edu/hcpr/qis_manual.php

Nursing Home Quality Indicator Survey (QIS) – Forms
http://www.uchsc.edu/hcpr/qis_forms.php
See forms: CMS-20052

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

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.

APPENDIX D
Average Health Deficiencies per Nursing Home Survey, by State CASPER data system
10/25/08

State	Surveys	Average Number of Health Deficiencies
Guam	1	18.0
District of Columbia	19	15.4
Puerto Rico	7	12.9
Delaware	45	12.7
California	1,254	11.5
Colorado	211	10.3
Oklahoma	319	10.2
Kansas *	343	10.1
Maryland	230	9.9
Minnesota *	388	9.9
Wyoming	39	9.9
Idaho	79	9.2
Arizona	135	8.8
Florida *	677	8.8
West Virginia	130	8.8
Virginia	281	8.4
Michigan	426	8.1
Nevada	48	8.1
Indiana	511	8.0
Hawaii	48	7.9
Louisiana *	284	7.9
Missouri	513	7.9
Connecticut *	240	7.8
Arkansas	231	7.3
New Mexico	70	7.2
Maine	109	7.0
Montana	90	7.0
Nebraska	225	6.5
South Carolina	175	6.4
Vermont	40	6.4
Georgia	358	6.1
Iowa	449	6.1
Illinois	794	6.0
Washington	239	6.0
Ohio *	959	5.7
Utah	95	5.7
Tennessee	319	5.5
Texas	1,145	5.3
Wisconsin	393	5.3
Alaska	15	5.2
Kentucky	286	5.2
Massachusetts	433	5.2
Mississippi	201	5.0
New Hampshire	80	5.0
Oregon	138	4.7
Pennsylvania	717	4.7
Alabama	232	4.6
New Jersey	360	4.6
New York	646	4.3
South Dakota	109	4.2
Virgin Islands	1	4.0
North Carolina	423	3.8
Rhode Island	86	2.9
North Dakota	83	2.8
Totals	15,729	7.0

* Denotes QIS states

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, FFY 2004, 2005, 2006 and 2007
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

Providers are encouraged to sign up for e-mail notification of MDH Information Bulletins and CMS Program Transmittals.
http://www.health.state.mn.us/divs/fpc/profinfo.html

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

Complaint Investigations of Minnesota Health Care Facilities Legislative Report, 2005, 2006, 2007, 2008, and 2009
http://www.health.state.mn.us/divs/fpc/legislativerpts.html

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-08-21

DATE: **May 16, 2008**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Updated Brochure Describing the Quality Indicator Survey (QIS)

Memorandum Summary

For your information, we are providing an updated, 2008 version of the brochure that provides a brief description of the QIS and an overview of the QIS training process.

Discussion: Attached to this memorandum is an updated, 2008 version of the brochure describing the QIS and an overview of the QIS training process for State implementation. State survey agencies and Centers for Medicare & Medicaid Services regional offices may use this brochure to provide information on QIS to providers, consumers, other stakeholders, and any interested party. (Please discard the earlier 2005 version of the brochure that was conveyed in S&C-06-02.)

Training: There is no training required concerning this information. This is being distributed for your information.

/s/
Thomas E. Hamilton

Attachment

cc: Survey and Certification Regional Office Management

Annual Quality Improvement Report on the Nursing Home Survey Process 40
June 2009

CMS Quality Indicator Survey

The Quality Indicator Survey

CMS is implementing the Quality Indicator Survey (QIS) which is a computer assisted long-term care survey process used by selected State Survey Agencies and CMS to determine if Medicare and Medicaid certified nursing homes meet the Federal requirements.

The QIS was designed to achieve several objectives:

- Improve consistency and accuracy of quality of care and quality of life problem identification by using a more structured process;
- Enable timely and effective feedback on survey processes for surveyors and managers;
- Systematically review requirements and objectively investigate all triggered regulatory areas within current survey resources;
- Provide tools for continuous improvement;
- Enhance documentation by organizing survey findings through automation; and
- Focus survey resources on facilities (and areas within facilities) with the largest number of quality concerns.

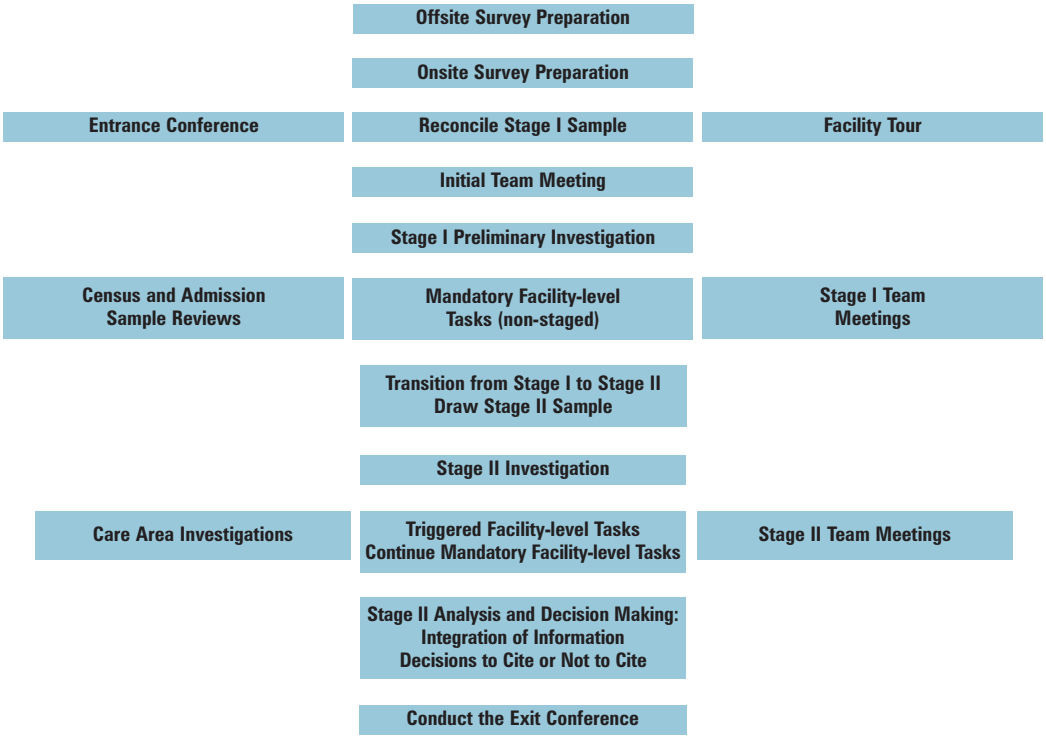
Description of QIS

The QIS is a two-staged process used by surveyors to systematically review specific nursing home requirements and objectively investigate any regulatory areas that are triggered. Although the survey process has been revised under the QIS, the Federal regulations and interpretive guidance remain unchanged. The QIS uses customized software (Data Collection Tool-DCT) on tablet personal computers (PCs) to guide surveyors through a structured investigation.

Figure 1 describes the QIS process. The process begins with offsite survey preparation activities including review of prior deficiencies, current complaints, ombudsman information, and existing waivers/variances, if applicable. Minimum Data Set (MDS) data for the facility are loaded offsite into surveyors' tablet PCs.

Upon entry at the nursing home, an entrance conference is conducted during which the team coordinator requests facility information. Concurrent with the entrance conference, surveyors conduct a brief tour to gain an overall impression of the facility and the resident population being served.

FIGURE 1: OVERVIEW OF THE QIS PROCESS



Three distinct Stage I samples are selected:

1) The census sample focuses on quality of care and quality of life and includes 40 randomly selected residents who are in the nursing home at the time of the survey.

2) The admission sample includes 30 recent admissions and emphasizes issues such as rehospitalization, death, or functional loss. This may include both current and discharged residents for a focused chart review.

3) The MDS data are used to create the resident pool from which the Stage I samples are randomly selected and to calculate the MDS-based Quality of Care and Quality of Life Indicators (QCLIs) for use in Stage II.

In addition, other residents and issues can be selected at the surveyors' discretion.

Stage I provides for an initial review of large samples of residents which includes resident, family, and staff interviews; resident observations; and clinical record reviews. Utilizing onsite automation, the results of these preliminary investigations are combined to provide a comprehensive set of QCLIs covering resident and facility-level regulatory areas. Mandatory facility-level tasks are started including resident council president interview; observations of dining and kitchen areas, infection control practices, and medication administration; and review of the Medicare demand billing process and the quality assessment and assurance program.

After the Stage I review is complete, the DCT uses the surveyors' findings together with MDS data to determine which QCLIs exceed a national threshold and consequently trigger care areas and/or triggered facility-level tasks for further investigation in Stage II.

Stage II investigation includes:

- Care area investigations using a set of investigative protocols that assist surveyors in completing an organized and systematic review of triggered care areas;
- Completion of mandatory facility-level tasks; and
- Triggered facility-level tasks which include abuse prohibition, environment, nursing services, sufficient staffing, personal funds, and admission, transfer, discharge.

After all investigations have been completed, the team analyzes the results to determine whether noncompliance with the Federal requirements exists. (The QIS uses the same decision-making process to determine noncompliance, including scope and severity designation, as is used in the traditional survey.) An exit conference is conducted, during which the nursing home is informed of the survey findings.

National Implementation of the QIS

National implementation of the QIS is progressing State by State as resources are available to conduct training of State and Federal surveyors. Once a State is selected by CMS to implement the QIS, the timeframe for achieving statewide QIS implementation can range from one to three years. The rate at which implementation occurs is dependent on the number of surveyors needing QIS training and other issues determined by the State. Therefore, until all nursing home surveyors in a selected State have received training in the QIS process, some nursing homes will continue to receive the traditional survey.

Federal Training for the QIS

Through a competitively awarded contract, CMS selected a contractor to conduct the initial QIS training and the subsequent training of a State's designated QIS trainers. This approach to training is to assure that QIS training is delivered in a uniform and consistent manner to achieve greater standardization.

Surveyors who successfully complete all QIS training components will be entered in the CMS Learning Management System as Registered QIS Surveyors. The training requirements include completion of selected Web-based lessons, classroom training, participation in a mock or training survey, and achievement of two successful compliance assessments during surveys of record. A State or CMS regional office selects certain Registered QIS Surveyors to receive additional instruction to become trainers in their own State or CMS regional office. The requirements for trainers include completion of four additional QIS surveys of record (for a total of at least six QIS surveys of record); participation in a Train-the-Trainer workshop; delivering classroom training to surveyors; observing and evaluating surveyors during a mock training survey; and evaluating surveyor performance during a survey of record. The CMS training contractor observes, instructs, monitors, and evaluates the trainers in every training component.

Differences between the Traditional Survey and the QIS

TRADITIONAL SURVEY	QIS
AUTOMATION	
• Survey team collects data and records the findings on paper • The computer is only used to prepare the deficiencies recorded on the CMS-2567	• Each survey team member uses a tablet PC throughout the survey process to record findings that are synthesized and organized by the QIS software
OFFSITE	
• Review OSCAR 3 and 4 report • Survey team uses QM/QIs report offsite to identify preliminary sample of residents (about 20% of facility census) and areas of concern	• Review the OSCAR 3 Report and current complaints • Download the MDS data to tablet PCs • DCT selects a random sample of residents for Stage I
ENTRANCE INFORMATION	
• Review of Roster Sample Matrix Form (CMS 802)	• Obtain alphabetical resident census with room numbers and units • List of new admissions over last 30 days
TOUR	
• Gather information about pre-selected residents and new concerns • Determine whether pre-selected residents are still appropriate	• No sample selection • Initial overview of facility
SAMPLE SELECTION	

• Sample size determined by facility census
• Residents selected based on QM/QI percentiles, and issues identified offsite and on tour
	• The DCT provides a randomly selected sample of residents for the following:
	  • Admission sample is a review of 30 current or discharged resident records
	  • Census sample includes 40 current residents for observation, interview, and record review

SURVEY STRUCTURE	

• Resident sample is about 20% of facility census for resident observations, interviews, and record reviews
  • Phase I: Focused and comprehensive reviews based on QM/QI report and issues identified from offsite information and facility tour
  • Phase II: Focused record reviews
  • Facility and environmental tasks completed during the survey
	• Stage I: Preliminary investigation of regulatory areas in the admission and census samples and mandatory facility-level tasks started
	• Stage II: Completion of in-depth investigation of triggered care areas and/or facility-level tasks based on Stage I findings

GROUP INTERVIEW	
• Meet with Resident Group/Council • Includes Resident Council minutes review to identify concerns	• Interview with Resident Council President or Representative

APPENDIX G

Average LSC Deficiencies per Nursing Home Survey, by State, CASPER data system 10/25/08

State	Surveys	Average Number of Health Deficiencies
Montana	90	8.9
Kansas	343	8.6
Pennsylvania	717	7.5
Colorado	211	7.4
Iowa	449	6.9
Illinois	794	6.6
Utah	95	6.5
Indiana	511	6.2
Michigan	426	6.2
Wyoming	39	6.2
Alaska	15	6.1
California	1,254	5.6
Puerto Rico	7	5.4
Wisconsin	393	5.3
Maryland	230	5.0
Ohio	959	5.0
Texas	1,145	4.6
Oklahoma	319	4.3
New Hampshire	80	4.2
Nebraska	225	4.1
New Mexico	70	4.0
North Carolina	423	3.9
Oregon	138	3.9
Tennessee	319	3.9
Virginia	281	3.7
Alabama	232	3.6
Missouri	513	3.6
Arizona	135	3.4

State	Surveys	Average Number of Health Deficiencies
Minnesota	388	3.3
Washington	239	3.0
South Dakota	109	2.9
Delaware	45	2.6
Idaho	79	2.6
New York	646	2.6
Louisiana	284	2.5
North Dakota	83	2.5
Georgia	358	2.4
District of Columbia	19	2.0
Nevada	48	1.9
Connecticut	240	1.8
Florida	677	1.7
New Jersey	360	1.7
South Carolina	175	1.7
West Virginia	130	1.7
Kentucky	286	1.6
Massachusetts	433	1.4
Maine	109	1.3
Mississippi	201	1.3
Arkansas	231	1.2
Vermont	40	1.2
Hawaii	48	0.5
Rhode Island	86	0.1
Guam	1	0.0
Virgin Islands	1	0.0
Totals	15,729	4.3

APPENDIX H

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey & Certification Group

Admin Info: 07-06

DATE: **January 12, 2007**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Release of Federal Documents by the State Survey Agency (SA)

Letter Summary

This memorandum provides guidance to States on the disclosure of Federal documents that are:

(1) Maintained by the SA on Medicare or dually-certified providers (both long-term care and non long-term care) as a result of implementation of its Agreement with the Secretary, Health and Human Services under §1864 of the Social Security Act (§ 1864 Agreement), and

(2) Accessible to SAs through the Automated Survey Processing Environment System (ASPEN), ASPEN Enforcement Manager System (AEM), Complaints/Incident Tracking System (ACTS), and Online Survey Certification & Reporting System (OSCAR)/ Online Data Input & Edit System (ODIE).[1]

Federal Documents Maintained by the SA

[1]The contractual and policy framework for this guidance is as follows:

- Articles III and XIII of the §1864 Agreement. These articles provide the overall framework within which SA disclosure decisions are governed. Specifically, Article III provides that States "shall comply with regulations and general instructions as the Secretary may prescribe for the administration of this Agreement." Article XIII, titled "Confidential Nature and Limitations on Use of Information and Records," further provides that the "State shall adopt policies and procedures to ensure that information contained in its records and obtained from the Secretary or from any provider or supplier of services will be disclosed only as provided in the [Social Security] Act or regulations." Article I of the § 1864 Agreement defines "Act" to be Title XVIII of the Social Security Act. Article XIII, therefore, incorporates Title XVIII of the Social Security Act and the regulations that implement Title XVIII.

- Sections 3300–3320 and 7900–7907 of the State Operations Manual (SOM). These instructions apply to the handling and disclosure of Federal documents.

- NOTE: Certain Federal and State records may be subject to 45 CFR Parts 160–164 (HHS' Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule). This letter does not address the specific requirements of the HIPAA Privacy Rule.

Section 3304 of the State Operations Manual (SOM) states that the SA should distinguish between information and documents obtained as an agent of the Centers for Medicare & Medicaid Services (CMS) and those documents the State independently acquires through a State program.

Information and documents that the State independently acquires through a State program must be handled under State law because the documents are State, not Federal, records. For example, requests for survey or certification documents for **Medicaid**-only providers would fall under applicable State open records laws because such records are State, not Federal, records.

However, information and documents the SA acquires solely in its role as an agent of CMS are subject to CMS disclosure rules. This means that the SA must comply with 42 CFR Part 401, 45 CFR Part 5, SOM §§ 3300 through 3320 and SOM §§ 7900 through 7907 in responding to requests for such documents. The SA, if it has not already done so, must adopt policies and procedures for the handling and disclosure of Federal records that comport with the cited regulations and instructions. Such policies and procedures should be developed in partnership with the Regional Office (RO) and include the involvement of the RO Freedom of Information Act (FOIA) Coordinator.

Documents the SA May Release

***Form CMS-2567 for Surveyed Providers and Suppliers (Other than SNFs or NFs)*:** The SA may release the Form CMS-2567 consistent with the provisions contained within this paragraph. Disclosure of any Form CMS-2567 that the State generates on a provider or supplier must comply specifically with 42 CFR 401.126(b)(1), 42 CFR 401.133(a), SOM § 3308A and SOM § 3314. This means that, when requested:

1. Prior to release, the provider must have had an opportunity to review the report (not exceeding 60 days) and offer comments within the overall time frames cited below.
2. Prior to release, the report must have been provided to CMS (through ASPEN), and the disclosure made within 30 days of CMS's receipt of the report.
3. The disclosure must be made within 90 days following completion of the survey by the SA.
4. Pertinent written comments, if received from the surveyed provider within the time frames above, must be disclosed with the report.
5. Individual identifiers within the report (of patients, health care practitioners, or others) must be deleted (this does not include alphanumeric patient/resident or staff identifiers).

Releasable Information on SNFs and NFs: Per 42 CFR 488.325 and SOM §§ 7900 and 7903A disclosure of SNF and NF results is made within 14 calendar days after such information is made available to those facilities. Plans of corrections are made available when approved (42 CFR 488.325(a)(3)). Additional releasable information/records are set forth at §7900.

Other Releasable Records on Surveyed Providers and Suppliers (including SNFs and NFs): SOM §§ 3308 and 3308A describe additional information that States may disclose directly to the public, upon request, including:

1. Whether a facility does or does not participate in the Medicare/Medicaid/CLIA program;

2. The Official Medicare/Medicaid/CLIA report of a survey **except** to the extent that it contains:

- The name of any patient;
- Medical information about any identifiable patient;
- The identity of a complainant;
- The address of anyone other than an owner of the facility; or
- Information which could be defamatory toward any identifiable person.

NOTE: The SA reviews the report of survey (CMS Form-2567), and if it contains any of the above elements, it deletes the information from the report by blocking it out fully prior to release of the report. (See 42 CFR 401.118)

3. Citations of deficiencies that have been conveyed to the provider following a survey, except to the extent the report contains any of the identifiable information listed above. The SA blocks this information out prior to release of the statement of deficiencies;

4. Plan of Correction (PoC) and pertinent comments submitted by the provider relating to Medicare/Medicaid/CLIA deficiencies cited following a survey, except to the extent the PoC or comments contain any of the identifiable information listed above. The SA blocks this information out prior to release of the PoC;

5. Official notices of involuntary provider termination (including alternative remedies);

6. Reports and information about a laboratory's performance in proficiency testing programs (Note: information about any individual person's performance may not be released);

7. Information contained within the CMS manuals distributed to the SAs, intermediaries, carriers, providers, or suppliers; and

8. Statistical data on provider characteristics that do not identify any specific provider or individual.

9. CMS-116, CLIA Application for Certification; however, the name of the laboratory director must be blocked prior to the release of the application. CMS-209, Laboratory Personnel Report (CLIA), may not be released.

Paper or electronic copies of these Federal electronic documents may be released by the SA. Again, any individual identifiers (other than patient/resident or staff alphanumeric identifiers) must be deleted from the information prior to release.

***Releasable By Agreement*:** SOM § 3318 states that confidential certification information may be released by the SA to another State component, or to a county or other local entity which performs survey functions for the SA. However, the SA must first obtain an agreement by the component or other entity to use the information for certification or licensure purposes with the understanding that such information may not be released to another party.

***Information Releasable to Original Source*:** SOM § 3316 states any party is entitled to information which that party originally supplied. For example, copies of medical records obtained during a survey can be released to the facility during the informal dispute resolution process.

Disclosure Requests Requiring Consultation With and Possible Submission to Regional Office

Section 3320 of the SOM directs the SA to obtain advice from the RO when a request is received for confidential Medicare information under circumstances other than as permitted by § 3308. CMS considers surveyor notes, worksheets, internal working papers, and other informal survey memoranda by the SA as covered by Article XIII of the § 1864 Agreement because these records embody information obtained from providers. Thus, the SA should consult the CMS RO with respect to the disclosure of these and other applicable documents. During this consultation, it should be clarified whether the records were generated and gathered solely for Federal purposes to comply with the § 1864 Agreement. If they were, the requested records are Federal records that are under the control of CMS. Under § 3314 of the SOM, in this situation, the SA is to decline to disclose the requested records, and direct the requester to contact the RO for those records. If the documents were not solely gathered for Federal purposes, see the paragraph below on *Documents Maintained by the SA for Joint Federal/State Use*.

The SA is to immediately forward to the RO any legal request for records, including subpoenas duces tecum and State court orders that are in the nature of a protective order, if the SA is not authorized to release the records under SOM §§ 3308, 3308A, 3314, 7900 and 7903A, which are discussed above in this letter.

Documents Maintained by the SA For Joint Federal/State Use

SOM §3304 states that when the SA obtains a record that is not in the public domain and is held for joint use by CMS and other State or Federal programs, the SA must apply the most restrictive confidentiality policies of all the programs to which the information relates.

> **Example**: A given Form CMS-2567 on a hospital is held for joint use by CMS and the State. Under State disclosure law, survey findings are releasable before a plan of correction is received. Under Federal law, the surveyed provider must be given a reasonable opportunity (not exceeding 60 days) to review the report and offer comments which may be incorporated into the report; and the report must be furnished to CMS. In this situation, the SA's disclosure must be based upon Federal law.

Under other circumstances, it is permissible for a SA to apply State law that is more stringent than Federal law.

> **Example**: Federal law requires the SA to delete the identity of individuals from the Form CMS-2567 prior to release. However, State law requires the deletion of additional information to ensure that the individual's identity is protected. In this situation, because the State's disclosure law is more stringent than Federal law, the SA's disclosure must be based upon State law.

In each State, the staff designated to release documents should be aware of: 1) Federal documents that are maintained by the SA; 2) Federal documents the State is authorized to release; and 3) the identity of the RO individual for consultation purposes.

Documents Accessible to the SA through Electronic Systems

Federal survey and certification systems, including ASPEN, AEM, ASPEN Central Office (ACO), ACTS, and OSCAR/ODIE originate from the Federal government. Generally speaking, when the SA enters individual files into these systems, it is as an agent of CMS. Therefore, any Federal electronic documents retrieved from these databases and the databases themselves may not be released by the State unless authorized to do so by CMS.

If you have any additional questions regarding this matter, please contact Melodye Hardy, Freedom of Information Officer, CMS, at (410) 786-5358.

Effective Date: Immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

Training: The information contained in this announcement should be shared with all State agency staff and supervisors designated to release documents.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

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APPENDIX I

2009 Quality Improvement Plan for Survey Agency
Working Document

Mission of Minnesota Department of Health:
Protecting, Maintaining and Improving the Health of Minnesotans

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 (NAR) 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 2009 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 and through understanding and use of the QIS data reports.
4. Maintain positive communication about regulatory programs 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) rate of 8.0% and Physical Restraints: rate of 5.9%. . 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 surveyor and provider 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.
- Support and advance collaboration among MDH, the Quality Improvement Organization, consumers and all provider types to prevent pressure ulcers.

Goal: Improve and maintain consistency and accuracy across survey teams through implementation of the Federal QIS Nursing Home survey process and use QIS Quality Improvement (QI) data.

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

- Orient current MDH staff to QIS survey process over a three-year period (2008-2011).
- Educate and work individually with MDH staff on how to use QIS survey process QI 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 for quality improvement.

- Expand understanding about survey outcomes by using QIS data reports that analyze survey data for variances.
- Educate surveyors about QIS data reports that analyze variations.

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

- Use QIS data to analyze variations and to take corrective action when appropriate.
- Use QIS survey process investigative pathways.
- 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, 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.

Objective: Ensure ongoing flow of information between MDH staff, providers, and external stakeholders.

- Participate in Long Term Care Issues 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 regional 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.
- Improve communication with customers through improved technology for the Nursing Assistant Registry (NAR).

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

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

APPENDIX J

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.