Annual Quality Improvement Report on the Nursing Home Survey Process

Report to the Minnesota Legislature

Minnesota Department of Health

Federal Fiscal Year 2009
Released May 2010

MINNESOTA MDH DEPARTMENT OF HEALTH

Commissioner's Office
625 Robert St. N., Suite 500
P.O. Box 64975
St. Paul, MN 55164-0975
(651) 201-5000
www.health.state.mn.us

Annual Quality Improvement Report on the Nursing Home Survey Process

Report to the Minnesota Legislature
Federal Fiscal Year 2009
Released May 2010

For more information, contact:
Division of Compliance Monitoring
Licensing and Certification Program
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN, 55164-0900

Phone: (651) 201-4101
Fax: (651) 215-9697
TDD: (651) 201-5797

As requested by Minnesota Statute 3.197: This report cost approximately $11,911 to prepare, including staff time, printing and mailing expenses.

Contents

List of Tables and Graphs

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 sixth 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 six 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 2004-2008 Reports).

This report describes activities initiated during the past year, focusing on the Federal Fiscal Year (FFY) 2009, which ran from 10-1-08 through 9-30-09.

As noted in last year's Legislative Report, MDH's Licensing and Certification Program's special focus area for 2009 was continued statewide implementation of the Quality Indicator Survey Process (QIS), a new federal survey process for nursing homes. MDH has made considerable progress in training its survey staff and implementing QIS, since last year's Legislative Report. In fact the Department is several months ahead of its planned implementation schedule for QIS. Training for QIS first started in January 2008 and by end of March 2010, MDH had trained all of its survey staff in QIS and all annual nursing home surveys are now being conducted using the QIS process. Evaluative information gathered so far indicates that both providers and surveyors seem to prefer the QIS process over the traditional process. They believe the QIS process is more comprehensive and examines quality of life and resident rights further than the traditional survey process.

In terms of deficiencies issued under QIS and the traditional survey process, MDH's FFY09 data shows a decrease in the average number of deficiencies issued in Minnesota for both survey processes, with a more significant decline in those deficiencies issued under the QIS process. MDH does not know the specific reasons for these declines, but believes there may be several contributing factors including better compliance by providers in Minnesota; better internal quality assurance programs by providers in Minnesota; more surveys being conducted using QIS (approx. 62% this year, vs. approx. 25% last year); surveyors having more experience with using the QIS tools; and, combined deficiency tags under CMS revised guidelines.

MDH also looked at the top 10 deficiency tags issued under QIS and compared those to the top 10 deficiency tags issued under the traditional survey process. MDH identified several overlaps in tags issued under the two survey processes. This is consistent with last year's finding. This continues to indicate to the Department that surveyors, even under the traditional survey process, were looking at and identifying issues in the right areas.

In addition to this data, CMS has been sending states, implementing QIS, Desk Audit Reports (DAR-SA and DAR-RO). These reports help states identify outliers and variances by areas and individual surveyors. MDH has been working with CMS staff to better understand this data and use it to its fullest extent.

In terms of comparing Minnesota to other QIS states, CMS has not yet modified its Aspen Central Office data base that will provide this comparison data. However, the Department has been monitoring deficiencies as a whole (QIS and traditional survey process) and comparing them to other states in CMS Region V and nationally. In FFY09 data shows that Minnesota's average number of deficiencies dropped, from 10.0 in FFY08 to 8.8 in FFY09. Minnesota also went from a ranking of 10th in the nation in average number of deficiencies issued to 14th. The reasons for this decrease may be due in part to the implementation of QIS and the training that has been provided on CMS revised guidelines, but other factors may also be contributing to the decline, including those mentioned previously. Minnesota continues to be low in average number of Life Safety Code deficiencies issued compared to other states in CMS Region V, which is consistent with previous years' reports.

The Department also continued its work on evaluating its post certification revisit (PCR) process, which was revised in November 2006, to determine if the PCR process needs further revision or if the random follow-up process needs to be discontinued to assure that deficiencies are corrected. At this time, more data is needed to make that determination. The Department will continue to evaluate this process and report on its progress in next year's Legislative Report.

As mentioned in last year's Legislative Report, another focus area for the Department in FFY09 was to prepare for the replacement of the current Minimum Data Set 2.0 (MDS 2.0) with MDS 3.0, effective October 1, 2010. MDS 2.0 is a standardized assessment instrument used by nursing homes and boarding care homes to complete comprehensive assessments of residents' needs. MDS 2.0 is also used by the federal and state government for payment purposes and for quality indicators. During FFY09 the Department began preparing for this transition by developing a training plan and program to provide both clinical and technical support to all stakeholders. This work is expected to continue and intensify throughout FFY 2010, as the plan is implemented.

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

In FFY 2010, the Department's primary focus will continue to be statewide implementation of the QIS process. This will include evaluating QIS; working with CMS to review and analyze QIS data reports and using the data to its fullest extent; and, obtaining clarification from CMS as to

how stand alone complaints are to be handled when QIS has been fully implemented and no QIS protocol for these complaints currently exists.

The Department will also work on implementation of MDS 3.0, by conducting the stakeholder training and support for this new program as mentioned above, and integrating MDS 3.0 into the QIS process.

Additionally, the Department will provide training to providers and surveyors on CMS revised guidelines, abuse reporting, and root cause analysis, and work closely with its partners on planning for and responding to emergencies.

A report on these and other quality improvement activities will be provided in next year's Legislative Report.

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 largely 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 sixth 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) 2009, which ran from October 1, 2008 through September 30, 2009.[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.

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 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 facility not being 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.[2] 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 provides the facility with a draft statement of deficiencies. A final 2567 is prepared and sent after the MDH supervisory review is complete.

Deficiency Citations[3]

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

[2] 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.
[3] 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.

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 FFY09 are discussed in Section II of this report.

Additionally, in September 2005 CMS initiated the Quality Indicator Survey (QIS) process, a new federal survey process for nursing homes that uses new technology to improve the accuracy, consistency an efficiency of the survey process. QIS started out as a pilot project with six states. In 2007 Minnesota was chosen by CMS to be the first state to implement QIS statewide beyond the demonstration project. Since then QIS expansion has continued, and 14 states are currently in different phases of implementing QIS. Minnesota's status of implementing QIS is discussed in Section II of this report.

Minnesota Compared to CMS Region V and Nationally in Deficiency Citations

For Federal Fiscal Year 2009, Minnesota's average deficiencies per health survey was 8.8. The average number of deficiencies per health survey for all states in Region V was 6.9. Table I, A-1 below shows the six states in CMS Region V with their respective average deficiency rates.

Table 1, A-1: Average Deficiencies per Health Survey for CMS Region V, FFY09

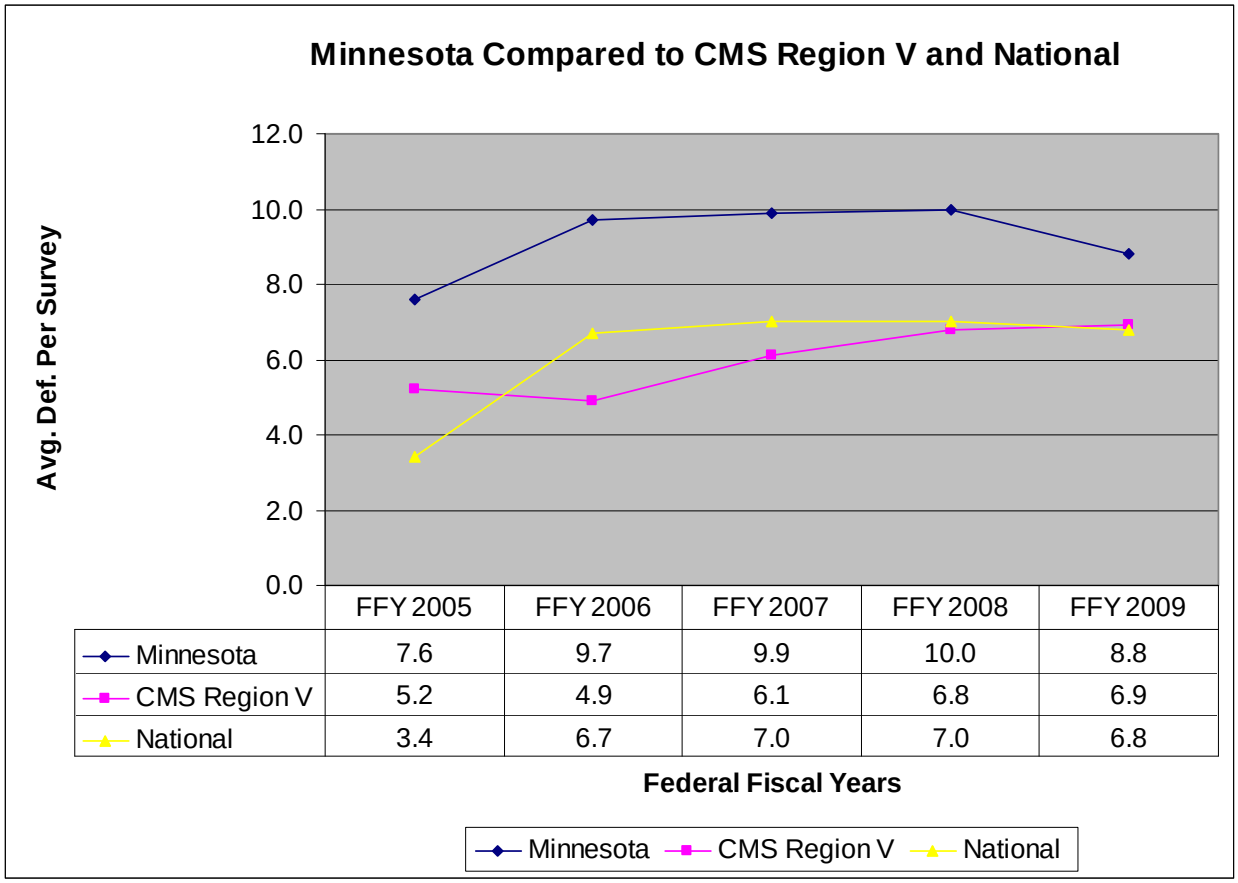
State	Surveys	Tags from Each Group	Average Defs. Per Survey
Illinois	776	4,859	6.3
Indiana	529	3,856	7.3
Michigan	466	3,956	8.5
Minnesota	389	3,432	8.8
Ohio	900	5,467	6.1
Wisconsin	373	2,183	5.9
Total	3,433	23,753	6.9

Source: Federal CASPER Data System, FFY09

The national average number of deficiencies per health survey for FFY09 was 6.8, and Minnesota ranked 14th in the nation. A table of national average number of health deficiencies per survey for FFY09 is attached as Appendix D.

Graph 1, A-1 below shows the average number of deficiencies per health survey for Minnesota, CMS Region V, and nationally, from FFY 2005 – 2009.

Graph I, A-1: Minnesota Compared to CMS Region V and National, FFY 2005-2009



	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009
Minnesota	7.6	9.7	9.9	10.0	8.8
CMS Region V	5.2	4.9	6.1	6.8	6.9
National	3.4	6.7	7.0	7.0	6.8

Source: Federal CASPER Data System

Minnesota's average number of deficiencies increased slightly each year from FFY05 to FFY08. However in FFY09, Minnesota experienced a decrease in average number of deficiencies issued, from a 10.0 in FFY08 to 8.8 in FFY09.

The average deficiency per health survey for all states in Region V continued to increase from 6.1 in FFY07, to 6.8 in FFY08, and to 6.9 in FFY09. However the range in average number of deficiencies decreased from a high of 10.0 and a low of 5.2 average deficiencies per survey in FFY08 to a high of 8.8 and a low of 5.9 in FFY09.

The national average deficiencies per health survey increased in FFY06, stayed the same in FFY07 and FFY08, and showed a slight decrease (0.2) in FFY09.

Although the Department does not know the specific reasons for Minnesota's and the national average number of deficiencies decline in FFY09, possible explanations may include CMS' revised guidelines which resulted in some deficiency tags being combined as well as the implementation of QIS in some states.

The Department continues to monitor the average deficiencies issued per health survey in Minnesota and compare them to CMS Region V and nationally.

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

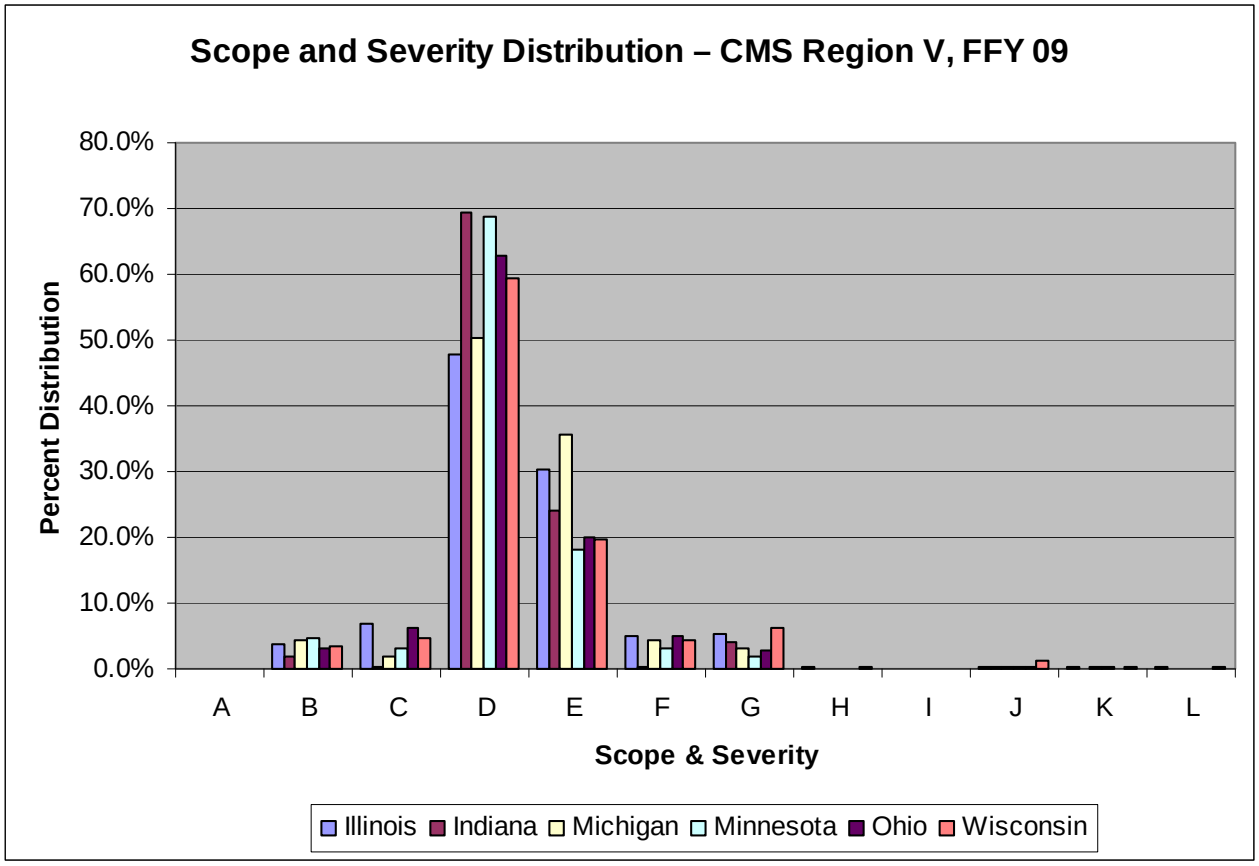
In Minnesota, the greatest number and percent of tags issued continue to be at scope and severity levels D and E (69% were at D and 18% were at E). This is comparable to other states in Region V (Table I, A-2 and Graph 1, A-2). Minnesota continues to have fewer tags written at scope and severity G and 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 FFY09

State	A	B	C	D	E	F	G	H	I	J	K	L	Total Surveys	Total Def.
Illinois	0	177	340	2,322	1,471	241	259	11	0	16	12	10	776	4,859
Indiana	0	71	14	2,670	928	9	152	1	0	7	3	1	529	3,856
Michigan	0	173	69	1,988	1,406	168	123	5	0	14	10	0	466	3,956
Minnesota	0	156	109	2,359	618	109	59	4	0	9	8	1	389	3,432
Ohio	0	172	345	3,434	1,086	265	149	2	0	13	1	0	900	5,467
Wisconsin	0	74	102	1,295	431	97	134	4	0	27	9	10	373	2,183
Total	0	823	979	14,068	5,940	889	876	27	0	86	43	22	3,433	23,753

Source: Federal CASPER Data System, FFY09

Graph I, A-2: Scope and Severity Distribution – CMS Region V, FFY09



Source: Federal CASPER Data System

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 -2008 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 continues the transition from the traditional survey process to the Quality Indicator Survey Process. It has only been since the end of March 2010 that all survey staff were trained and all annual nursing home surveys were being conducted using the QIS process. As discussed in last years report, the transition from the traditional survey process to QIS, made it difficult for the Department to continue to report this data in a meaningful way. Now that QIS has been fully implemented statewide, MDH will once again start tracking and reporting that data by team. Data will be provided in next year's Legislative Report. More information about QIS, including the Department'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 (e.g. K-76).

The average number of deficiencies per LSC survey nationally during FFY09 was 4.2 and the average in Minnesota was 2.8, Minnesota ranked 32nd in the nation. A table of national average number of LSC deficiencies per survey is attached as Appendix G.

Within CMS Region V, the average number of deficiencies per LSC survey was 5.1, and the average in Minnesota was 2.8. Like previous years, Minnesota had the fewest number of LSC deficiencies issued in CMS Region V (Table I, A-3 below).

Table I, A-3: Average Deficiencies per LSC Survey, CMS Region V, FFY09

State	Surveys	Tags from Each Group	Average Defs. Per Survey
Illinois	776	4,726	6.1
Indiana	529	2,418	4.6
Michigan	466	2,794	6.0
Minnesota	389	1,072	2.8
Ohio	900	4,417	4.9
Wisconsin	373	2,169	5.8
Total	3,433	17,596	5.1

Source: Federal CASPER Data System, FFY09

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 2004-2008 Reports). Briefly, it means that a deficient practice is cited 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) nationwide will likely narrow the gap in variation in number of deficiencies issued between states once it is fully implemented. As mentioned previously, improving accuracy and consistency of the survey process was one of the objectives that QIS was designed to achieve
. 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.[4]

IDR

The IDR is performed by an MDH supervisor who has not previously been involved in the survey. For surveys with exit dates during FFY09, 21 IDRs were requested. A total of 37 tags were disputed. Of the disputed tags, the reviewer's decision was to change the scope and severity for 5 tags, and to delete 8 tags, for a total of 13 tags (35%) 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, 126 IIDR requests have been made through FFY09. In FFY09, there were 15 requests involving 21 tags. Of the 15 requests, 6 were withdrawn by the facility prior to the IIDR review, and those 6 included 9 tags; 2 were changed to IDRs at the facilities request, and one has yet to be scheduled. Table I, C-1 summarizes the tags that went forward with an IIDR in FFY09.

Table I, C-1: Summary of IIDR Results, FFY09

	Number of tags in dispute: 7	
ALJ recommended action:		Number of tags:
Uphold tags as written		3
Uphold scope and severity, but delete some findings		0
Total tags upheld	**3**	
Dismiss		1
Adjust scope and severity		3
Total tags adjusted or dismissed	**4**	
Commissioner's decision:		Number of tags:
Uphold tags as written		3
Uphold scope and severity, but delete some findings		0

[4] 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.

Total tags upheld	**3**	
Dismiss tags		0
Adjust scope and severity		4
Adjust scope		0
Total number of tags adjusted or dismissed	**4**	

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 2009 were approximately $19,986 with MDH paying approximately $14,520 and nursing homes paying approximately $5,466 (Table I, C-2).

Table I, C-2: OAH Costs Paid by Nursing Homes and MDH through FFY09

OAH Cost Apportionment	Number of Nursing Homes	Number of Tags	Cost Amount
Nursing Home paid 100% of costs	2	3	$ 5,466
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	4	4	$14,520

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 FFY09. 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 FFY08 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. Two IIDR requests from FFY08 and one from FFY09 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 -- FFY 2009

Process	Number of Reviews	Total Supervisor & Surveyor Time	Average Supervisor & Surveyor Time (hrs.) per Review
IIDR	10*	177.25	9
IDR	20	169.25	15

Source: Paradise Data System
**Includes work that was done on IIDR requests that were withdrawn.*

MDH continues to use 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 three nursing homes that initiated an appeal at the federal level during FFY09.

E. Compliance with Timelines for Survey Revisits and Complaint Investigations

If a survey team finds deficiencies at a 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, subdivision 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 (more severe) 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 revisits.

For facilities surveyed during FFY09, there were 37 facilities with surveys where category 2 or 3 remedies were imposed. Seventy nine (79) revisits were conducted at these 37 facilities. Of the 79 revisits:

- 43 revisits (52%) were completed within the 15 calendar days after the facility's identified date of correction.[5]

- 36 revisits (48%) for 32 facilities were not completed within the 15 calendar days after the facility's identified date of correction. Eighteen (18) of these were L & C revisits, 8 were OHFC revisits and 10 were LSC revisits. Of these 36 revisits not completed within the 15 calendar days after the facility's alleged compliance date, in no case did the date of revisit result in additional category 2 or 3 remedies and/or increased financial burden to the facility.

Summary: The number of facilities having category 2 or 3 remedies decreased from 46 in FFY08 to 37 in FFY09 (a 22% decrease). This resulted in a required 79 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 2004-2008 Reports). These activities are also described in MDH's Licensing and Certification (L&C) Program's Quality Assurance Plan (Appendix I). Throughout FFY09 the L&C Program continued efforts to give surveyors the tools/training necessary to conduct their work.

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

Minnesota Statutes, section 144A.101, subdivision 2 requires the Commissioner to provide facilities with draft statements of deficiencies at the time of the survey exit and with completed statements of deficiencies (the 2567) within 15 working days of the exit conference.

MDH has been delivering draft statements of deficiencies at the time of survey exit for several years, and has been electronically monitoring the timeline for delivery of completed statements of deficiencies within the 15 working day requirement since the system was implemented in October of 2004.

In FFY09, three hundred and ninety one (391) surveys were exited and the rough draft statement of deficiencies was left with the facility at the survey exit in three hundred and eighty nine (389) instances. In the two instances when the draft statement of deficiencies was not left with the

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

facility, there was no need to leave it because no deficiencies were issued. The survey findings were mailed to the facility.

Of the 391 surveys exited during FFY09, approximately 99% met the 15 day requirement for delivering final 2567s. Only seven surveys (approximately 1%) exceeded the 15 day requirement. Of those seven surveys, three delays related to a shortage of staff at the Metro Area District Office while existing staff was being trained in the Quality Indicator Survey (QIS) process. This issue was resolved after staff was hired and QIS training was completed. Three delays related to surveys which required extra review due to the complexity of deficiencies issued or additional information submitted by the facility. The final delay occurred while the Mankato District Office was moving to a new location.

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 goals or Government Performance Results Act (GPRA) goals for nursing facilities. These goals (National Target FFY09) 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 below 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, 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

Table I, H-2: GPRA Goal Rates for CMS Region V and Minnesota; National Target Period for FFY09, October 1, 2008 – September 30, 2009

Goal Type	National Goal	CMS Region V Goal	Minnesota's Rate FFY09	# of NHs in MN Above National Goal	# of NH in MN Above CMS Reg. V Goal
Pressure Ulcers	8.0%	7.4%	5.1%	56 (out of 388 NHs)	69 (out of 388 NHs)
Physical Restraints	5.9%	4.5%	1.5%	22 (out of 388 NHs)	45 (out of 388 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 and sharing GPRA rates so provider associations can assist their members in reaching these goals. Specific to the pressure ulcer goal, in FFY09 MDH and Stratis Health met with the Minnesota Hospital Association and talked with one provider system about pressure ulcer prevention. MDH also tried to identify community systems and models that worked effectively across the continuum on pressure ulcer prevention, but was not able to commit a lot of time and resources to this initiative because of the implementation of QIS and other priorities. MDH will continue to work on GPRA goals in FFY 2010.

II. Summary of Improvements Made to Date on the Nursing Home Survey Process: Areas of Special Focus for 2009

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

As discussed in the 2008 Report to the Legislature, implementation of the revised federal survey process, or Quality Indicator Survey (QIS) process, has been a primary focus area for MDH Licensing and Certification Program for the past two years.

In short, QIS uses new technology and structure to improve the accuracy, consistency and efficiency of the survey process. Strengths of QIS 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). The Department's progress in implementing QIS and analyzing deficiency data is discussed below.

Training of Survey Staff

MDH started training its first group of QIS surveyors on January 7, 2008. As explained in the 2008 Legislative Report, this group was considered the core group of surveyors who would be responsible for training other surveyors through a train the trainer model. Nursing Home Quality, CMS' contracted QIS trainer for state survey agencies, trained this core group of surveyors. By end of March 2010, the Department was several months ahead of its planned implementation schedule for QIS and all survey staff had been trained and all annual nursing home surveys were being conducted using the QIS process.

Communications with Providers

The Department continues to have ongoing communications with providers and other interested parties 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. In FFY09 conference calls to discuss QIS and other issues were held on January 26, 2009, March 30, 2009 and June 15, 2009. Besides providing an update on training and implementation of QIS, data was shared which compared QIS deficiencies to deficiencies under the traditional survey process. More information about this data is discussed below.

Evaluation of QIS and QIS Survey Deficiency Data

FFY09 was the second year of a three year statewide implementation plan for QIS. Besides the feedback received on QIS during the statewide provider and surveyor conference calls and other meetings, MDH has been doing its own evaluation of QIS and monitoring deficiencies issued under the two survey processes. Table II, A-1 below shows that 241 surveys out of 391 total surveys, or approximately 62% of surveys, were conducted using the QIS process. This is a significant increase from last year's 25%.

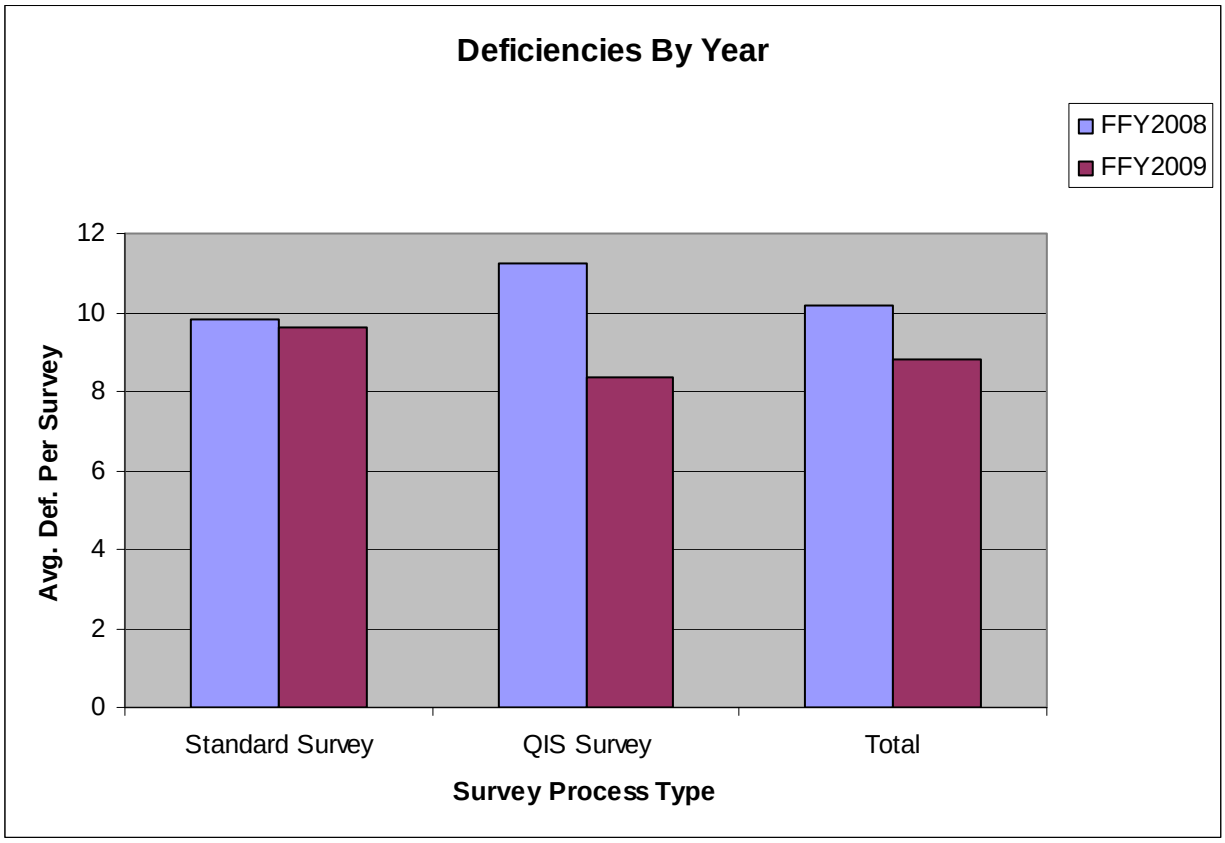
Table II, A-1: Average Deficiencies per Health Survey Traditional Survey Process vs. QIS Process, CY 2008-FFY 2009

		CY 2008*	FFY 2009
	Traditional Survey Process		
# Surveys w/ Def.		296	150
Deficiencies		2910	1441
Avg. Def. per Survey		9.83	9.61
	QIS		
# Surveys w/ Def.		97	241
Deficiencies		1089	2013
Avg. Def. per Survey		11.23	8.35
	Total		
# Surveys w/ Def.		393	391
Deficiencies		3999	3454
Avg. Def. per Survey		10.18	8.83

Source: Paradise Data System
**Calendar year 2008 (CY2008)*

Graph II, A- 1 shows the average number of deficiencies per health survey for both the traditional survey process and the QIS process.

Graph II, A-1: Average Deficiencies per Health Survey Traditional Survey Process vs. QIS Process, FFY09



The trend shows a yearly decline in average number of deficiencies per survey for both survey process types (QIS and traditional). From FFY08 to FFY09, the difference was 2.88 average deficiencies per survey for QIS and a 0.22 decrease for the average deficiencies per survey for the traditional survey type.

From this, we can see that the yearly trend for the number of deficiencies issued and number of surveys conducted are also declining for both survey process types.

The reasons for these declines could be attributed to many factors, including, but not limited to:

- better compliance by providers in Minnesota;
- better internal quality assurance programs by providers in Minnesota;
- more surveys conducted using QIS (approx. 62% FFY09, vs. approx. 25% FFY08);
- larger sample size under QIS process ;
- collapse or combining of some deficiency tags through CMS' revised guidance (e.g. quality of life/dignity);
- surveyors having more experience with using the QIS method; and,
- de-licensing of nursing home beds and conversions to housing with services establishments.

In terms of the types of deficiency tags cited under QIS compared to those under the traditional survey process, a review of tags in 2008 and FFY09 identified several overlaps in tags issued under the two survey processes (Table II, A-2). This continues to indicate 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: Top 10 Deficiencies - - Traditional Survey Deficiencies Compared to QIS Survey Deficiencies, FFY09

Traditional Survey Process (148 Surveys w/Deficiencies)	# Cited	QIS Process (238 Surveys w/Deficiencies)	# Cited
F314 Pressure Ulcer Tx,/Prevention	95	F329 Unnecessary Medications	125
F282 Prov. Care According to Care Plan	87	F272 Comprehensive Assessment	104
F329 Unnecessary Medications	80	F279 Comprehensive Care Plan	100
F315 Urinary Incontinence	77	F323 Accidents/Supervision	97
F323 Accidents/Supervision	75	F428 Drug Regimen Review	96
F371 Food Handling & Sanitation	60	F371 Food Handling & Sanitation	95
F272 Comprehensive Assessment	58	F282 Prov. Care According to Care Plan	78
F279 Comprehensive Care Plan	54	F315 Urinary Incontinence	75
F465 Other Environment Conditions	50	F280 Care Plan Revision	72
F274 Resident Assess. Significant Change	49	F309 Quality of Care	65

* Shaded area denotes difference in tags cited per survey method.
Source: Paradise Data System

Data that MDH collects on IIDRs for FFY08 shows that only seven out of 241 QIS surveys requested an IIDR.

In addition to the Department's data, the University of Colorado, under contract with CMS, has been providing states implementing QIS with Desk Audit Reports for state agencies (DAR-SA). These reports identify outliers and variances by areas and individual surveyors. MDH has received training from Nursing Home Quality on the interpretation and use of this data, and MDH has done its best to analyze and share data reports with survey staff. While these reports are intended to identify outliers in implementing the QIS process, the data reports have been difficult to read and very time consuming to analyze and understand. In fact, the Department estimates that it takes approximately one full-time staff person to review all the reports in their entirety. MDH has expressed concern to CMS and Nursing Home Quality about the difficulty and time involved in analyzing and understanding the DAR-SA reports, but to date has not received a response to those concerns.

The University of Colorado also provides CMS' regional offices with QIS data reports (DAR-RO) which are then shared with state agencies implementing QIS in specific CMS regions (e.g. CMS Region V for Minnesota). MDH has found the DAR-RO reports to be easier to understand and more "user friendly" than the DAR-SA Reports. MDH analyzes these reports and shares the information with survey staff. The DAR-RO reports will be used by CMS Regional Office V

during the federal onsite reviews of QIS (FOQIS) surveys. These surveys will begin in FFY 2011, and MDH has requested attendance at the CMS' training on the FOQIS process. It should be noted that the 2008 Legislative Report indicated that federal survey staff would be visiting MDH the last quarter of FFY09 to conduct a focus survey of QIS as part of the federal oversight process and evaluation of QIS. This visit did not occur, because there were issues with computer compatibility that needed to be worked out first.

In terms of comparing Minnesota deficiencies to deficiencies in other QIS states, CMS is working on modifying the Aspen Central Office data base to be able to provide that kind of data. Currently that data is unavailable.

Overall anecdotal comments from providers about QIS indicate that they have more confidence in the QIS process than the traditional survey process, and they like the fact that the QIS process examines quality of life and residents' rights more than the traditional survey process. While there has been concern expressed in the past about deficiencies being issued at a higher scope and severity under QIS, there is no data to support that allegation in Minnesota. Providers have also expressed concern about there being no QIS protocol for complaints that are investigated outside of the recertification survey. MDH is currently following up with CMS on this issue.

From a surveyor's perspective, surveyors continue to prefer QIS over the traditional survey process. One thing that MDH has noticed, however, is that the QIS process takes approximately 30-40 hours more than the traditional survey process to complete a survey. Some of this time can be attributed to the fact that surveyors are on a learning curve for understanding this new survey process. Improved QIS software, which will be implemented in FFY 2011, should improve survey time completion. In the meantime, MDH has successfully secured the resources from CMS to conduct the hours needed to complete these surveys. Another factor that may increase the length of time needed for conducting a QIS survey, according to Dr. Andrew Kramer, a national QIS expert, is the number of care areas that are "triggered" in the Stage 1 investigation part of the QIS process. If there are several care areas triggered, the survey could be considerably longer.

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.

B. Monitor and Evaluate the Revised Post Certification Revisit Process

As explained in the 2008 Legislative Report, on November 3, 2006, MDH revised its process for performing federal post certification revisit (PCR) follow-up surveys for nursing facilities (Appendix J). PCR follow-up surveys are conducted to assure providers have corrected deficiencies found during an annual survey.

When a federally certified provider receives a deficiency at a B scope and severity level or above (see Appendix B for CMS' Scope and Severity Matrix), federal regulations require them to complete and submit to MDH an acceptable plan of correction (PoC). The PoC must include the following elements to be considered acceptable:

- address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
- include dates when corrective action will be completed; and,
- include signature of provider and date.

Upon receipt of the PoC, MDH verifies that compliance has been achieved by either conducting an onsite post certification revisit survey or non-onsite acceptable PoC review. The method of verification used is dependent upon the scope and severity level of the deficiency issued.

Prior to November 3, 2006, nursing homes that were issued a deficiency at a D level scope and severity or above were required to submit an acceptable plan of correction (PoC), and in most cases received an onsite PCR follow-up inspection. If corrections were not made, or additional non-compliance was found, citations were issued, another acceptable PoC was required, and an onsite PCR follow-up survey was scheduled.

As of November 3, 2006, the date the PCR policy revisions took effect, PCR follow-up visits were prioritized according to the severity of the citations issued. Those surveys with deficiencies indicating harm, substandard quality of care or immediate jeopardy to resident health or safety, and/or those facilities listed on CMS' special focus facilities list received a mandatory onsite PCR inspection. Surveys resulting in lower scope and severity deficiencies were randomly selected for an onsite, non-mandatory, PCR follow-up visit.

Providers not selected for an onsite, non-mandatory, PCR were required to complete and submit an acceptable PoC in writing to MDH. MDH performed that non-onsite, non-mandatory, PCR follow-up inspection via an acceptable PoC verification.

Under the revised PCR process, approximately 25% of the providers with less than an F scope and severity level deficiency citation received an onsite follow-up inspection.

MDH is currently monitoring deficiencies to determine the effectiveness of the revised policy in maintaining compliance with federal and state resident nursing home health and safety requirements. MDH has established three measures, listed below, to monitor the policy's outcome.

1. Do providers who are selected for random onsite, non-mandatory, PCR follow-up visits have deficiencies corrected at the time of the onsite follow-up inspection? Approximately 75% of providers who are eligible for the random selection process will not receive an onsite PCR under the revised policy. MDH will be monitoring onsite PCR

surveys to verify that correction patterns are not changing. If correction rates worsen, MDH can alter or eliminate the random follow-up process.

- During FFY06, from October 1, 2005 through September 30, 2006 (before the revised PCR process was in effect), 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 FFY07, from October 1, 2006 through September 30, 2007, 72 surveys received an onsite, non-mandatory, PCR inspection. Of those 72 surveys, 14 or 19.4% did not have deficiencies adequately corrected on the first follow-up inspection and required additional revisits from MDH (Table II, B-1).
- During FFY08, from October 1, 2007 through September 30, 2008, 77 surveys received an onsite, non-mandatory, PCR inspection. Of those 77 surveys, 21 or 27.3% did not have deficiencies adequately corrected on the first follow-up inspection and required additional revisits from MDH.
- During FFY09, from October 1, 2008 and September 30, 2009, 67 surveys received an onsite, non-mandatory, PCR inspection. Of those 67 surveys, 7 or 10.5% did not have deficiencies adequately corrected on the first follow-up visit and required additional revisits.
- Correction rates for surveys requiring additional follow-up inspections were consistent, within 0.3% between FFY06 and FFY07 for providers meeting the random selection criteria. However correction rates requiring a follow-up inspection increased 7.9% from FFY07 to FFY08. Correction rates for the additional follow-up inspections decreased from 27.3% to 10.5% or by 16.8% between FFY08 and FFY09. Since correction rates appear to be fluctuating, MDH believes more time and data is needed to be able to determine if corrections rates are getting worse and warrant altering or eliminating the current PCR process.

2. Are complaint substantiation patterns different between providers randomly selected for onsite, mandatory, PCR follow-up surveys and those receiving non-onsite, non-mandatory, PCR inspections?

   MDH started tracking the complaint substantiation levels for providers randomly selected for the onsite, non-mandatory, PCR follow-up process. Table II, B-1 below includes complaints resolved between FFY07 and FFY09; the complaint substantiation rate for the non-onsite, non-mandatory, PCR providers is 2.3% higher than the onsite, non-mandatory, inspection group for FFY07.

   The number of substantiated complaints for the onsite, non-mandatory, PCR inspection increased from 14 (FFY07) to 23 (FFY08). Similarly, the number of substantiated complaints for the non-onsite, non-mandatory, group increased from 39 in FFY07 to 58 in FFY08. The substantiation rates for the onsite, non-mandatory, and the non-onsite, non-mandatory, groups increased the most in FFY09. Additionally, the substantiation rates for total complaints for the onsite, non-mandatory, and the non-onsite, non-mandatory, categories were the highest in FFY09.

The overall trend indicates that from FFY07 to FFY09 the substantiation rate for complaints has been increasing for the onsite, non-mandatory, group. Over this same period, the rate of change was smaller (24.4) for the onsite, non-mandatory, group than the non-onsite, non-mandatory, group (29.7).

Table II, B-1: Nursing Home Follow-up Surveys (PCR), FFY07 - FFY09

Nursing Home Follow-up Surveys (PCRs) by Federal Fiscal Year						
PCR Type	**Number of Facilities/ PCR Surveys**	**Number & Percent of Uncorrected PCRs on the 1st Follow-up Visit or Unacceptable PoC**	**Number of Facilities with Complaint**	**Total Complaints Received**	**Number & Percent of Complaints Substantiated**	**Number & Percent of PCRs/Facilities with Repeat Deficiencies***
FFY 2007						
Non-Onsite Non-Mandatory	197	6 (3.1%)	105	224	39 (17.4%)	156 (79.2%)
Onsite Non-Mandatory	72	14 (19.4%)	38	93	14 (15.1%)	57 (79.2%)
Onsite Mandatory	75	31 (41.3%)	46	213	40 (53.3%)	65 (86.67%)
FFY 2008						
Non-Onsite Non-Mandatory	218	2 (0.92%)	115	318	54 (17.0%)	177 (81.2%)
Onsite Non-Mandatory	77	21 (27.3%)	46	124	23 (18.5%)	63 (81.8%)
Onsite Mandatory	73	21 (28.8%)	40	129	32 (43.8%)	68 (93.2%)
FFY 2009						
Non-Onsite Non-Mandatory	232	2 (0.86%)	106	212	63 (29.7%)	*Data Available FFY 2010*
Onsite Non-Mandatory	67	7 (10.5%)	41	86	21 (24.4%)	*FFY 2010 Data*
Onsite Mandatory	70	18 (25.7%)	39	120	46 (38.3%)	*FFY 2010 Data*

Source: Paradise Data System

**The repeat deficiencies for annual recertification survey data (FFY 2007 and 2008; FFY 2008 and 2009). Repeat deficiencies is when the identical tag is cited on two consecutive recertification surveys*

3. In last year's Legislative Report, MDH indicated that they would begin monitoring the degree to which the onsite, non-mandatory, and the non-onsite, non-mandatory, groups 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 citations of the same deficiency in the non-onsite, non-mandatory, group may indicate higher rates of uncorrected problems carrying forward into the next year.

   MDH analyzed the number of repeat deficiency surveys for FFY07 and FFY08 (Table II, B-1) and found that the number of surveys with repeat deficiencies increased by 5.8 for both follow-up survey inspection types. Based on this trend, it appears that the random onsite, non-mandatory, inspection does not differ from the random non-onsite, non-mandatory, inspection. The rates of changes for both follow-up types are identical.

   A more significant finding is that, regardless of whether an onsite, non-mandatory, PCR follow-up survey or a non-onsite, non-mandatory, PCR follow-up survey is conducted, 75% to 81% of facilities are not staying in compliance. Data is showing a significant number of repeat deficiencies. MDH will work with providers to review their quality assurance plans and systems so they sustain compliance over a period of time. Additionally, MDH will continue to monitor deficiencies to see if the number of facilities with repeat deficiencies goes down. The Department will pursue monitoring further by looking at its data systems and programs and consider whether the following can be done:

   - looking at the type of deficiency tags issued;
   - examining data at the individual facility level to see if the scope and severity of the deficiency issued is higher for those facilities who received a non-onsite, non-mandatory PCR follow-up inspection versus a random onsite, non-mandatory PCR follow-up inspection; and,
   - identifying and flagging those facilities whose total number of deficiencies exceed the state average of deficiencies written and examining the type of PCR inspection conducted.

   MDH believes that the collection and analysis of more data will provide more information to evaluate whether the revised policy is working or whether changes need to be made to the PCR process. MDH will continue to report its progress in evaluating the PCR process in next year's Legislative Report.

C. Implementation of Minimum Data Set 3.0 (MDS 3.0)

As mentioned in the 2008 Legislative Report, federal regulations require all certified nursing and boarding care homes to use a standardized assessment instrument when completing comprehensive assessments of residents' 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.

MDH's Licensing and Certification Program is working with providers, DHS, and its Case Mix Review section in order to provide a seamless transition to MDS 3.0. This work will continue and intensify throughout 2010 in order to provide training and both clinical and technical support to all stakeholders.

The department's training plan envisions a multi-modal approach to providing the necessary education, including:

- Eight (8) webinars that will be archived and accessible to interested parties for at least one (1) year.
- Seven (7) one day face-to-face training session throughout the state to follow up the webinars.
- Telephone conference calls - Q & A sessions with questions to be faxed in
- MDS 3.0 Webpage on the Compliance Monitoring website http://www.health.state.mn.us/divs/fpc/MinnesotaMDS3_0.html

MDH will also work on integrating MDS 3.0 into the new QIS process and monitoring that integration closely.

D. Other Quality Improvement Activities

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 FFY09, CMS issued revised guidance on Pain Management/Quality of Care (F309) and Quality of Life and Environment and Food Procurement and Self Determination (F241). MDH, together with the collaborative joint training group, developed training programs and tools on these new guidelines. A chart that summarizes these training initiatives is found in Appendix K.

Future guidance to be issued by CMS in FFY10 includes Infection Control (F441). Other than those guidelines, CMS has not released a new list of deficiency tag areas to be addressed. Abuse is one area that has been discussed in the past. However, recent communication from CMS indicates that "End of Life Care" may be the next area for guidance to be issued. 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 pursuant to M.S. 144A.10, subdivision 1.

Besides the training provided on CMS revised guidelines, MDH also revised its Tuberculosis Prevention and Control Guidelines to follow the United States Centers for Disease Control (CDC) "Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* (TB) in Health-Care Settings, 2005". A webinar was developed and a statewide telephone conference call for providers and surveyors was held on April 17, 2009. MDH is granting licensed nursing home providers a waiver from the TB requirements in Minnesota's Rules in order to follow the CDC's guidelines.

Nursing Home Emergency Preparedness Training and Activities

Recent events such as 911, Hurricane Katrina and other emergencies have highlighted the need for states to do better planning and responding to emergencies. MDH's Licensing and Certification staff have become increasingly involved in such activity.

In March of 2009, MDH's Office of Emergency Preparedness, Aging Services of Minnesota, Care Providers of Minnesota, and Minnesota Department of Human Services jointly sponsored six, free, day-long, training sessions in various regions of the state on Nursing Home Emergency Preparedness. Over 400 providers attended this training. A tool kit and templates were given to providers to develop and customize facility and community specific emergency plans. The tool kit is available on the Department's web site at: http://www.health.state.mn.us/oep/responsesystems/ltcprepare.pdf . These trainings and resources were provided using Civil Money Penalty funds, which are monies received from fines to nursing homes for non-compliance. These funds are used for statewide provider training and other projects that improve resident quality of care and quality of life.

Around this same time, flooding was occurring in the Northwestern part of the state (Fargo/ Moorhead). MDH Licensing and Certification staff assisted facilities in preparing for the evacuation of nursing home residents and identifying available beds in near by facilities.

Later that spring the threat of the H1N1 virus occurred. MDH Licensing and Certification staff spent a considerable amount of time preparing for and responding to this new virus. Besides participating in H1N1 and emergency response training, the Licensing and Certification Program worked with the MDH Office of Emergency Preparedness to create a web site of information and resources specifically for long term care providers on this new virus (web site is available at http://www.health.state.mn.us/divs/idepc/diseases/flu/index.html). Licensing and Certification staff also set up an e-mail account and phone line to address H1N1 regulatory type questions. This was in addition to the general H1N1 phone lines for the public and providers that was set up by the Department as a whole. Licensing and Certification staff not only worked those public and provider call lines, but also served on task forces to discuss and resolve issues around infection control guidelines and the use of protective equipment (N95 mask), visitor restriction policies, etc. The Department is always trying to improve its emergency preparedness and response activities and will continue to work closely with its public and private partners in responding to these and other types of emergencies that occur.

Dental Care Video

The Department recently completed its production of a training video and workbook for providers on providing proper oral health care to residents of nursing homes. MDH worked with University of Minnesota School of Dentistry Oral Health for Seniors Program and various long-term care stakeholders on this project. Copies of the video are in the process of being made and will be sent to all certified nursing home providers and other interested parties soon.

Culture Change Initiatives

MDH continues to be an active member of the Minnesota Culture Change Coalition. This group meets regularly to discuss ideas and plan activities that advance resident centered and resident directed care.

Related to culture change activity, are the revised guidelines that CMS issued regarding Quality of Life and Environment and Food Procurement and Self Determination (F 241). Before these guidelines were issued, Minnesota had already been promoting and advancing many of the revisions included in these guidelines. This was done through its joint surveyor/provider training sessions that were held on culture change for surveyors, investigators and providers between 2006 and 2008.

Additionally, when CMS issued these revised guidelines in June 2009 MDH, providers and other state survey agencies raised concerns with the guidance and training that CMS provided on this topic. The guidance appeared to conflict with the culture change model specifically as it related to dignity, and the use of clothing protectors and programmatic symbols and signage on the door for staff purposes. This prompted CMS to issue additional clarification on these guidelines which were more aligned with the culture change model.

III. Areas of Special Focus for 2010

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

Statewide implementation of QIS will continue to be a primary focus for the Department in FFY 2010. Although the Department is now fully implemented in the QIS process, MDH will be focusing on the evaluation of QIS in FFY 2010. MDH will continue to analyze QIS reports from CMS (DAR-SA and DAR-RO) and share those results with survey staff. Areas and individuals which are determined to be outliers will be examined and a plan for follow-up will be developed. The Department will also work with CMS to make the DAR-SA reports easier to analyze, understand, and make use of the data to its fullest extent.

Additionally, MDH will continue to track QIS deficiencies through its own data programs. While it appears that the number of deficiencies per survey is starting to level off with the implementation of QIS, more data is needed to confirm that analysis.

As it relates to complaint investigations, MDH will seek clarification from CMS on how complaints are to be handled, now that QIS has been fully implemented in Minnesota, when to date a QIS protocol for stand alone complaints as not been released by CMS.

B. Implementation of MDS 3.0

The Department will work with providers to assure a seamless transition from MDS 2.0 to MDS 3.0. MDH will carry out its plan to provide training and clinical and technical support to stakeholders during FFY 2010 and integrate MDS 3.0 in the new QIS process.

C. Additional Provider and Surveyor Training

Besides the training that will be done on implementation of CMS revised guidelines, MDH will be providing additional training on care area assessments under MDS 3.0. These would include training on clinical areas where there have been immediate jeopardy or actual harm deficiencies issued, hospitalizations incurred, common errors made, etc. Such areas include end of life and pain management; unnecessary medications; medical direction; accidents and supervision; notification of physicians; and, dignity. MDH has once again contracted with Dr. Steven A. Levenson to provide this training to surveyors and providers. Dr. Levenson has served on various Technical Expert Panels (TEPs) for CMS and has been involved in writing revisions to the State Operations Manual and developing new and revised CMS guidelines. A toolkit will be developed and distributed to all nursing home providers.

The Department also plans to provide Root Cause Analysis training and follow-up activities to providers in the Twin Cities Metro area. This is an expansion of the same training that was provided in the Northeast Region of the state in 2008 as part of a pilot project. Providers who attended the training in Duluth, were pleased with the training and requested that the training be offered to providers in other areas of the state. The Licensing and Certification Program will be working with MDH Adverse Health Events Program and Stratis Health to conduct this training.

Finally, the Department will be providing a statewide, video-conference training on Abuse and Neglect Reporting. The primary goals of this video-conference are to: promote heightened awareness regarding abuse and neglect reporting and cooperation between providers and OHFC; reduce duplication of information and paperwork; and to promote a streamlined process geared toward a more efficient use of resources on the part of OHFC and nursing home providers. MDH will work collaboratively with DHS, provider organizations and other stakeholder groups to develop a program specifically geared toward nursing home reporting systems. Topics will include clarification on abuse/neglect reports and complaints under federal and state law; definition of the roles and responsibilities of OHFC as well as providers; and, what and how to report to the Common Entry Point (CEP). Each session will include scenarios of reportable/non reportable incidents and a question and answer session to clarify reportable abuse/neglect complaints and reports. Following the training, a DVD of the training session will be sent to all certified nursing homes so all nursing home staff have access to the information, not just those who attended the training session.

All three of the above mentioned training initiatives involve the use of Civil Money Penalty Funds, which as mentioned previously, are monies received from fines to nursing homes for non-compliance. These funds are used for statewide provider training and other projects that improve resident quality of care and quality of life.

D. Greater Coordination with Public and Private Sector Organizations and Programs on Emergency Preparedness Planning and Response

MDH will continue to work closely with its public and private partners in preparing for and responding to emergency situations. This will include enhancing its communication systems and developing a system to track such information as long term care bed availability. During FFY 2010 Licensing and Certification Program, in collaboration with the MDH Office of Emergency Preparedness, also plans to provide additional training to providers on how to carry out their facility emergency plans in the event of an emergency.

IV. 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' 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 K.	Chart that Describes MDH Collaborative Joint Training Activities on CMS Revised Guidelines

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

	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	K PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	L PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2
Actual harm that is not immediate jeopardy	G PoC Required* Cat. 2 Optional: Cat. 1	H PoC Required* Cat. 2 Optional: Cat. 1	I PoC Required* Cat. 2 Optional: Cat. 1 Optional: Temporary 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 HCFA-2567	B PoC	C PoC

Substandard quality of care in 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

REMEDY CATEGORIES

Category 1 (Cat. 1)

Directed Plan of Correction
State Monitor; and/or
Directed In-service Training

Category 2 (Cat. 2)

Denial of Payment for New Admissions
Denial of Payment for All Individuals
imposed by CMS; and/or
Civil Money Penalties;
$50 - $3,000 per day
$1,000 - $10,000/instance

Category 3 (Cat. 3)

Temp. Mgmt.
Termination

Optional:
Civil money penalties:
$3,050 - $10,000 per day
$1,000 - $10,000/instance

Denial of payment for new admissions must be imposed when a facility is not in substantial compliance within 3 months after being found out of compliance.
Denial of payment and State monitoring must be imposed when a facility has been found to have provided substandard quality of care on three consecutive standard surveys.

12/02 CMSGRID.FRM

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

CMS' 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 for State Survey Agencies.
http://nursinghomequality.com/

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 FFY2009

State	Surveys	Average Number of Health Deficiencies
Puerto Rico	7	15.9
District of Columbia	18	15.3
Delaware	46	12
California	1,166	10.9
Colorado	221	10.4
Arizona	123	10.2
Kansas *	293	9.8
Idaho	74	9.7
Oklahoma	308	9.7
Nevada	51	9.2
Maryland	230	9.1
Virginia	249	9
Wyoming	34	8.9
Minnesota *	389	8.8
Hawaii	51	8.5
Michigan	466	8.5
Missouri	518	8.4
West Virginia	119	8.2
Florida *	666	7.9
Arkansas	243	7.8
Connecticut *	236	7.4
Indiana	529	7.3
Louisiana *	288	7.3
Vermont	42	7.3
Maine	105	7.1
Montana	90	7.1
Washington	243	6.8
Illinois	776	6.3
Alaska	16	6.1
Ohio *	900	6.1
Iowa	463	6
Virgin Islands	1	6
South Carolina	169	5.9
Wisconsin	373	5.9
Utah	81	5.7
Georgia	347	5.5
New Jersey	363	5.5
Texas	1,179	5.5
Nebraska	223	5.4
Kentucky	266	5.2
North Dakota	81	5.1
Tennessee	289	5
Mississippi	204	4.9
New York	656	4.8
Pennsylvania	745	4.7
South Dakota	115	4.7
New Hampshire	83	4.6
Massachusetts	469	4.5
New Mexico	70	4.4
Alabama	237	4.3
Oregon	140	4.3
North Carolina	441	3.9
Rhode Island	85	3.1
Totals	15,577	6.8

* 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
This site includes a link to the 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

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.

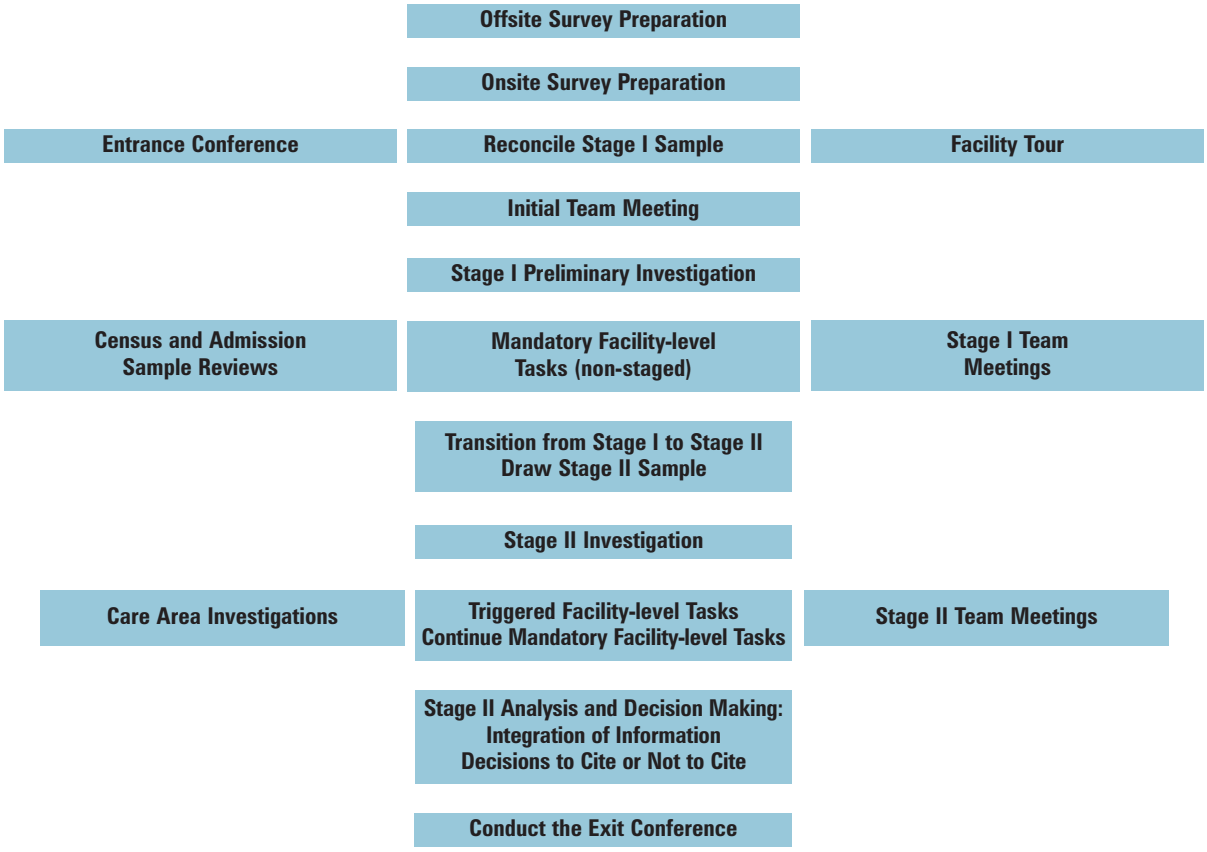
Description of QIS

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 FFY2009

State	Surveys	Average Number of Health Deficiencies
Montana	90	9.4
Pennsylvania	745	7.3
Kansas	293	7.1
Iowa	463	6.3
Colorado	221	6.1
Illinois	776	6.1
New Hampshire	83	6.1
Michigan	466	6
Utah	81	6
Wyoming	34	6
Wisconsin	373	5.8
California	1,166	5.7
Nebraska	223	5.6
Puerto Rico	7	5.6
Ohio	900	4.9
Oklahoma	308	4.9
Texas	1,179	4.8
Maryland	230	4.7
Indiana	529	4.6
New Mexico	70	4.4
Alaska	16	4.1
Missouri	518	4
Oregon	140	3.9
Alabama	237	3.7
North Carolina	441	3.7
Tennessee	289	3.7
Virginia	249	3.5
Arizona	123	2.9

State	Surveys	Average Number of Health Deficiencies
South Dakota	115	2.9
Washington	243	2.9
Minnesota	389	2.8
Idaho	74	2.5
New York	656	2.5
Kentucky	266	2.4
Louisiana	288	2.4
North Dakota	81	2.3
Nevada	51	2.2
Delaware	46	2.1
Connecticut	236	2
Georgia	347	2
District of Columbia	18	1.9
New Jersey	363	1.9
West Virginia	119	1.8
South Carolina	169	1.7
Arkansas	243	1.6
Florida	666	1.6
Massachusetts	469	1.3
Mississippi	204	1.1
Maine	105	1
Vermont	42	0.9
Hawaii	51	0.4
Rhode Island	85	0.2
Virgin Islands	1	0.0
Totals	15,577	4.2

APPENDIX H

Release of Federal Documents by the State Survey Agencies, Administrative Information Bulletin 07-06, issued January 12, 2007

June 2008

Information Bulletin 08-07
All Medicare Certified Providers
All Dually Medicare/Medicaid Certified Providers
CLIA - Laboratories

Release of Federal Documents by the Minnesota Department of Health (MDH), the State Survey Agency (SA)

Clarification from CMS to MDH

The Centers for Medicare and Medicaid Services (CMS) has clarified that under MDH's Agreement with the Secretary, Health and Human Services under §1864 of the Social Security Act (§1864 Agreement) certain documents are directly releasable by MDH. This means that certain documents which MDH may have released in the past must be requested from CMS under the Freedom of Information Act (FOIA).

This clarification from CMS is addressed in CMS Administrative Information Memorandum 07-06. This memo indicates which documents are releasable by the State Survey Agency. The Minnesota Department of Health is the State Survey Agency.

Freedom of Information Act (FOIA) Request

Requests for records that are not included on the list of documents that MDH may directly release should be requested from CMS under FOIA.

Details about FOIA requests, including a downloadable form that may be used to submit a request to CMS, are available on the CMS website at http://www.cms.hhs.gov/FOIA/.

If you have any additional questions about filing a request for documents on the direct release list, please contact Mary Cahill with MDH at 651-201-3701.

For information about filing a FOIA request with CMS, please contact Susan Hahn Reizner, CMS Region V FOIA Coordinator, at (312) 353-1504.

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

APPENDIX I

2010 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 Individualized 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 2009 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. http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSOPAFY2011.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).
- Orient newly hired MDH staff to QIS survey process on an ongoing basis.
- Seek adequate resources from CMS to understand and use QIS data tools, and 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.

- Use information gained from QIS survey process and Federal Oversight Quality Indicator Surveys to indentify areas for quality improvement.
- Seek adequate resources from CMS to analyze and fully understand data from DAR-SA reports.
- Expand understanding of survey outcomes by using QIS data reports that analyze survey data for variances.

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 occur.

- 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 and other issues affecting long term care providers.

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).
- Participate in statewide emergency preparedness activities.

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.

APPENDIX K

MDH Collaborative Joint Training Activities
on CMS Revised Guidelines - FFY09

Deficiency Tag #	Revised/New Guideline Deficiency Description	CMS Date Issued	Joint Training/Tools	MDH Implementation Date / Information Bulletin #
F 309	Pain Management/ Quality of Care	April 2009	Joint training sessions were held at 5 locations throughout the state May 11– 15, 2009. Copies of handouts and a tool kit for providers is available on MDH's Clinical Web Window. Statewide follow-up phone conferences to discuss the implementation of these and other guidelines are planned for February, April and June 2010.	May 18, 2009
F241	Quality of Life and Environment & Food Procurement and Self Determination	June 2009	Statewide phone conference was held on July 23, 2009. Educational Resources were posted on MDH's Clinical Web Window. Statewide follow-up phone conferences to discuss the implementation of these and other guidelines are planned for February, April and June 2010.	August 1, 2009

Future CMS Guidelines to be issued:

- F 441 Infection Control
- F 223-226 Abuse
- Comment by CMS that End of Life Care may be next guidance issued, however specific deficiency tags were not identified.

As new guidelines are issued by CMS, MDH and the collaborative joint stakeholders group will develop training and guidance tools and implement new protocols.