Broken and Beyond Repair:

Recommendations to Reform The Survey and Certification System

Task Force on Survey, Certification and Enforcement

American Association of Homes and Services for the Aging

June 2008

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OVERVIEW

The current survey and certification system is broken and beyond repair. The AAHSA Task Force on Survey, Certification and Enforcement agrees with the basic vision behind the "OBRA '87" legislation, which launched the current survey process. We applaud the thoughtful effort, taken more than 20 years ago, to create an oversight system that strives to ensure "sustained compliance" of nursing homes with a set of carefully designed regulations and, at the same time, attempts to foster a high quality of care and high quality of life for residents who live in these homes. While these two goals are laudable, the original vision of OBRA has been lost and the current system does not meet either of these objectives.

Only bold action can remedy this situation. Therefore, the Task Force calls on AAHSA to facilitate the creation of a broad-based national coalition of organizations, agencies and individuals who have a stake in the nation's survey and certification system. That coalition should call for a bold, national reexamination of the process of oversight for nursing facilities. An objective and widely respected organization, such as the Institute of Medicine, should guide this reexamination process, which should tap the creative ideas and the expertise of individuals in a variety of fields. The national reexamination should strive to create a common vision for how our nation should care for its frailest citizens and should recommend a new oversight model for ensuring that this vision becomes reality in every nursing home in the country.

To improve the effectiveness of the current survey system until it can be redesigned, the Task Force also proposes 31 recommendations for immediate AAHSA advocacy. These recommendations outline action that AAHSA should take to help the Center for Medicare and Medicaid Services improve the quality of survey teams; foster effective communication among regulators, surveyors and providers; better ensure consistent application of regulations; encourage providers to strive for excellence; facilitate accurate reporting to consumers; and improve the fairness of enforcement and dispute resolution.

CHAPTER ONE:

The Task Force and Its Work

AAHSA members' widespread anger and acute frustration with the current survey and certification system – regarded by many to be complicated, inconsistent and ineffective – was the primary impetus for creating the association's Task Force on Survey, Certification and Enforcement in late 2006. In addition, several related developments in the field of long-term care made an examination of the current oversight system particularly timely.

Just as Task Force members were being appointed, the Center for Medicare and Medicaid Services (CMS) was concluding its own decades-long experiment to reform the survey system through implementation of a new model called the Quality Indicator Survey (QIS). AAHSA members were hopeful that the QIS would significantly improve the survey process by increasing its accuracy and efficiency, reducing its onerous nature and substantially improving consistency. They, along with CMS, anticipated that the QIS would be implemented broadly if the survey model's demonstration phase was successful. The association and its members were eager to have the Task Force monitor the progress and evaluate the impact of this promising new survey model.

AAHSA has always supported nursing home oversight and has spearheaded its own efforts to educate consumers so they are better able to make wise care choices. In light of these ongoing commitments, it had a strong desire to participate actively in any national conversation about oversight and reporting, and to make sure that conversation took place in the context of fairness and accuracy.

Faced with these opportunities and challenges, AAHSA charged the Task Force on Survey, Certification and Enforcement with four duties:

1. To articulate specific issues related to the survey and certification system and the origins of those issues, including public reporting of survey data.

2. To identify short-term and long-term solutions to the issues and problems thus identified.

3. To develop strategies for implementing these short- and long-term solutions.

4. To identify enforcement issues and develop strategies for resolving problems.

The Task Force Process

AAHSA chose 20 individuals, who have extensive experience with and knowledge of the survey system, to serve on the Task Force. Collectively the Task Force members have over 400 years of experience in the field (see Appendix A for brief descriptions of the Task Force members' experience). These members were recruited from the highest levels of their organizations and included presidents and chief executive officers of AAHSA-affiliated state associations, skilled nursing facilities, continuing care retirement communities, regional health and/or geriatric care systems, geriatric education and training institutes and law firms. Several members of the Task Force had previously served with state survey agencies as members of survey teams and in other capacities, including State Agency Director.

AAHSA made a deliberate effort to ensure that the Task Force was as diverse a group as possible. Recognizing that survey issues are national issues, members were recruited from 18 states in every region of the country, including Pennsylvania, South Carolina, Michigan, Wisconsin, Georgia, Connecticut, New Jersey, Missouri, Ohio, Kansas, Texas, Illinois, Indiana, Iowa, Florida, New York, Minnesota and Kentucky. The group consisted of an equal number of men and women. Members represented organizations that were affiliated with religious groups or denominations as well as organizations with no such affiliations.

While the bulk of the Task Force's work took place during seven multi-day meetings held over 14 months, members also worked in small groups, between meetings, to explore specific aspects of the survey system. Every facet of the group's work was supported by thorough fact-finding initiatives, including a review of the literature by Task Force members, testimony of experts who offered presentations during Task Force meetings, and original research conducted by individual Task Force members and AAHSA staff. Through those research efforts, the Task Force sought the input of AAHSA-affiliated state associations as well as representatives of state survey agencies in seven states, who were interviewed in June 2007. The Task Force also conducted surveys among a variety of stakeholders on such topics as the Informal Dispute Resolution process and qualifications for survey personnel. (See the Appendices for results of these special surveys.)

The Task Force relied on all of these resources, as well as its own experiences with the survey system, to develop a cohesive understanding of the challenges that the current system poses to all its participants. It then assessed the system's capacity to ensure that nursing homes comply with federal regulations and provide the highest quality of care and services.

A Flawed System

When Task Force members arrived in Washington, D.C. in February 2007, for their first meeting, it quickly became abundantly clear why providers were so angry and frustrated with the survey system. Task Force members brought to that first meeting a plethora of personal stories about the survey process – stories that were hauntingly similar, given members' geographic diversity. Hailing from such distant and diverse states as Florida and Wisconsin or Ohio and Oregon, providers described in detail the dilemma they faced at least annually when surveyors appeared at the doors of their nursing homes. Despite their deliberate and ongoing efforts to provide high-quality care and services to their residents – efforts that were often mandated by the mission statements guiding their

organizations – these providers found themselves, year after year, embroiled in negative and adversarial encounters with surveyors who seemed bent on "finding something wrong." By the end of each survey, providers reported that they were frequently angry and fed up – and their staffs were demoralized and ready to quit.

Punishment, not quality improvement. The adversarial atmosphere created during many surveys seemed particularly difficult to accept for providers who have always believed strongly in the value of an effective oversight system. Clearly, the majority of nursing home facilities are not resistant to government oversight. On the contrary, many of these facilities are already involved in long-standing initiatives to monitor and improve the quality of their own care and fully recognize the importance of productive external evaluation. Sadly, what the current survey offers instead is a complex and punitive process that often resembles an interrogation rather than an effective communication between surveyors and providers, and leaves facility staff members feeling as if they have been deemed guilty of negligence until they can prove otherwise.

Providers are not the only ones who would prefer a survey system that—while recognizing the role of compliance determination and enforcement-- is more productively positive and collaborative, rather than relentlessly critical and adversarial. High-level staff working in survey agencies in seven states, who were interviewed in June 2007, by Task Force members and staff of relevant state affiliates, overwhelmingly supported a more consultative role for their survey teams (see Appendix B). Staff in several states recommended that consultation be built into the survey system, either by scheduling regular consultation visits by surveyors or by mandating ongoing consulting for poor-performing facilities. One survey staff member summed up his colleague's comments by suggesting, "providers could learn strategies from surveyors if a consultative process was permitted."

Complexity breeds inconsistency. The punitive nature of the typical survey is furthered by extensive and highly detailed regulatory guidelines that challenge both surveyors and providers. In one of the very few objective, scientific evaluations conducted on the

implementation of one of these numerous guidelines—the revised federal guidance for incontinence care—researchers found substantial problems among both survey teams and nursing home staff and concluded "The revised guidance will be unlikely to improve the quality of urinary incontinence care in nursing homes."[1] This overwhelming complexity is exacerbated by the fact that no standardized qualifications or training requirements exist to ensure that surveyors have the knowledge and skills they need to fully understand the system and its requirements or to conduct objective surveys. For their part, state survey agencies also seem troubled by the nature of the survey system they are charged with implementing. Survey staff interviewed in the 7-state sample expressed frustration at being saddled with a process that is developed and/or periodically changed by federal regulators who have little or no survey experience. Some state employees lamented the fact that process changes are not field-tested by providers and surveyors before implementation. Others said they were challenged by requirements that they carry out new survey tasks without additional funding. Many agency staff members called for increased flexibility so they could use their limited survey resources where they felt they could be most effective–i.e., in troubled facilities in need of close oversight and intervention.

Not surprisingly, providers observed that inadequately prepared and overtaxed surveyors tend to make subjective assessments of facility operations – assessments that are often based on the surveyors' own, idiosyncratic interpretation of CMS guidelines, rather than the regulations themselves. The result is an alarming inconsistency in how surveyors interpret and apply requirements and cite deficiencies. This perception is supported by a number of independent evaluations of the system, in which analysts confirm substantial inconsistencies in rule application and call for various solutions to the problem.[2,3,4,5,6]

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[1] Catherine DuBeau, Joseph Oustlander, and Mary Palmer. 2007. "Knowledge and Attitudes of Nursing Home Staff and Surveyors about the Revised Federal Guidance for Incontinence Care," *The Gerontologist,* 47:4.

[2] Institute of Medicine. 2001. *Improving the Quality of Long-Term Care*. Washington, D.C.: National Academy Press.

[3] Walshe, K. 2001. "Regulating U.S. Nursing Homes: Are We Learning From Experience?" *Health Affairs*, 20:6.

[4] Walshe, K. and Harrington, C. 2002. "Regulation of Nursing Facilities in the United States: An Analysis of Resources and Performance of State Survey Agencies." *The Gerontologist*, 42:4, 475–486.

One recent study, for example, concluded that state-by-state differences in the patterns of deficiency citations could not be blamed on underlying differences in quality:

> *"…[T]he average facility in California was cited for about 13 violations in 2004, but only about five percent of facilities in the state were cited for causing actual harm or immediate jeopardy. On the other hand, New Hampshire averaged only a bit more than five deficiencies per facility, but more than 15 percent of facilities were cited for causing actual harm or placing patients in immediate jeopardy. While there may be some difference in the absolute underlying level of quality of facilities in these two states, it is unlikely that this difference is sufficient to fully explain the different patterns of deficiency citations"*[7]

Provider comments to the Task Force provided additional, albeit anecdotal, evidence that surveyor inconsistency and subjectivity can also plague individual facilities. These providers told stories about specific facility practices, unchanged from one year to the next, which were essentially approved by one survey team and cited as deficient by the next team. While the Informal Dispute Resolution (IDR) process is intended to help providers question such deficiencies, many providers who have used the IDR process characterized it as a "kangaroo court" that values expediency over fairness, frequently denying providers the opportunity to fully present relevant evidence or information. Some survey agency staffers in the states where we conducted interviews agreed that the process is often marred by a loose structure and an inability to change the scope and severity of deficiencies.[8]

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[5] Winzelberg, G.S. 2003. "The Quest for Nursing Home Quality." *Archives of Internal Medicine*, Nov. 24, 2003.

[6] Miller, E.A. and Mor, V. 2008. "Balancing Regulatory Controls and Incentives: Toward Smarter and More Transparent Oversight in Long-Term Care." *Journal of Health Politics, Policy and Law*, 33:2, April 2008.

[7] *Ibid*.

[8] The IDR process varies from state to state. See Appendix D for a summary.

Inconsistency signals deeper flaws. At the outset, Task Force members identified lack of consistency as one of the most corrosive features of the current survey system and began to explore steps that might help improve the situation. However, the more Task Force members examined the root causes of these inconsistencies, the more they became convinced that incremental changes would only contribute to a modest amelioration of the problem. The Task Force came to believe that the system's lack of consistency is only one symptom of fundamental flaws in the structure of the survey system. Essentially, these flaws guarantee that neither nursing homes nor surveyors can succeed within the system because, in the words of Dr. Jack Schnelle of Vanderbilt University, that system is built on mythology.

According to Dr. Schnelle, a professor in Vanderbilt's School of Medicine and a staff member at its Center for Quality Aging, the survey system inevitably leads to inconsistent results and poor feedback regarding real quality issues because it is characterized by:

> *"unrealistic expectations about how many recommended care processes can be measured; poor definition of measures and methods of measurement; confusing rules linking measures to deficiency statements; and a survey culture that depends on expert judgment."*[9]

The *Interpretive Guidelines* – the extensive CMS guidance to surveyors contained in the State Operations Manual (SOM) that attempts to clarify and/or explain the intent of regulations – stands at the heart of the survey system. The publication contains page after page of discussion about quality care processes. Dr. Schnelle's research shows that, despite all of this "guidance," nursing homes find it virtually impossible to carry out all of the recommended processes. Likewise, surveyors continually fall short in their attempts to measure compliance systematically.

[9] Schnelle, J.F. 2007. Presentation to Task Force on Survey, Certification and Enforcement.

During a presentation at one Task Force meeting, Dr. Schnelle outlined several steps he believes would fundamentally reshape the survey system to address these problems. His recommendations call for using the existing *Interpretive Guidelines* to develop and test standardized investigative protocols that would focus on a realistic set of quality measures. Dr. Schnelle emphasized that sufficient resources must be allocated to implement the protocols, which must be communicated clearly to nursing home staffs to obtain consensus.

While the Task Force did not specifically incorporate Dr. Schnelle's formula for reforming the survey system into its recommendations, the group found his analysis compelling and is convinced that creative thinking and solid research like his should play an integral role in any serious effort to reform the survey process.

Regulations and quality improvement. In addition to concerns about consistent interpretation of regulations, providers and state survey staff alike also expressed deep concerns about the substance of some federal regulations governing nursing homes. For example, providers who have invested considerable time and energy in culture change initiatives often feel thwarted and hamstrung by regulations that either don't encourage or don't allow certain person-centered innovations. In addition, both providers and surveyors questioned whether enforcement mechanisms associated with the survey system are really helping to improve quality of care and quality of life. Survey agency leaders, in particular, questioned whether written plans of correction brought about real change or simply added to a facility's paperwork burden; whether the oversight system was overly dependent on fines as the enforcement mechanism of choice; and whether the two-year ban on nurse aide training programs triggered automatically under certain conditions of noncompliance encourages quality improvement or actually serves as a barrier to quality improvement.

Poor communication. Underlying and aggravating all these problems is the fact that communication between providers and surveyors is often strained during the survey and is virtually nonexistent between surveys. Far from fostering open dialogue as a way to

achieve superior results, the system's communication barriers encourage all participants to be distrustful of one another and to carefully guard their words for fear of open conflict or retribution. State surveyors acknowledged these problems and several described actions they have taken to improve communication between themselves and providers. These improvements included quarterly meetings between surveyors and providers in Illinois and Connecticut, a Surveyor/Provider Forum in Oregon, and the publication of a regulatory update newsletter (in addition to annual meetings for providers) in Missouri.

One Primary Recommendation

The Task Force on Survey, Certification and Enforcement ended its 14-month evaluation of the survey system by coming to a single, striking consensus:

The current survey and certification system is broken and beyond repair.

Given this consensus, the Task Force decided that it could not offer, as its primary recommendation, a collection of incremental "fixes" for the current survey system. The more the Task Force learned, the more strongly its members believed that the time for these "fixes" has passed.

The Task Force agrees with the basic concept behind the "OBRA '87" legislation, which launched the current survey system. We applaud the thoughtful effort, taken more than 20 years ago, to create a system with two laudable goals: (1) to ensure "sustained compliance" of federally-certified nursing facilities with a set of carefully designed regulations; and (2) to foster high quality of care and quality of life for residents who live in these homes.[10] However, the original vision of OBRA has been lost and the current

[10] CMS describes its belief about what the current survey measures in the following manner: "… findings of inspections do not present a complete picture of the quality of care provided by the nursing home. The inspection measures whether the nursing home meets the minimum standard for a particular set of requirements. If a nursing home has no deficiencies, it means that it met the minimum standards at the time of the inspection. However, this information cannot be used to identify nursing homes that provide outstanding care" (http://www.medicare.gov/NHCompare/Static/Related/ImportantInformation.asp?dest=NAV|Home|About|NursingHomeCompare#TabTop; accessed June 13, 2008).

system meets neither goal. Essentially, the system has failed us as providers and regulators, and worse, has failed the frail and elderly people whom we serve.

Only bold action can remedy this situation. Therefore, the Task Force on Survey, Certification and Enforcement calls for a broad-based, national effort that will take a completely new look at the entire survey process and boldly redesign that system so that it supports and facilitates the original vision on which it was based. Chapter 2 of this report describes in more detail the Task Force's primary recommendation which reads as follows:

> *AAHSA should facilitate the creation of a broad-based national coalition of organizations, agencies and individuals who have a stake in the nation's survey and certification system. That coalition should call for a bold, national reexamination of the system that provides oversight of nursing facilities. An objective and widely respected organization, such as the Institute of Medicine, should guide this reexamination process, which should tap the creative ideas and the expertise of individuals in a variety of fields. The national reexamination should strive to create a common vision for how our nation should care for its frailest citizens and should recommend a new oversight model for ensuring that this vision becomes reality in every nursing home in the country.*

Short-Term Remedies

A national reexamination of the survey system will not be an easy task. It will take time, energy and resources to complete. In the meantime, providers and surveyors continue to struggle within a dysfunctional system. Eager to offer these providers some relief, and to improve the effectiveness of the current survey system until it can be redesigned, the Task Force also proposes 31 recommendations for immediate AAHSA advocacy in six categories. These recommendations outline action that AAHSA can take to help CMS improve the quality of the survey team; foster effective communication between

regulators, surveyors and providers; ensure consistent application of regulations; encourage providers to strive for excellence; facilitate accurate reporting to consumers; and improve the fairness of enforcement and dispute resolution. These recommendations are described in Chapter 3.

CHAPTER TWO:

A Vision for a Transformed Survey and Certification System

Recommendation

AAHSA should facilitate the creation of a broad-based national coalition of organizations, agencies and individuals who have a stake in the nation's survey and certification system. That coalition should call for a bold, national reexamination of the system that provides oversight of nursing facilities. An objective and widely respected organization, such as the Institute of Medicine, should guide this reexamination process, which should tap the creative ideas and the expertise of individuals in a variety of fields. The national reexamination should strive to create a common vision for how our nation should care for its frailest citizens and should recommend a new oversight model for ensuring that this vision becomes reality in every nursing home in the country.

In May 1982, the Health Care Financing Administration (HCFA) – now called the Centers for Medicare and Medicaid Services or CMS – announced a proposal to change some of the regulations governing the process it used to certify the eligibility of nursing homes to participate in Medicare and Medicaid. HCFA proposed its changes in response to provider complaints that regulations were unreasonably rigid. If implemented as proposed, the changes would have eased the annual inspection and certification requirements for facilities with a good record of compliance and authorized states to accept accreditation of nursing homes by the Joint Commission on Accreditation of Hospitals.

Consumer groups and most state regulatory agencies opposed the changes because they felt, among other things, that HCFA's reforms did not address fundamental weaknesses in the regulatory system. The outcry was loud enough to force a delay in the implementation of HCFA's proposal and for HCFA to ask the Institute of Medicine

(IOM) to undertake a study that would "serve as a basis for adjusting federal (and state) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible." The IOM report, entitled *Improving the Quality of Care in Nursing Homes,*[11] was widely respected when it was released in 1986 and many of its recommendations were incorporated into the landmark 1987 legislation – now commonly referred to as "OBRA '87 – which brought sweeping changes to nursing home operations.

OBRA put residents in the forefront of the survey and certification system, guaranteeing them certain rights and ensuring that they could have a voice in decision making about their treatment and the way they lived their lives. Most significantly, the legislation shifted the focus of regulatory oversight from facilities' capacity to provide care – that is, its "paper compliance" with regulations – to a focus on the actual care provided. OBRA focused needed attention on systematic, multi-disciplinary assessments and care-planning and provided critical tools to accomplish this. The statute provided a framework for collecting, electronically transmitting, analyzing and disseminating potentially useful and nationally standardized information on patient progress and outcomes. The vast and enduring reduction in the use of physical and chemical restraints on nursing home residents remains one of the legislation's most significant accomplishments.

OBRA '87 also transformed the government's system of enforcing its regulations. The legislation placed an emphasis not merely on punishing and closing poor-performing facilities, but on implementing a process that would help those facilities achieve "sustained compliance." This practice of working with facilities by applying remedies designed to correct problems, work towards sustained compliance, and improve care had never before been part of the survey system.

AAHSA supported the passage and implementation of OBRA '87. The association was one of the initial members of the Campaign for Quality Care, a coalition coordinated by

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[11] Institute of Medicine. 1986. *Improving the Quality of Care in Nursing Homes*. Washington, D.C.: National Academy Press.

the National Citizens' Coalition for Nursing Home Reform that worked to reach consensus on 12 key areas of nursing home reform. AAHSA has continued to serve on various committees and workgroups to develop a reasonable and equitable implementation of the regulations and interpretive guidance that resulted from the OBRA requirements.

AAHSA remains an advocate for the presence of these federal standards because it believes that many of the policies and care practices of AAHSA members have been enhanced as a result of their existence. However, after 20 years' experience with OBRA, and in view of the evolution of the long-term care field, the association and the Task Force on Survey, Certification and Enforcement are convinced that in the process of implementation, the original vision has been lost, leaving the promise of OBRA unfulfilled. Some aspects of the system, as implemented, have become impediments to the provision of quality care and services.

Recalling the Original Vision

It is difficult to reread the 22-year-old *Improving the Quality of Care in Nursing Homes* without being impressed both by how much has changed in long-term care over the past decades – and how much things have stayed the same. Then, as now, there was an overwhelming sentiment in the country that government regulation of nursing homes wasn't working. Then, as now, none of the stakeholders in the survey system were satisfied with the way government regulations were administered. Consumer advocates thought government standards were inadequate and their enforcement too lax; providers were concerned that the system was excessively detailed, inflexible, ambiguous, inconsistent and subjective. Particularly poignant to the Task Force on Survey, Certification and Enforcement are the conclusions that the IOM Committee on Nursing Home Regulation drew from its investigation. The same conclusions could easily be drawn today about our current survey and certification system.

- First, the committee recommended that ***a major reorientation was needed to focus the regulatory system on the care being provided to residents and the effects of that care.*** The AAHSA Task Force on Survey, Certification and Enforcement makes the same recommendation today.

- Second, the IOM committee proclaimed that ***"regulation is necessary but not sufficient for high-quality care."*** Instead, it suggested that skilled and properly motivated management, well-trained, well-supervised and highly motivated staff, community involvement and support, and effective consumer involvement were also required if quality was to be attained. The AAHSA Task Force on Survey, Certification and Enforcement agrees with this assessment, which it believes applies to today's survey system as well.

- Finally, the committee suggested that ***the regulatory system "should be dynamic and evolutionary in outlook."*** The committee recommended that specific regulatory standards should be modified to reflect changes "in the art of long-term care, in experience with the regulatory system, and in the techniques of assessing outcomes more objectively."

This final conclusion resonates strongly with the Task Force and reflects the primary recommendation of this report. Clearly, we as a nation would do well to follow this last conclusion by taking immediate steps to ensure that our current regulatory system becomes truly "dynamic and evolutionary."

How do we accomplish this? The Task Force is convinced that the thoughtful reexamination of the nursing home regulatory system, which took the IOM from 1983-1986 to complete, must be repeated today, at the dawning of the 21st century. Such a reexamination should be conducted by an objective and well-respected organization like the IOM. It must have as its goal the creation of a common vision for how our nation should care for its frailest citizens and it should include recommendations for a new oversight model that will ensure this vision becomes a reality in every nursing home in the country.

The 1986 IOM report brought significant changes to nursing home regulation and resulted in some significantly positive outcomes, as noted above. The Task Force on Survey, Certification and Enforcement is convinced that a similarly thorough process to reexamine the survey and certification system is needed today to bring about similarly dramatic results and support the continued evolution of nursing home quality.

Evaluation of a Potential New Approach (the QIS) Reveals Persistent Problems

Task Force members are clearly not the only ones to recognize that there are fundamental problems with the survey and certification system. Indeed, CMS has been working for the last decade to develop a new survey approach to correct systemic flaws that have led to serious problems with survey accuracy, consistency and efficiency.

The new approach, called "the Quality Indicator Survey" (QIS), is a two-staged survey process that was designed to produce a "standardized, resident-centered, outcome-oriented quality review."[12] Its automated process guides surveyors through a structured investigation that is intended to allow them to systematically and objectively review all regulatory areas and then focus on selected areas for further review. After a decade of development work, CMS launched a five-state demonstration in 2005 to evaluate whether the QIS:

- Improved survey accuracy.
- Improved documentation of survey deficiencies.
- Decreased the time required to complete the survey.
- Impacted the number and severity of deficiencies cited.
- Improved surveyor efficiency.

[12] White, A, Schnelle, J, Bertrand R, Hickey, K, Hurd, D, Squires, D, Sweetland, R, Moore T. 2007. *Evaluation of the Quality Indicator Survey (QIS)*. Abt Associates.

Members of the Task Force, like other AAHSA members, originally had great hopes that the QIS would resolve many of the concerns they had about the current survey system and would become a successful model for the future. Those hopes were encouraged during a discussion in early 2007 between Task Force members and representatives of CMS, who described the new survey in a positive fashion, focusing on the agency's goals for improving the survey with the new QIS approach. To assure that they understood the QIS approach, the Task Force held a conference call with the system's designer, who was also afforded an opportunity to present at AAHSA's annual convention.

In light of these consistently upbeat descriptions of the QIS, the Task Force found the findings of the QIS evaluation, conducted by Abt Associates, to be both stunning and compelling. That evaluation clearly established that the QIS has been substantially *unsuccessful* in all of the five areas which it was intended to address.

The Task Force is deeply concerned about spending already-limited federal resources to implement a new system that provides negligible benefits. Instead, the Task Force believes that its call for a comprehensive and candid reexamination of the entire survey system would allow an objective, third party to assess whether widespread adoption of the QIS is advisable or if another approach to survey and certification would better serve consumers, providers, regulators and national policy. At the time of this writing, CMS has yet to release officially the QIS evaluation or its official response to the findings. The delay in releasing the evaluation report is itself troubling.[13] The Task Force recommends that AAHSA give due consideration to the CMS response, if soon provided. But given the information available at this point, the Task Force strongly believes that further implementation is the wrong course of action.

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[13] Members of Congress pressed CMS to release the report during a hearing (on May 15, 2008) of the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, as reported in a statement issued by the Committee after the hearing: "During the hearing, lawmakers also questioned the ability of the Centers for Medicare and Medicaid Services (CMS) to monitor and track ownership of nursing homes. [Congressman] Stupak pressed CMS to release a report … that evaluates the current system used by CMS to survey nursing homes. The report has been completed since March of 2007. CMS Acting Administrator Kerry Weems said that the report's public release had been delayed because the agency was preparing an action plan to accompany the report. Under further questioning from Stupak, Weems said the report would be released this summer." (http://energycommerce.house.gov/Press_110/110nr279.shtml, accessed June 8, 2008).

The Changing Long-Term Care Environment

As noted above, the Task Force believes that an objective reexamination of the survey system is warranted. In addition, recent changes in the long-term care field not only make this reexamination an appropriate next step, but also make this an auspicious time to begin such a process. Consider these significant changes, which have taken place in the past 20 years but are not reflected in the current survey and certification system:

- The acuity level of residents has changed dramatically in recent years, partly because older people with less intensive care needs can choose to receive care in a setting other than a nursing home. As a result, long-term nursing home residents today are older and have greater care needs than the nursing home populations of previous decades. In addition, a significant population of younger, short-stay patients is using nursing homes as a place to recuperate, after hospitalization, from an illness or injury. These changes in the population we serve – and the implication of these changes for the care we provide – are often not recognized by the current system.

- Technology is bringing dramatic changes to the way nursing home providers are identifying, addressing and tracking care needs. These innovations promise to streamline the work of front line employees and managers, and improve the care and support that residents receive. They will also make care planning more cohesive and less prone to errors, and will improve how quality is measured. Our success at incorporating technology into the care setting – and the continuing potential of technology to revolutionize the delivery of future aging services – must be incorporated into the oversight system.

- Care practices and providers have changed since the IOM released its report in 1986. The impact of person-centered care and culture change on nursing homes cannot be overstated. While OBRA has focused on measuring compliance with minimum standards of quality, these new culture change initiatives are

encouraging and recognizing excellence in care that goes *beyond* the minimum. These provider-led initiatives need to be encouraged and these new models of care need to be integrated into our "old" concepts of quality assurance.

It should be noted that this positive action on the part of nursing home providers has not gone unnoticed. A variety of audiences are starting to recognize that programs to encourage higher quality can – and have – originated in the provider community. This is a powerful testimony to the fact that nursing homes are changing – and that long-term care providers can be a driving force in, not an obstacle to, efforts to bring about that change.

The Importance of Coalitions

The Task Force on Survey, Certification and Enforcement is particularly hopeful that new data-driven quality improvement models, which are being initiated and supported by broad-based coalitions, will serve as a powerful force in building widespread support for a reexamination of the nursing home oversight system. In addition, these coalitions provide an important model for the type of collaboration that must characterize that reexamination process. Long-term care providers have either initiated or been active participants in several notable coalitions, including the following:

- ***The Wellspring Model*** brings providers together in a network that uses increased training and empowerment of line staff, careful tracking of quality indicators and resident/family satisfaction measures to improve care.

- Through the ***Quality First Initiative*** providers work in partnership with all stakeholders – government, consumers and the people we serve and their families – to reaffirm their public commitment to quality; assess their strengths and opportunities for improvement; pursue continuous quality improvement based on the belief that improvement is always possible; and earn the public's trust and the confidence of consumers.

- ***Advancing Excellence (AE) in America's Nursing Homes*** is a coalition of stakeholders dedicated to helping nursing homes improve on eight quality measures. AE has attracted the participation of more than 6,000 nursing homes, representatives of virtually every stakeholder group involved in the OBRA '87 legislation, and other influential consumers, researchers, foundation executives, physicians, nurses, Quality Improvement Organizations and government representatives. As a result of the alliance, nursing home quality is improving and stakeholders who had never talked with one another are working collectively and individually to advance quality in nursing homes.

- ***The National Commission for Quality Long-Term Care (NCQLTC),*** a bipartisan study group funded by three provider groups, brought current and former members of Congress, governors, consumer advocates, researchers and policy experts together to create a roadmap for comprehensive reform of the long-term care system. The Commission's December 2007 report, coming as it did from a multidisciplinary and distinguished group, provides powerful evidence of a growing desire among influential individuals to reform the way long-term care is provided and how quality of care is measured.

Committed Individuals, Valuable Expertise

In addition to advancing the cause of enhanced nursing home quality, these coalitions have succeeded in engaging committed, influential and thoughtful individuals in efforts to advocate for nursing home quality. Many of the individuals who spearhead these coalitions could also play an important role in the reexamination of the survey system that the Task Force is proposing.

For example, a vice-president of the Commonwealth Fund – who is also a former licensure director – chairs the AE coalition this year and has been influential in funding research on the positive impact of culture change. Another former licensure director, who has experience in state Quality Improvement Organizations, is heading the Commonwealth Fund project to improve the effectiveness of AE's Local Area Networks for Excellence (LANES). Through LANES, dedicated, proactive leaders play a central role in driving and coordinating nursing home improvement work at the local level.

Similar expertise and commitment can be found among the members of the NCQLTC. One Commissioner heads the Reforming State Governments project at the Milbank Memorial Fund and has convened a group of state officials and national stakeholders to discuss long-term care regulation. Another Commissioner now heads the Institute of Medicine. The two former members of Congress, who co-chaired the Commission, are

committed to developing legislation to implement the Commission's recommendations. Two other Commissioners, who are members of Congress, could become active and influential participants in any effort to develop and pass legislation to change the regulatory system.

On another front, three former federal employees – the former head of CMS, the former head of that agency's nursing home licensure branch, and a staff member who was involved in research on the QIS – have left government but remain interested in nursing home quality issues. Two of these individuals now hold policy positions in the private sector; the third serves on the staff of a member of Congress. All three acknowledge that the current survey and certification system needs improvement.

It remains to be seen whether any of these individuals would be appointed to serve on whatever panel guides the reexamination of the nursing home oversight system. However, at a minimum, these individuals, who are widely recognized for their expertise in nursing home quality issues, could add significantly to the reexamination process by testifying before that panel.

Not Without Risk

In addition to significant time, energy and resources, any reexamination of the survey and certification system will also require an open-mindedness and flexibility that have not always been the hallmark of the nursing home regulatory system. That open-mindedness is essential because efforts to reinvent the survey and certification system must be started "from scratch" and must include creative discussions not only of how quality in nursing homes will be measured, but also of how quality of life and quality of care for older Americans and Americans with disabilities will be defined and by whom.

Task Force members agree that providers cannot attempt to control the reexamination process or to act alone in calling for it. Instead, the effort must be initiated, designed and carried out by an objective group that represents a wide variety of stakeholders –

including consumers, their families and advocates as well as regulators, surveyors, policymakers, health care professionals, direct care workers, providers and others. Providers must commit themselves to working with a variety of new partners throughout the process – both during the discussions and after a final assessment is completed. Only through participation in broad-based coalitions can we ensure that bold ideas will be translated into bold policy and bold practice.

Placing the fate of the survey and certification system in the hands of this broad stakeholder group will present some challenges for providers. Specifically, we face three risks:

1. A third-party group could recommend a new survey system that is more restrictive and punitive than the one that is now in place. Providers must recognize that despite recent positive developments in the field of long-term care, serious issues around quality, staffing and accountability still exist. Nursing homes continue to suffer from bad press and public distrust – and these issues may surface, in a very public way, during the reform process.

2. Several individuals, who served on the original IOM Committee on Nursing Home Regulation, are still working in the field and may be asked to participate in a second reexamination of the survey and certification system. These individuals may or may not have changed their ideas about regulation.

3. CMS could move ahead to implement the QIS nationally before the reexamination process is complete and a new model is recommended. This action would make it extremely difficult to change the system yet again.

The Task Force acknowledged these risks but concluded that engaging in an open national dialogue about nursing home oversight is the only way to avoid an even greater risk: the risk involved in perpetuating the current system. However, members of the Task Force firmly believe that the potential improvements in the survey and certification

system – indeed, the potential improvements in the way long-term care in this country is provided – are well worth any risks that a bold reexamination may present.

CHAPTER THREE

Short-Term Remedies to Improve The Survey, Certification and Enforcement Process

The long-term vision of a completely transformed survey process, outlined in the Part I of this report, will take many years and a great deal of thought and negotiation to achieve. In the meantime, members of the AAHSA Task Force on Survey, Certification and Enforcement believe that the current survey system could be enhanced through the adoption of a variety of shorter-term remedies that have the potential to expand the knowledge base of providers and surveyors, increase the system's transparency and fairness, promote high-quality care and innovation, and empower consumers.

The following pages feature brief summaries of 13 major issues facing nursing home providers as they attempt to navigate the survey, certification and enforcement process. Those issues fall into six general categories:

- Improving the Quality and Preparedness of the Survey Team.
- Enhancing Communication between Regulators, Surveyors and Providers.
- Applying Regulations in a Consistent Manner.
- Encouraging and Rewarding Providers That Strive for Excellence.
- Providing Consumers with Meaningful Information.
- Ensuring Fair Enforcement and Dispute Resolution.

Each issue brief contains one or more Task Force recommendations. These recommendations are based on the Task Force's review of the current literature and on the experiences of AAHSA members who interact with the survey system on a regular basis and have considerable insight into the system's flaws and the areas where improvements are most needed. In most cases, the recommendations contained in the following pages outline action that should ultimately be taken by such entities as the U.S. Congress, the Centers for Medicare and Medicaid Services (CMS) and state survey

agencies. However, the Task Force deliberately addresses its recommendations directly to AAHSA and calls on the association to lead efforts that will bring about the reforms proposed here. AAHSA has an important role to play in helping its members become equal partners with government policymakers, regulators and surveyors so we can all work together toward a common goal: to ensure that all older Americans have access to high-quality nursing home care and services if and when they require them.

IMPROVING THE QUALITY AND MAKE-UP OF THE SURVEY TEAM

Qualifications of the Surveyor Workforce

Recommendation Summary

AAHSA should call for national consistency in surveyor job descriptions; the identification of core competencies for surveyors; the development of training and evaluation models that will allow surveyors to achieve those competencies; and a variety of strategies to ensure the accountability of survey teams and agencies.

The survey teams that evaluate nursing facilities in the United States not less than every 15 months with a state-wide average of 12 months stand at the center of a complex national process to ensure that Americans living in nursing facilities enjoy quality of life and quality of care. Within that national system, survey teams have a critical mission: to assess whether skilled nursing facilities participating in the Medicare and Medicaid programs meet regulatory requirements in such categories as resident rights, quality of life, quality of care, resident assessment, dietary, pharmacy, rehabilitation, nursing services, physician services, physical environment and administration. Indeed, many of the resources invested in nursing facility licensing and certification are used to employ the people who make these assessments and investigate complaints against nursing facilities. Despite this costly investment, however, the survey workforce is far from stable.

According to one study, published in a 2002 issue of *The Gerontologist*[14], many states (27.5%) report problems in recruiting and retaining survey staff, with annual vacancy and turnover rates as high as 40 percent. Only seven states said they had ample or sufficient

[14] Walske, K., and C. Harrington. 2002. "Regulation of Nursing Facilities in the United States: An Analysis of Resources and Performance of State Survey Agencies." *The Gerontologist* Vol. 42, No. 4, 475-486.

staff to fulfill their licensing and certification function for nursing facilities and 15 states indicated that current staffing levels were barely adequate. Nine states described current staffing levels as seriously lacking. Other studies[15] have described the serious impact that inadequate training of survey staff has had on the survey process. For example, surveyors interviewed for a 2003 report by the Office of the Inspector General in the U.S. Department of Health and Human Services[16] stated that high turnover has adversely affected the consistency of the survey process because a disproportionate number of survey team members are new to their work and lack the experience and expertise necessary to carry out their jobs.

Clearly, the quality of the survey team affects the quality of the entire survey process. For that reason, CMS and the states must be more vigilant in their efforts to recruit and retain surveyors who bring adequate experience and expertise to their roles. Unfortunately, as illustrated in the "Table of Surveyor Job Descriptions," (Appendix C), not all states have clear requirements for members of their survey workforce. For example, states vary widely in the appropriate professional credentials or the amount of clinical experience in long-term care they require of surveyors. Additionally, not all states require that surveyors receive adequate training in conducting surveys and interpreting regulations. Many states do not require that surveyors possess certain "soft skills," including the ability to communicate clearly and directly with nursing facility staff. This lack of consistency leads to disturbing variations in surveyor competence and capacity to conduct surveys.

The Task Force on Survey, Certification and Enforcement is aware that survey agencies and providers hold differing views about what specific qualifications are appropriate to the job of the surveyor. The Task Force believes strongly that these differing expectations

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[15] See: Louwe et al. 2007. "Improving Nursing Home Enforcement: Findings from Enforcement Case Studies," *Health Care Policy and Research*, March 22. and White et al. 2007. Evaluation of the Quality Indicator Survey (QIS). Washington, DC: Abt Associates Inc.

[16] Office of Inspector General. 2003. "Nursing Home Deficiency Trends and Survey and Certification Process Consistency." Washington, D.C.: U.S. Department of Health and Human Services.

must be reconciled in order to achieve greater consistency and greater quality in the survey process.

Recommendations for Improving Survey Workforce Qualifications

1. ***AAHSA should advocate for national consistency in surveyor job descriptions.*** The association should urge CMS to identify a standard list of core skills and competencies for surveyors in several key areas:
    a. Knowledge of federal regulations and the *Guidance to Surveyors*.
    b. Use of the *Guidance to Surveyors*.
    c. Current clinical standards of practice.
    d. Effective communication strategies.
    e. Conduct of an investigation, including interviewing.

2. ***AAHSA should request a national study on the skills and competencies of surveyors.*** That study should:

    a. ***Identify the skills and competencies*** of high-quality surveyors and survey team leaders through interviews with state survey agency and provider representatives.

    b. ***Recommend a set of core surveyor and survey team leader attributes, skills, knowledge and competencies.*** These core competencies should identify entry-level skills and competencies for initial employment as a surveyor, including work experience in a long-term care setting. Core competencies should also include additional qualifications and criteria – including demonstrated experience, skills and competencies – for the positions of survey team leader and supervisor.

    c. ***Identify the critical components of an orientation and training curriculum for all surveyors.*** This curriculum should provide

surveyor candidates with a working knowledge and understanding of federal regulations and the survey and certification process; should teach effective communication skills; and should ensure that surveyors know how to conduct investigations and how to determine compliance based on credible evidence.

d. ***Develop recommendations for measurable criteria*** by which the skills and competencies of the surveyor and survey team leader can be evaluated on an ongoing basis.

e. ***Support the "credentialing" of surveyors*** based on demonstrated knowledge, skills and competencies.

3. ***AAHSA should advocate for the establishment of a method to obtain feedback about survey teams from providers.*** This feedback method should focus on surveyor and team leader skills and competencies and should be designed so it reduces the risk of retaliation against providers by surveyors.

4. ***AAHSA should encourage CMS to make information about required qualifications for individual surveyors available to the public.*** States should be encouraged to use this information on an ongoing basis to hire, educate, develop and evaluate surveyors.

5. ***AAHSA should advocate for mechanisms that ensure the public accountability of survey agencies including the tracking, trending, and availability of performance data.***

Multidisciplinary Survey Teams

> ***Recommendation Summary***
>
> *AAHSA should advocate for CMS policies that would assure that survey teams meet requirements to be multidisciplinary and to consult with a qualified expert before citing a deficiency that is rated at Level G or higher.*

States are required to place at least one qualified health professional – a registered nurse –on each survey team. In addition, survey teams should *ideally* include other professionals – social workers, therapist, dieticians, pharmacists, administrators, physicians and others – who have the expertise necessary to evaluate specific aspects of nursing home operation.

Unfortunately, the composition of survey teams does not always meet the requirements or this ideal. Providers report that, too often, survey teams are not multidisciplinary and that survey team members are evaluating and citing areas of a nursing facility's operation in which they lack expertise.

Recommendations for Ensuring the Multidisciplinary Nature of Survey Teams

1. ***AAHSA should urge CMS to assure that multidisciplinary survey team requirements are met and that surveyors are competent in the areas they survey.*** State agencies should make reasonable efforts to recruit surveyors credentialed in a variety of disciplines. If these efforts are unsuccessful, state agencies should have the right to apply for a hardship waiver from CMS.

2. ***AAHSA should urge CMS to require that survey teams consult with a qualified expert*** in the appropriate regulatory area before citing a deficiency that is rated at Level G or higher.

ENHANCING EFFECTIVE COMMUNICATION AMONG REGULATORS, SURVEYORS AND PROVIDERS

Provider and Surveyor Joint Education

Recommendation Summary

AAHSA should advocate for legislation that supports joint education of providers and surveyors. The association should work to ensure that joint education occurs and that it incorporates proven best practices.

Given the complexity of the survey and certification system, it is not surprising that many surveyors and providers have differing interpretations of nursing home quality requirements, related expectations and the repercussions of deficiency citations. These differing interpretations can compromise the survey process; therefore, it is imperative that CMS and state agencies take deliberate steps to ensure that surveyors and providers are all “on the same page” when a survey begins.

Members of the Task Force on Survey, Certification and Enforcement have heard anecdotal reports about surveyors who take inappropriate liberties in interpreting regulations and providers who are increasingly frustrated about their inability to anticipate and meet survey requirements and surveyor expectations. The Task Force believes that many of these issues could be resolved if providers and surveyors received standardized, joint education about regulations and how they should be applied.

A number of states are using this joint education model with good results. Providers who have participated in these joint sessions report that attendance is generally excellent and that feedback is consistently positive, especially when face-to-face education sessions (rather than teleconference or web-based trainings) are held. In some states, the joint events provide a valuable opportunity for surveyors and providers to interact in an

informal and non-adversarial way, to learn about new regulations and interpretations and to discuss areas that are cited most frequently in the state's recent surveys.

The Task Force believes that more widespread use of joint education would resolve much of the confusion and differing interpretations that now mar the consistency of the survey process. However, the Task Force recognizes that more information about the efficacy of joint education is needed and more work needs to be done to resolve state-by-state variations in the definition and implementation of joint training. The Medicare and Medicaid Nursing Facility Quality Improvement Act of 2005, introduced several years ago by Rep. David Camp (R-Mich.), would have required states to establish a process for joint training and education of surveyors and providers that would be held regularly as well as when regulations, guidelines and policy governing nursing facility operations were changed. While the bill never became law, the Task Force applauds its intent and believes that AAHSA should support similar legislation in the future.

Recommendations Regarding Joint Education

1. ***AAHSA should continue to advocate for legislation that supports joint education of providers and surveyors.***

2. ***AAHSA should call for a study on joint education best practices among states***.

3. ***AAHSA should work to ensure that joint education occurs and incorporates best practices found in states.*** The association should develop a proposal for a joint education process that emphasizes and incorporates continuous quality improvement and is based on surveyor and provider input. Joint training and education sessions described in the AAHSA proposal should:

    a. ***Be held regionally*** so it is accessible to providers and surveyors.

    b. ***Provide consistent information***.

c. ***Focus on CMS regulations and guidelines*** rather than on training surveyors to conduct surveys.

d. ***Be a dialogue***, not a lecture.

Communication of Regulations, Guidance and Interpretation

Recommendation Summary

AAHSA should work with CMS and state agencies to ensure that providers and surveyors receive the same information – at the same time – about new requirements, interpretive guidance, agency memos and changes to the survey process. AAHSA should build its capacity to participate in the development, review and interpretation of regulations, guidelines and changes to the survey process. The association should also evaluate and enhance its methods for communicating with its members regarding regulatory matters.

In addition to receiving standardized education about nursing home regulations, surveyors and providers also need to be kept up-to-date on changes in regulations, guidance and interpretations. CMS is not officially required to give consistent notice to providers regarding these changes and, as a result, providers and state survey agencies are at times provided with different versions of the same information. This weakness in the CMS communications system can adversely impact survey results and place providers at a distinct disadvantage.

Most providers have a strong desire to receive the same information from CMS that it provides to survey agencies – and to receive that information at the same time surveyors receive it. The Task Force on Survey, Certification and Enforcement shares this view. More consistent and equitable information sharing would improve provider understanding of surveyor expectations and enhance the survey process. Such a system would also help providers avoid situations in which surveys and citations occur before providers have received information about new guidelines.

Recommendations for Improving Communication Among State Agencies, CMS and Providers

1. ***AAHSA should request a review of communication methods through which CMS and state agencies*** share information with providers about new requirements, interpretive guidance, agency memos and changes to the survey process. This review should also identify factors that enhance or detract from effective communication.

2. ***After this review is completed, AAHSA should promote policies designed to ensure that providers and surveyors receive the same communications*** from CMS and state agencies about requirements of participation, new interpretive guidance, agency memos and changes to the survey process. The process of communicating new information and changes should be transparent, consistent, coherent and streamlined.

3. ***AAHSA should have available enough qualified, clinical resources*** to help develop, review and interpret regulations, guidelines and changes to the survey process.

4. ***AAHSA should review its own methods of disseminating information about regulatory matters to its members.*** This review should also include an assessment of how AAHSA members make use of these communiqués. Based on these findings, AAHSA should develop any needed enhancements to its process for communicating regulatory matters to members.

Mid- and Post-Survey Communication and Problem-Solving

Recommendation Summary

AAHSA should call for a study that examines state efforts to address problems and conflicts between providers and surveyors that occur during and after surveys. An ongoing effort should be established that identifies and recommends best practices to improve short- and long-term communication and conflict resolution related to the survey and enforcement processes.

The adversarial nature of the current survey process – as well as the high stakes involved in a poor survey outcome – make it inevitable that conflicts and disagreements between providers and survey team members will occur either during or after a survey, complaint investigation or verification visit. Yet, the current system does not provide a standard opportunity for problem solving or conflict resolution among survey participants.

Not all states have a process in place to respond to provider-reported concerns such as surveyor misconduct, biases and pre-judgment that might surface during a survey. Similarly, not all states have a mechanism in place that gives providers, surveyors and advocates an opportunity, after a survey is completed, to discuss such issues as citation trends, surveyor misconduct or provider confusion about the survey process. The absence of these problem-solving mechanisms creates a troubling situation in which surveyors and survey agencies are insufficiently accountable when questions arise about whether surveys are conducted appropriately or whether surveyors are acting in a consistent manner when they interpret and apply regulations or when they enforce remedies.

Without this accountability, some surveys proceed under an atmosphere of unresolved tension between surveyors and providers. Lacking an official mechanism through which to voice their concerns, providers undergoing such surveys feel powerless to respond to

egregious surveyor behavior, to resolve conflicts with surveyors or to settle confusion about survey rules, interpretations and procedures.

Recommendations for Improving Communication and Problem-Solving

1. ***AAHSA should call for a study that examines state efforts to address survey-related problems, resolve conflict and foster constructive and effective two-way communication between providers and surveyors.*** The study should include an investigation of best practices in problem solving and dispute resolution during and after surveys, complaint investigations or verification visits.

   Mid-survey best practices might include methods to permit providers and surveyors to discuss and seek assistance in resolving disputes, without fear of retaliation.

   Post-survey best practices might include regular meetings and ongoing discussions among long-term care stakeholders (providers, survey agency, advocacy groups, health professionals, residents/consumers and others, as appropriate) to:

   a. ***Identify positive and negative trends,*** and factors contributing to those trends, in the areas of resident care, deficient practices and enforcement.

   b. ***Identify problems and issues of concern*** that emerge during surveys, complaint investigations and verification visits.

   c. ***Use consensus to identify methods or strategies*** that may resolve the identified problems or concerns.

d. ***Evaluate changes*** that have been implemented to resolve the identified problems and concerns.

2. ***AAHSA should identify an agency or organization that could recommend best practices*** to improve short-term and long-term communication and conflict resolution related to the survey process, complaint investigations and the enforcement process.

APPLYING REGULATIONS IN A CONSISTENT MANNER

State Operations Manual and the Interpretive Guidelines

Recommendation Summary

AAHSA should strengthen advocacy efforts to ensure that the Interpretive Guidelines remain aligned with the law as changes are proposed. AAHSA should expand its clinical capacity to proactively influence the nursing facility oversight system and respond to specific regulatory initiatives.

In January 2008, CMS clarified that the *Interpretive Guidelines* contained in the *State Operations Manual* (SOM) do not have the force and effect of law. In a memo entitled *Use of Interpretive Guidance by Surveyors for Long-Term Care Facilities* (S&C-08-10), released on January 18, CMS directed surveyors to "base all cited deficiencies on a violation of statutory and/or regulatory requirements, rather than sections of the interpretive guidelines. The deficiency citation must be written to explain how the entity fails to comply with the regulatory requirements, not how the facility fails to comply with the guidelines for the interpretation of those requirements."

The collective experience of the Task Force on Survey, Certification and Enforcement suggests that, despite this latest clarification, surveyors continue to directly apply and use the *Interpretive Guidelines* to determine compliance. In addition, these surveyors are using the *Interpretive Guidelines* as a basis to impose highly punitive remedies on nursing facilities, even though the citations do not always align with the statutory or regulatory requirements.

The SOM, including the *Interpretive Guidelines* shape the entire survey and certification system. Use of the Interpretive Guidelines rather than the statutory or regulatory

requirements as the basis for compliance is of particular concern given the lack of the same *formal* right to review and comment on the SOM that is afforded to the public when regulations and laws are proposed. It should be noted that members of the AAHSA staff usually are invited to comment on proposed changes to the SOM, but these invitations are less formal than the public's right to comment on regulations.

The Task Force acknowledges the difficulty of transforming every SOM guideline into a regulation upon which providers and their representatives could formally comment. The group is not recommending that all existing guidelines in the SOM be revised. However, the Task Force does believe that, going forward, efforts to assure that the guidelines are more closely aligned with existing law, would improve the fairness and consistency of the survey process.

Recommendations for Rebalancing the *State Operations Manual*

1. ***AAHSA should expand and strengthen its advocacy efforts to keep the* Interpretive Guidelines *aligned with the law*** as changes are proposed or as past issues come to AAHSA's attention.

2. ***AAHSA should expand its clinical capacity to proactively influence the nursing facility oversight system and respond to specific regulatory initiatives***. AAHSA can accomplish this by building its internal expertise, calling on the expertise of professionals working outside the association, or a combination of these options.

ENCOURAGING AND REWARDING PROVIDERS THAT STRIVE FOR EXCELLENCE

Efficient Targeting of Survey Resources

Recommendation Summary

AAHSA should urge CMS to spend its limited survey resources more efficiently by concentrating its oversight efforts on poor-performing facilities and placing less emphasis, focus and/or intensity on facilities that consistently perform well. The association should work with appropriate agencies and stakeholders to define the characteristics of superior nursing facilities that require less frequent or less intensive surveys than facilities that consistently perform poorly.

Current law requires that all skilled nursing facility participating in the Medicare or Medicaid programs be surveyed at the same time interval, no matter what past surveys show about the quality of the care and services they provide. As a result, CMS and states regulatory agencies spend roughly same amount of time and resources surveying consistently superior facilities as surveying facilities that perform poorly on a consistent basis.

Given the financial stress under which most state regulatory agencies now operate, the Task Force on Survey, Certification and Enforcement questions whether this allocation of resources is fiscally sound. According to a 2002 study published in *The Gerontologist,*[17] 37 state survey agencies – representing three-quarters of the states – reported that their 2000 allocation of federal resources was not adequate to meet CMS's certification requirements. Twenty-six states said their licensing and certification activities had been

[17] Walske, K., and C. Harrington. 2002. "Regulation of Nursing Facilities in the United States: An Analysis of Resources and Performance of State Survey Agencies." *The Gerontologist* Vol. 42, No. 4, 475-486.

curtailed or restricted due to lack of funds, and 14 of those states admitted that funding problems had caused them to cut back on investigations of complaints about nursing homes.

As it struggles to implement an increasingly costly work plan against the backdrop of growing budget deficits, CMS must explore ways in which it can operate more efficiently. The Task Force believes that CMS can invest its limited resources most wisely by focusing its oversight efforts on poor-performing nursing facilities. This policy shift would allow state survey agencies to spend more time identifying deficiencies in poor-performing facilities and working closely with those facilities to correct deficiencies and improve quality of care. At the same time, CMS and state survey agencies would be rewarding consistently superior nursing facilities with surveys that are either less frequent or less intensive.

Recommendations for Investing Survey Resources More Wisely

1. ***AAHSA should advocate for a change in the law that would allow more flexibility in sequence, timing and/or intensity of nursing home surveys.*** This flexible system would allow CMS to concentrate its effort and funds more efficiently by focusing on poor performers and placing less emphasis, focus and/or intensity on facilities that are performing well.

2. ***AAHSA should work with appropriate agencies and stakeholders to define the characteristics of superior nursing facilities*** that do not require as frequent or intensive surveys as facilities that are poor performers.

Accommodation to New Models of Care and Practice Services

Recommendation Summary

AAHSA should advocate for the establishment of an ongoing process to adapt regulations and their interpretation to new models of care and service provision. The association should work with its Life Safety Code (LSC) consultant and the National Fire Protection Association to ensure that LSC requirements take culture change into account and afford appropriate flexibility.

Many skilled nursing facilities around the country are embarking on exciting initiatives to transform long-term care by changing the very culture of the skilled nursing facility. These facilities are adopting a variety of new care models that may call for redesigning nursing homes so they feel more like home, placing residents at the very center of care planning, empowering frontline workers in an effort to decrease turnover, or implementing other innovative practices.

Culture change initiatives clearly represent an intentional departure from past practice. While this departure appeals to many providers, consumers and their advocates, it often puts nursing facilities at odds with the decades-old regulatory system.

Members of the Task Force on Survey, Certification and Enforcement support culture change efforts and believe that government at all levels should encourage innovation. Therefore, as nursing homes experiment with new ways of doing business, CMS must make sure that regulations and their interpretation adapt to and remain congruent with new and emerging models of care and services. The Life Safety Code (LSC) – and the interpretation of its requirements – is one example of regulations that need attention. The LSC does not appropriately or consistently recognize and/or consider new models of care and can represent a barrier to facilities seeking to redesign their physical plants in order to create more homelike environments. These facilities currently receive inconsistent

rulings from CMS regarding the acceptability of certain physical changes, such as the installation of working fireplaces, within nursing facilities.

Recommendations for Accommodating New Care Models

1. ***AAHSA should advocate for the adoption of an ongoing process*** that adapts regulations and interpretations so they are consistent with new models of care and service provision.

2. ***AAHSA should work with its Life Safety Code (LSC) consultant and the National Fire Protection Association*** to ensure that LSC requirements and their interpretation, to the extent possible, take culture change into account and afford appropriate flexibility.

PROVIDING CONSUMERS WITH MEANINGFUL INFORMATION

Reporting Survey Information to Consumers

> ***Recommendation Summary***
>
> *AAHSA should encourage CMS to revise the Nursing Home Compare Web site so its language is less pejorative and the data it presents is easier to understand and includes a full explanation of survey results. This can be accomplished by giving providers the opportunity to elaborate on the Statement of Deficiencies posted on Nursing Home Compare by adding specific facts related to its cited deficiencies in a standardized format established by CMS.*

CMS currently posts data from nursing home survey reports on its Nursing Home Compare Web site.[18] The data is presented without elaboration or explanation, taking the form of a simple list that identifies the deficiency citation that a particular facility has received. The Task Force on Survey, Certification and Enforcement believes that this list provides insufficient information to consumers and may encourage them to make judgments about a facility without fully understanding the nature of the events behind the citation. The Task Force also worries that consumers could use the information on Nursing Home Compare to draw unfair comparisons among facilities that do not share similar characteristics. Because the Web site reports hard data without elaboration or explanation, that data could also be vulnerable to subjective manipulation by third parties.

Task Force members are also concerned that the language employed on the Nursing Home Compare Web site is confusing and pejorative and that the information presented there is often difficult for consumers and other members of the general public to

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18 http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp?version=default&browser=Firefox%7C2%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True

understand. Even more important, the Task Force questions the accuracy and timeliness of survey results posted on this Web site. Finally, the Task Force is concerned that the ability of providers to correct inaccuracies in a timely manner is limited.

Recommendations for Improving Reporting to Consumers

1. ***AAHSA should continue to support public reporting and disclosure of survey reports.*** However, the association should encourage CMS to reduce the risk of consumer misunderstanding and/or misperception by making sure that reported data is accurate and timely.

2. ***AAHSA should encourage CMS to involve providers in needed efforts to revise the Nursing Home Compare Web site so the data it presents is more easily understood by the public.*** The Task Force recognizes that available resources may limit CMS's ability to explain fully each facility's survey results. Instead, AAHSA should encourage CMS to revise Nursing Home Compare by taking the following steps:

    a. ***Place the burden of elaboration on the provider rather than on CMS***. Providers should have the opportunity to elaborate the listing of deficiency citations posted on the Nursing Home Compare Web site with specific facts related to its cited noncompliance, to explain the deficiency in plain language and to offer a contextual framework for its noncompliance. Such context might include an accounting of the number of times the incident occurred compared with the number of opportunities. This information should be linked through CMS in accordance with a form/format to be agreed upon by the relevant parties. (Task Force members noted that there is precedent for such a process. The HHS National Practitioner Data Bank [NPDB] that publishes adverse findings about individual and organizational health care providers, allows practitioners the opportunity to post a response according to specific guidelines.)

b. ***Establish criteria and/or parameters for provider entries on the Nursing Home Compare Web site***. Examples of CMS-established criteria might include a timeframe during which postings could be added to the Web site, a schedule for how long that posting would be available to the public, requirements for the length of postings and a directive that providers could only include verifiable facts when describing their deficiency citations.

c. ***Explain the inter-related nature of survey requirements***. CMS should include a statement (preferably in the "About" section of the Nursing Home Compare Web site) explaining that one occurrence or incident could make a facility noncompliant with more than one F-tag. Consumers should understand that citations at multiple F-tags could be based on a single event or occurrence.

d. ***Revise the current reporting format*** of the Nursing Home Compare Web site so its language is less pejorative. For example, instead of reporting that "The facility failed to…" carry out an action, the Web site should use a more objective statement, such as "The facility did not meet the requirements…"

3. ***AAHSA should provide CMS with a prototype of a provider posting for the Nursing Home Compare Web site.*** That prototype should present facts about a deficiency in an understandable and useful way. The prototype should also elaborate on cited F-tags using plainly stated, factual descriptions of the identified noncompliance.

Self-Reported Incidents and Complaints

> ***Recommendation Summary***
>
> *AAHSA should encourage CMS to make a clear distinction between "self reports" and external "complaints" when reporting nursing home deficiency citations to the public.*

Since January 2004, CMS has used the ASPEN Complaints/Incidents Tracking System to keep separate track of incidents that facilities are required to "self report" and complaints that are lodged against a nursing facility from residents, families or other sources "outside" the nursing home. This distinction makes sense. A self-reported occurrence is usually one that the facility has recognized and taken action to correct, whereas "external" complaints may indicate that the facility did not recognize or take action to correct a troubling occurrence or circumstance or prevent its future occurrence.

Unfortunately, this policy of separate tracking does not apply to the CMS Nursing Home Compare Web site, where self-reported incidents and "outside" complaints are merged into a single data report. This data merging gives consumers the misleading impression that there is no distinction between a self-reported occurrence and an external complaint. It also presents a skewed picture to consumers, researchers and policymakers regarding the number of complaints a facility or state has received.

The confusion regarding self reports and outside complaints is compounded by the fact that there is significant variation among and within states regarding the types of incidents that must be self-reported. Federal regulations require facilities to report allegations of mistreatment, neglect, misappropriation of resident property and abuse, including "any injuries of unknown source." In some states, however, a broad interpretation of this requirement could mean that a minor, but unexplained, injury on a resident's arm must be reported as "abuse."

Recommendations for Ensuring Clarity on Self-Reported Incidents

1. ***AAHSA should work to ensure that CMS makes an official distinction between "self reports" and external "complaints."***

2. ***AAHSA should work with its fellow participants in the Poor Performing Nursing Home Initiative*** to ensure that the group's proposed "early warning system" makes a clear distinction between complaints brought forward by sources "outside" the facility and problems that the facility has recognized, reported and taken action to correct. The Poor Performing Nursing Home Initiative, a coalition that includes AAHSA, CMS, AARP, the American Health Care Association and the National Citizen's Coalition for Nursing Home Reform, is working to identify financial and quality indicators that may give consumers and others early notice that a facility is or may be experiencing quality problems.

ENSURING FAIR ENFORCEMENT AND DISPUTE RESOLUTION

Timeframe for Compliance

Recommendation Summary

AAHSA should advocate for the development of a compliance system that includes biannual scheduling and a six-month transitioning period for all new regulations, interpretive guidance and changes to the survey and enforcement processes. The association should work to change the statutory mandate and CMS policy so that facilities demonstrating a good-faith effort to correct deficiencies within six months will not be subject to automatic, mandatory termination if correction plans take longer than 180 days to achieve.

As mentioned earlier in this report, providers sometimes have difficulty keeping pace with the rapid release of new and revised CMS requirements and guidelines. The Task Force on Survey, Certification and Enforcement has already recommended that CMS and AAHSA enhance their communication efforts to ensure that providers receive up-to-date information about new and revised requirements and guidelines. In addition, the Task Force believes that a second layer of protection should be instituted to ensure that providers have adequate time, after learning about revised requirements and guidelines, to prepare for a survey in which they will be applied. A six-month transition period would give providers adequate time to learn about relevant changes and to take actions necessary – such as amending policies and procedures, training staff and monitoring compliance through Quality Assurance efforts – to bring the facility into compliance. When a nursing facility has been cited for substantial noncompliance with Requirements of Participation in Medicare or Medicaid, it has 180 days (six months) from the date of the survey to bring itself into compliance. If the facility remains out of compliance after 180 days, it faces automatic termination from Medicare and Medicaid. While the Task Force recognizes the need for timelines, it is concerned that automatic termination of

nursing facilities may unfairly penalize those facilities that are working in good faith to meet the requirements as quickly as possible.

In some situations, the nature of a specific deficiency can make the six-month timeframe infeasible. For example, facilities often need more than six months to comply with Life Safety Code (LSC) requirements, despite their good faith efforts to correct problems. LSC deficiencies frequently involve physical plant issues that could require the facility to plan and implement structural changes, new construction or the installation of additional devices or equipment. Facilities that must hire outside contractors or vendors to complete this work could easily find that, through no fault of their own, the work stretches beyond the six-month compliance period.

Recommendations for Revising the Compliance Timeframe

1. ***AAHSA should advocate for the development of a compliance system that includes regular scheduling and adequate transitioning of new regulations, interpretive guidance and changes to the survey and enforcement processes.*** Except in matters of emergency or urgency:

    a. ***Changes should be scheduled not more than twice a year***.

    b. ***Prior full enforcement, providers should be given up to six months to implement new guidance or regulations.*** During the transition period, CMS and state agencies should offer providers and surveyors identical information about the changes during joint sessions presented by representatives of provider and survey agencies.

    c. ***During the six-month transition period, state agencies should be allowed to survey to the new expectations or requirements.*** However, they should not be allowed to issue deficiency citations based on the new expectations or requirements. Instead, surveyors should focus on

providing guidance to facilities by identifying either areas of home operation needing improvement or areas in which the provider could benefit from additional training, education or supervision.

2. ***AAHSA should work to eliminate the federal requirement for automatic, mandatory termination at 180 days in cases where the facility has demonstrated a good-faith effort to correct deficiencies.*** When making decisions about termination, states should have the flexibility to take into consideration the negative impact that this termination could have on residents and the risks those residents will face if a facility is closed.

Nurse Aide Training 'Lockout'

> ***Recommendation Summary***
>
> *AAHSA should work to change the law governing nurse aide training 'lockouts' to ensure that bans on nurse aide training are not an automatic consequence that may bear no relationship to the cited deficiency, but become one of the full range of penalties that could be imposed on nursing homes for deficiencies related to training or staffing issues.*

Nursing homes with deficiencies above certain levels automatically lose their authority to train nurse aides for two years, in addition to whatever penalties are imposed for the specific care problems. The Task Force on Survey, Certification and Enforcement believes these "nursing home training lockout" provisions are:

- ***Counterproductive.*** Nursing homes with quality problems generally need to increase their staffing levels and expand their training initiatives in order to improve the quality of their care and services.

- ***Arbitrary.*** The automatic nature of this penalty means that it can be imposed on a facility that has been cited for a deficiency that is unrelated to training or staffing issues. The Task Force believes strongly that when a facility receives a deficiency that has no relationship to the provision of direct care, for instance because it has a problem with hot water, it should not lose its ability to train nurse aides.

- ***Unfair.*** Once facilities have corrected their deficiencies and demonstrated compliance, they should be allowed to resume their nurse-aide training programs, rather than being forced to wait the required two years. The Task Force acknowledges that the Medicare Prescription Drug, Improvement, and Modernization Act provides for an expedited appeals process for facilities that have lost their training authority. However, the Task Force maintains that CMS

can best ensure quality care in nursing homes, and remain faithful to the intent of the Omnibus Budget Reconciliation Act of 1987 (OBRA), if its penalties do not impede a facility's ability to recruit and retain adequate and qualified staff.

- ***Unduly onerous.*** The inability to train nurse aides can impose a heavy burden on facilities that have limited access to alternative training programs. In rural areas, alternative training facilities often are not available within a reasonable distance. Even urban facilities can have difficulty finding alternative training sites if other nursing homes are unable or unwilling to train their staff or if the state has not approved external training sites, such as vocational schools.

Recommendation for Revising the Ban on Nurse Aide Training

1. ***AAHSA should work to secure a change in the law regarding the ban on nurse aide training.*** A revised law should elevate the loss of nurse aide training to one of the full range of penalties that may be imposed if appropriate. Imposition of this consequence would be most appropriate in situations where the cited deficiency has a direct relation to training or staffing issues.

Informal Dispute Resolution System(s)

Recommendation Summary

AAHSA should work to bring about reforms that ensure that the Informal Dispute Resolution (IDR) system is objective, structured, transparent and fair. A reformed IDR system should be handled by an objective, reliable third-party; establish timeframes for completion of the IDR process; mandate that providers be notified of an IDR final decision and supplied with a full explanation of that decision; allow providers to request and receive a face-to-face review; and give a facility the right to appeal the severity and scope of a deficiency.

Federal law requires each state to develop an Informal Dispute Resolution (IDR) process that Medicare- and Medicaid-certified nursing facilities can use to question or challenge determinations of noncompliance prior to formal appeal. However, providers have lost confidence that the IDR process, as administered by state survey agencies, represents a fair and objective method of resolving disputes about survey findings. As a result, providers are less likely than ever to make IDR requests.

The Task Force on Survey, Certification and Enforcement has several serious concerns with the IDR process, which it believes is costly, both in financial and human resources. Providers are increasingly frustrated with the process, largely because state agencies can be slow to respond to IDR requests and to provide notification of IDR results. The Task Force shares this frustration. Because the enforcement "clock" continues to run throughout the IDR process, a slow state response means that remedies may be imposed before the IDR process has been completed. This outcome was not intended when the system was established, and has the potential to make the entire IDR process meaningless.

The Task Force also has concerns about the fairness of the IDR process, which in many states lack a well-defined system of checks and balances. Specifically, not all states carry out a cross-checking process to ensure that information submitted by the facility is reviewed in an unbiased manner. In states such as Connecticut, for example, the same surveyor that determined a facility's deficiency is not precluded from reviewing the IDR. In these situations, deficiencies are rarely overturned.

In addition, the standards used to judge the validity of an IDR claim are not always applied consistently among reviewers. Anecdotal reports suggest that reviewers frequently make decisions based on information that is not directly related to the survey requirements and/or the interpretive guidance to surveyors. In other cases, reviewers appear to make their decisions without fully considering the additional evidence or testimony that a facility has provided.

The inability of providers to challenge scope and severity of deficiencies is particularly unjust. State survey agencies impose remedies on a nursing facility based on a determination of scope and severity, yet providers who find a scope and severity determination excessive are left with no meaningful opportunity to present their cases. Indeed, these providers have no alternative but to use the IDR process to challenge the entire F-tag rather than just the determination of scope and severity. These broad challenges represent a waste of time and resources for all parties. Since formal appeal is prohibited unless a remedy is actually imposed, the IDR process may provide the only opportunity to address severity and scope.

In conjunction with the development of this set of recommendations, the Task Force collected and reviewed information on states' current IDR procedures (See Appendix D)

Recommendation for Revising the Dispute Resolution System(s)

1. ***AAHSA should work to bring about reforms that ensure that the Informal Dispute Resolution (IDR) system is objective, structured, transparent and fair.*** Specific reforms should include requirements that:

    a. ***The IDR process is handled by an objective, reliable third-party***. This has been successfully tried in some states.

    b. ***The IDR process is more structured***. Timeframes should be established for completion of the IDR. In addition, the process should include a mandate that providers be notified of IDR final decisions and supplied with a full explanation of that decision. If the state agency's decision differs from the third party's recommendation, the provider notification should include an explanation of the agency's final decision.

    c. ***State survey agencies and CMS give all facilities an opportunity to request and receive a face-to-face review*** for deficiencies the provider feels cannot be adequately addressed through telephone or written communication. If necessary, this review should be conducted at the facility.

    d. ***A facility's rights under IDR include the ability to appeal the severity and scope of a deficiency.*** As an alternative, the IDR process should be amended through legislation that requires CMS to allow facilities to challenge the scope and severity of non-substandard care deficiencies under IDR.

CONCLUSION

The AAHSA Task Force on Survey, Certification and Enforcement believes strongly that despite some measurable, specific successes, the nursing home oversight system has, overall, failed to fulfill its 20-year-old goals to ensure a nursing facility's "sustained compliance" with regulations and to enhance quality of care and quality of life for residents living in those facilities. The Task Force's year-long examination has convinced each of its members not only that the system is not working today – but also that the system will not work in the future, when a growing number of older Americans with increasingly complex care needs will seek care in nursing homes. Now is the time – not tomorrow or next year or five years from now – to take bold steps to design a new system for ensuring quality of care and quality of life in this country's nursing homes.

The National Commission for Quality Long-Term Care, a bipartisan study group, suggested in its December 2007, report that the long-term care system can no longer depend on "the old ways of doing things."[19] In this report, the Task Force on Survey, Certification and Enforcement urges AAHSA to take the lead in advocating for steps that will introduce "new ways of doing things" into the survey and certification system. We urge the association to consider our recommendations carefully and to act on them boldly.

[19] National Commission for Quality Long-Term Care. 2007. *From Isolation to Integration: Recommendations to Improve Quality in Long-Term Care*. Washington, D.C., Dec. 3.

Appendix A
Members of the Task Force—Brief Overview of Experience

Ronald Barth has over 30 years experience in the field.

Mr. Barth's experience includes numerous and diverse aspects of long term care. He has been an administrator of both an investor-owned and not-for-profit facility. He has been a consumer, with both parents spending time in nursing facilities and assisted living; and he has been part of the government regulatory process, having served in the Illinois Department of Health as the Associate Director of Health Regulation – the Office in charge of regulation and oversight of all health care facilities, including nursing homes, hospitals, ambulatory surgical facilities, and the like. In addition, Mr. Barth is an advocate for senior service providers, having been the Director of Regulatory Affairs with the Illinois Health Care Association, and, for the past 17 years, serving as the President/CEO of PANPHA--the Pennsylvania Association of Non-Profit Homes for the Aging.

David B. Buckshorn has over 18 years experience in the field**.**

Mr. Buckshorn began his career with the Corporation in 1992 as the associate administrator of the Health Care Center. In 1994, he was appointed Health Care Administrator. He has served as President/CEO of the Corporation since 1995. Under his leadership, through two major expansions, Wesley Commons has grown from a small, financially frail healthcare organization into a dynamic operation serving close to 500 residents on its campus today.

Mr. Buckshorn has held several offices in the South Carolina Association of Homes and Services for the Aging (SCANPHA) over the years, including Chair, and has also served in the House of Delegates of the American Association of Homes and Services for the Aging (AAHSA). His professional leadership activities also include serving on the South Carolina Board of Long Term Health Care Administrators as Vice Chair, and as a Nursing Home Administrator Preceptor for the State of South Carolina. Mr. Buckshorn has also served on the Regulatory Issues Committee with SC DHEC representing SCANPHA, and recently acted as a resource for the Department of Health and Environmental Control of South Carolina's review and revisions of its State Regulations for Skilled Nursing Facilities.

Mr. Buckshorn holds a Master of Business Administration from Clemson University and a Bachelor's degree in business from the University of West Georgia. He holds a nursing home administrator's license, community residential care administrator's license (assisted living), and national retirement housing professional/certified aging services professional (RHP/CASP) certification.

Margaret A Chamberlain has 20 years of experience in the field.

Ms. Chamberlain began her professional career in 1988 as a social worker in long-term care facilities and has worked in and/or with long term care facilities ever since. She is currently a member of the long term care practice group at Kitch Drutchas Wagner Valitutti & Sherbrook. Her practice is dedicated almost solely to long term care clients and issues with a focus in the area of regulatory compliance. She is a member of the Michigan Association of Homes and Services for the Aging and frequently lectures on legal issues facing long term care providers and other healthcare professionals across the state of Michigan.

Ms. Chamberlain received a Bachelor of Arts in Psychology from Knox College in Galesburg, Illinois and a J.D., cum laude, from the Thomas M. Cooley Law School.

Linda Dawson has 13 years of experience in long term care regulation.

Ms. Dawson was the Deputy Chief Legal Counsel for the Wisconsin Department of Health and Family Services for 11 years. In that position, she was responsible for advising and representing the state survey agency in its interpretation of the federal regulations, establishing policies and procedures with regard to its regulatory efforts and training investigators and surveyors on how to conduct effective investigations. More recently, in the past two years she has represented long term care and other health care providers, assisting them to prepare for surveys and investigations and to respond to allegations of non-compliance with state and federal regulations. She is a frequent presenter for the Wisconsin survey agency as well as for national organizations and organizations in other states on legal issues confronting the elderly, long term care providers and other healthcare professionals. Ms. Dawson is a member of the Wisconsin Association of Homes and Services for the Aging.

Liza Fritchley has 8 years of experience in the field.

Ms. Fritchley became Vice President of Senior Services at West Georgia Health System in 2000, where she oversees the care of over 350 residents. The Senior Services division of the health system consists of two skilled nursing facilities and one independent/assisted living community. The organizations are members of both AAHSA and the Georgia Association of Homes and Services for the Aging (GAHSA).

Ms. Fritchley is a licensed nursing home administrator, Certified Professional in Healthcare Risk Management and a Fellow in the American College of Healthcare Executives.

Bonnie Gauthier has more than 34 years of experience in the field**.**

Ms. Gauthier entered the field in 1974, with “no background in gerontology or aging services, except a short stint as a volunteer in the geriatric unit of the Maine VA Hospital during college.” As an unemployed English teacher, she answered an ad in a long term care facility seeking someone "with a four-year degree and good writing skills." Since that time, she has served in two different non-profit skilled nursing settings as an employee and public relations director, assistant administrator, administrator, vice president and CEO.

Ms. Gauthier’s experience spans the entire spectrum of geriatric services. She has been involved in the development of adult day programs, assisted living and supportive housing projects, CON development for new construction and new licenses, the establishment of a home health care agency, hospice care, meals-on-wheels, primary medical care clinics, in-home emergency response services, outpatient rehabilitation and geriatric medical consultation, respite care, and most recently, the development of behavioral health and medically complex inpatient services for geriatric patients at the hospital level. Her current responsibilities include serving as the designated hospital administrator for a 45-bed chronic disease hospital unit, co-located within the 287-bed hospital-based SNF of the organization she leads. She has served as an appointed member of three different state task forces-- on nursing home reimbursement, on regulation, and on staffing.

Ms. Gauthier holds a Master's degree in Gerontology and teaches in the Master's program in gerontology at St. Joseph College in West Hartford, CT. She holds a nursing home administrator license in two states.

Gary F. Gilmore has nearly 20 years experience in the field.

Mr. Gilmore has been a licensed nursing home administrator since 1989, and is currently the Executive Director of the Wiley Mission. He served as Chair of the New Jersey Association of Homes and Services for the Aging from 2005- 2007, and has served on numerous committees and task forces of the association. Additionally, he is a member of the AAHSA Ethics Commission and represents NJAHSA as an AAHSA House of Delegate member. Since 2006, he has served on the NJ Medicaid Long Term Care Funding Advisory Council.

Demetria (Demi) Haffenreffer has 35 years experience in the field**.**

Ms. Haffenreffer has made Long-Term Care her profession since 1973, first as a Director of Nursing and for the last thirty years as a consultant. She is founder and President of Haffenreffer & Associates, Inc., an Oregon-based consulting firm specializing in Long-Term Care, Assisted Living and Hospital regulatory compliance and education. She is Chief Quality Officer for Avamere Health Services, Inc., an organization that provides a

spectrum of healthcare solutions for seniors in more than 30 communities throughout Oregon and Washington

Ms. Haffenreffer currently serves on the AHCA Quality Improvement Committee, is a Senior Board Examiner for AHCA's Quality Award, and is a facilitator for the Radiating Excellence Nurse Leadership Self-Assessment System. She is a member of the Steering Committee of MOVE (Making Oregon Vital for Elders), an outreach of the Pioneer Network, and serves on the fund raising committee for the Pioneer Network. She has taught workshops nationally and internationally on a variety of subjects pertinent to long-term care and has authored four policy and procedure manuals. In addition, she has been retained by nationally known law firms as an expert on regulatory compliance issues.

Ms. Haffenreffer received her Masters in Business Administration from Boston University, Boston, MA, her BS Nursing from N.Y.U. External Degree Program, Albany, NY, and a Diploma in Nursing from Truesdale Hospital School, Fall River, MA.

Patricia P. Kapsar has 18 years experience in the field.

Ms. Kapsar has been involved in long term care since 1990: first, as an Administrator of a hospital-associated Skilled Nursing Facility (SNF), while also serving as that hospital's Director of Nursing, and then as a Corporate Compliance Officer (1999-present) for a multi-facility organization serving over 600 licensed SNF beds. As a compliance officer she has become very familiar with the survey and certification process for our long term care facilities. She has also served on several Missouri State task forces over the years that have addressed both federal and Missouri state regulations. On several occasions, she has served as a state-recommended consultant to nursing facilities that were having problems with federal/Centers for Medicare and Medicaid Services (CMS) requirements.

Martha M. Kutik has 28 years experience in the field.

Ms. Kutik has been the President/Chief Executive Officer of Jennings Center for Older Adults since 1991. She began her association with Jennings when she joined its Board of Trustees in 1983. During her board-membership at Jennings, Ms. Kutik was a hospital administrator with the Cleveland Metrohealth Hospital System for seven years, serving as Vice President for Management Services for two years, and acting Chief Operating Officer for one year. She has also served in administrative capacities with Menorah Park Center for the Aging in Beachwood, Ohio, and the Cleveland Veterans Administration Hospitals. Before arriving in Cleveland, she was employed as a lobbyist for the national office of the Epilepsy Foundation of America in Washington, D.C.

Ms. Kutik is a graduate of Colgate University, where she majored in Biology. She holds a Masters in Health Care Administration degree from The George Washington University in Washington, D.C.

K.J. Langlais has more than 26 years of experience in the field.

Ms. Langlais' experience in nursing home leadership includes administrator, consultant and now CEO of a non-profit organization with a 112-bed mission-driven SNF dedicated to providing quality care to Medicaid recipients. Her commitment to improving care and services led her organization to create GERTI (Geriatric Education Resource & Training Institute) in October 2003, currently serving over 1400 participants from more than169 organizations. Ms. Langlais is the author of *Managing with Integrity for Long Term Care* published by McGraw-Hill in 1997. Her career spans both non-profit and for-profit sectors giving her a vast knowledge of long-term care in both arenas.

Ms. Langlais and her Director of Education were selected by Ingram's Business Magazine as Hero's in Healthcare for 2005, for their work in developing award winning educational programs to help improve care and services to seniors.

Ms. Langlais serves on the Foundation on Aging Advisory Board, Kansas Adult Care Executive (KACE) Board; ACHCA Kansas Chapter President-Elect; Kansas Health Occupations & Credentialing Committee; Business Advisory Board for Kansas City Kansas Community College, MCC-Penn Valley Community College Advisory Committee; Kansas City ATS Nursing Advisory Committee. She is also currently Vice Chair of the Leavenworth Wyandotte and Johnson County Workforce Investment Board.

Mark Lenhard has over 14 years experience in the field.

Mr. Lenhard's many roles in the field of long term care include administrator, executive director, vice president of operations and senior vice president. He began his long term care career by doing crisis management for a large for-profit company, working with facilities needing to be brought back into compliance. After managing seven facilities in just over three years, he moved to the not-for-profit sector as a campus Executive Director for a faith-based organization. This CCRC provided services to the subsidized and unsubsidized from independent living to skilled nursing. Mr. Lenhard remained with this organization through the time it could no longer support its predominately Medicaid nursing home and participated in and directed the closing of that facility.

Mr. Lenhard subsequently became the Vice President and then Senior Vice President of another faith-based not-for-profit organization, serving the indigent on a much larger scale. Over 75% of the campus is dedicated to providing care and services to those who cannot provide for themselves. During Mr. Lenhard's tenure the organization has increased the number of individuals served and added additional "gap filling" services such as an Assisted Living Conversion Program in conjunction with the 202/Section 8 HUD housing program. This has enabled residents to age in place from independent living to assisted living without having to leave the community they have come to call home.

Mr. Lenhard served as a board member of the Texas Association of Homes and Services for the Aging for over eight years, and was selected as a House of Delegates member for

the American Association of Homes and Services for the Aging. He is an active participant in lobbying on behalf of senior services and has contributed to the research for individual legislation. He believes "this work is significantly more than a job, it is a calling."

Mr. Lenhard holds a Master's degree in Gerontology from Baylor University.

Connie March has 30 years experience in the field**.**

Ms. March has have worked in the field of geriatrics since 1978, beginning as a nurse practitioner with a caseload of nursing home residents. Every position she has held since then has been in geriatrics. She has led Provena Senior Services and its predecessor organization since 1987. In her role as CEO, she provides strategic leadership and operations oversight for the ministry's 17 campuses located in Illinois and Indiana. She is a Board member and past Board Chair of Life Services Network (LSN) which is the Illinois state not-for-profit senior services provider association; a member of the American Association of Homes and Services for the Aging (AAHSA) Board and House of Delegates; a member of the Kankakee County Salvation Army Board; a board member and secretary-treasurer of the Illinois Catholic Health Association (ICHA; and an advisory board member for the Northern Illinois University School of Nursing.

Ms. March received her Bachelors and Masters degrees in Nursing from the University of Illinois and has authored various articles and books. She has been certified as both an adult and geriatric nurse practitioner and has worked in various nursing positions including education, clinical, consultation and administration.

Linda O'Neill has over 30 years of experience in the field.

Ms. O'Neill is the Executive Director of Franciscan Communities of St. Anthony Campus where she is responsible for the overall operations of this long-term care retirement community. The services provided include long-term care, assisted living, home care, adult day care, childcare, as well as outpatient hospice services in Crown Point; satellite operations for adult day and hospice are also available. Ms. O'Neill has also served as an adjunct professor in the School of Public and Environmental Affairs for the last 10 years at Indiana University, and has served as an adjunct professor teaching various health care management topics at DeVry University and Keller Graduate School of Management.

Ms. O'Neill holds a Bachelor's degree in Nursing from Purdue University and a Masters degree in Public Administration from Indiana University. She is a Licensed Registered Nurse (Indiana and Illinois) and a Licensed Health Facility Administrator.

Dana Petrowsky has 33 years experience in the field.

Ms. Petrowsky's substantial experience in the nursing home regulatory arena includes her service on the National Academy of Sciences, Institute of Medicine Committee on Nursing Home Regulation, the Committee that authored the report *Improving the Quality of Care in Nursing Homes*, which served as the basis of OBRA '87 Nursing Home Reform.

Ms. Petrowsky served in the Health Facilities Division of the Iowa Department of Inspections and Appeals from 1975 – 1990, including the position of Administrator of the Division. She subsequently served the G.H.W. Bush administration as the Regional Director of the U.S. Department of Health and Human Services, Kansas City Region, as the Secretary's personal representative to political leadership in Kansas, Missouri, Nebraska and Iowa, 1990 - 1994. She served the nation wide Association of Health Facilities Licensing and Certification Directors as Secretary, Vice President and President and has testified numerous times before both the US Senate and House committees concerning quality of care in nursing homes.

Currently, Ms. Petrowsky is the President/CEO of the Iowa Association of Homes and Services for the Aging—a position she has held for over 10 years. IAHSA represents 144 not-for-profit long-term care providers including skilled nursing facilities, nursing facilities, residential care facilities, assisted living, senior housing and community-based services.

Neil Roberts has 35 years experience in the field.

From 1973 to 2003, Mr. Roberts worked for United Methodist Health and Housing. During those years the organization ran a Skilled Nursing Facility growing from 164 to 356 beds, subsidized housing, market rate housing, adult day care, and assisted living. Mr. Roberts held various positions in the administration, including business manager, personnel director, and for the last 15 years, Administrator/CEO.

During Mr. Robert's tenure, the organization worked to make quality of life a reality for all populations served -- by expanding access and services, by empowering the right to make a home at all levels of care. In addition, programming was changed to improve the quality of life and care of residents/tenants, emphasizing the empowerment clients, creating a more home-like atmosphere, and adding services including AIDS services, a dementia unit, IV therapy and day services.

Mr. Roberts has also served NYAHSA and AAHSA in leadership positions for many years. He is currently on the Board of Directors of an AAHSA member facility.

Lynn Starkovich has 33 years experience in the field.

Ms. Starkovich currently serves as President & CEO of Walker Methodist which is a faith-based, mission driven organization serving about 2500 seniors in diverse ways. Her 33 years of experience in long term care includes 5 years in direct care, 20 years in service administration, 8 years of legal representation, and 3 years as a consumer and advocate for her parents in 2 states.

Ms. Starkovich holds a BA degree in biology and psychology, Masters degrees in both psychology and special education, and a Juris Doctor.

Keli Swales has 14 years experience in the field.

Ms. Swales served eleven and a half years as Administrator then Associate Executive Director at a multi-facility sponsor continuing care retirement community. Her responsibilities included overseeing a skilled nursing facility with a high skilled needs population, Assisted Living, Memory Support, Wellness and Home Care. During that time, turnover in the SNF was significantly reduced and the organization demonstrated a good compliance history, including a deficiency free survey. During Ms. Swales' tenure, the community developed an enhanced payor mix and revenue to become the most cost-effective SNF within the American Baptist Homes of the West (ABHOW) without compromising quality care and resident satisfaction. The community has received an AAHSA quality first award and 3 Quality First awards from the state association, Aging Services of CA. Ms. Swales has been a member of the state association's health services subcommittee for the past 4 years, serving most recently as Chair. For the last two years, she has been the Executive Director of the CCRC, receiving three Peak Performance Awards.

Timothy L. Veno has more than 20 years experience in the field.

Mr. Veno is currently the President of the Kentucky Association of Homes and Services for the Aging (KAHSA), based in Louisville. KAHSA is a professional services organization of member elder housing and long term health care providers. Mr. Veno has extensive governmental experience, having served for over 12 years in the health care regulatory and program integrity field. Most notably, Mr. Veno served as the Inspector General for the Kentucky Cabinet for Health Services and Family Services, in which he supervised and directed all regulatory, audit and investigative functions of the cabinet.

Mr. Veno also served as the Director of the KY Division of Licensing and Regulation, the state agency, as a contractor for the Federal Centers for Medicare and Medicaid Services, which monitors regulatory compliance and conducts investigations of health care consumer complaints for health care facilities participating in the Medicare and Medicaid programs. Mr. Veno also served as the Executive Director of the Center for Benefit integrity with Medicare's designated Quality Improvement Organization in Kentucky.

Appendix B

Summary of TF Interviews with State Agency Staff, June 2007

Interviewed:

Illinois
Licensure Director, Department of Public Health

Iowa
Administrator, Division of Health Facilities, Department of Inspections and Appeals
Assistant Administrator, Division of Health Facilities, Department of Inspections and Appeals

Kansas
Director, Ombudsman Program
Director, Survey and Certification

Missouri
Director, Division of Regulations and Licensure (DRL) Department of Health and Senior Services (DHSS)
Administrator, Section Long Term Care Regulations (SLTCR), DRL, DHSS
Chief, Quality Assurance Unit, SLTCR, DRL, DHSS
Chief, Operations Unit, SLTCR, DRL, DHSS

New Jersey
Director, Assessment and Survey, Department of Health and Senior Services

Oregon
State Agency Area Supervisor

Questions and Answers

1. **Assuming you could change anything, that nothing is sacred, what suggestions do you have for improving the survey and certification process?**

<u>Common Themes</u>

- Allow flexibility in survey cycle
- Allow flexibility in allocating resources
- Allow for a consultative role in the process

State Responses

State A
Many individuals with no survey experience create processes that are untested. Any [process] change should go to the State Agency and providers, and be tested in the field to assure effectiveness.

State B
Halt unfunded mandates, new tasks, refining tasks, and elongating tasks. New work is added without additional resources, then we are told to take it out of other survey types.

Some providers now have an eight year cycle.

State C
General suggestions:

- Change to a consultative approach
- More of a quality improvement goal verses indicators
- Quarterly visits for on-going consulting
- Extend timelines with longer gaps in surveys (e.g. 18-24 months)
- System very confusing to consumers
- Very strong public image that deficiencies and process is a measure of quality of a facility

Regarding the complaint hotline:

- This state has added staff to handle an increase in calls
- The hotline should be kept for an avenue for reporting abuse, not as a self-reporting tool
- The database should separate actual issues and self-reporting

State D
The process is too narrowly defined and does not allow for a consultative role. Providers could learn strategies from surveyors if a consultative process was permitted.

State E
Redefine the survey process; would like to see more flexibility. For example: when a good provider calls in a complaint, the department sends a surveyor. That could possibly be the survey for that facility, rather than a team entering later for a full survey. Preferably, surveyors would be utilized for the "problem" providers and give more flexibility toward the providers who consistently have good surveys.

Flexibility with the length of time for surveys: More information is available ahead of time, thus survey teams could enter and leave a facility after one day if they feel comfortable (i.e. have the flexibility to do this in order to spend more time in the "problem" facilities).

State F
It is not necessary to survey some buildings as often. Change the timing of the survey process to less than annually. (*Interviewer note*: When asked to explain, the supervisor stated that the timing could be based on complaints or perhaps every three years for some buildings.)

2. **What suggestions do you have for improving the enforcement process?**

State Responses

State 1
Look more at the JCAHO process being implemented. Do not look at a punitive process. Look at root causes and address these with facilities.

State 2
Eliminate Plans of Correction. They are an unnecessary exercise. Providers spend a lot of time writing them, the survey agency spends time reviewing them, and they are never looked at to see if they were implemented or not. They look only for compliance.

State 3

- Quality based user fee – not supported
- Do away with No Harm level; focus on Actual Harm issues triggering consultation requirements
- Denial of payment – needs to be more flexible
- Look at denial of new admissions & fines
- Seems to be 'big G's and 'little' G's, yet fines on both

State 4
CMS should implement a process change to address the "roller coaster" providers. For example: establish a definite time period for improvement / closure, etc.

State 5
With regard to the enforcement process, New Jersey does well with the process used.

CMS does not move fast enough. For example: a provider won an IDR case, yet two years later, CMS responded they didn't agree and cited the provider with fines.

Use consultants rather than fines. Fines do not work with the habitually "bad" providers

"Bad" providers continue to pay fines and continue to operate the same way. Mandatory consultants could be a better avenue because they help to bring providers into compliance. However, consultants should be required on a longer-term basis (currently, after consultants leave, some facilities do not continue with consultant's recommendations).

State 6
Naming facilities as the "poor performers" for ongoing monitoring does not necessarily improve the care and services of those buildings. In fact, it often makes things worse because the facility's focus is on the survey, and this leads to high turnover in key positions.

State 7
Better communication, clear expectations, and clearly stated consequences for continued non-compliance. Facilities should not be surprised to find they are special focus facilities; facilities should clearly understand the ramifications of the designation.

Evaluate the effectiveness of civil penalties.

3. **If CMS would grant one request, what would be the most effective change that could be made at the federal level to improve the survey process?**

<u>Common Themes</u>

- Allow flexibility in allocating resources

<u>State Responses</u>

State 1
Prioritize survey activities.

Provide funding for all survey activities. Tiers 1-4: Tier 1 is mandated activities. Tier 2 takes longer to get done. Tiers 3 and 4 – some get done for 3; Tier 4 activities do not get done.

State 2
It would be impossible to change one area without affecting the entire process.

The number of surveys – including the complaint surveys.

State 3
The six month enforcement process requiring termination should be eliminated because the impact of complaints makes it very hard to reach full compliance.

State 6
Allow direction of resources to the facilities and situations where they can be most effective.

4. **What would be the most effective change that could be made at the federal level to improve the enforcement process?**

Common Themes

- Revise the use of fines

State Responses

State 7
Change the survey process to the QIS. (However, the state's implementation dates are extended because of low/no funding for the QIS.)

State 2
Change the belief at the federal level that denial of payment or fines are the only enforcement tool that works.

State 3

- Reviewing closed records a waste of time
- 2567 Electronic submission
- Exit Conference – done at findings meeting and then email 2567

State 4
Delete the two year ban on CNA training programs when the provider is out of compliance.

State 5
CMS needs to act faster. Example: a provider won an IDR case, yet two years later, CMS responded they didn't agree and cited provider with fines.

Prefer to use consultants rather than fines. When a consultant is required, the consultant should stay for a longer period of time.

State 6
Repeated visits to "poor" performers have the opposite effect in terms of compliance and improvement; therefore, eliminate the focus facility program.

State 7
Provide resources so that technical expertise can be directed at a facilities to improve operations at that facility.

5. **Do you believe that positive recognition can and should be built into the survey and certification process?**

Common Themes

- Yes; however,
    - Varied responses regarding whether recognition should come through the survey process or another avenue

State Responses

State 1
Yes – although this is not the purpose, we often give recognition.

Yes – this is why we are starting a "Innovative Practice" award.

State 2
Positive recognition can and should be given. The survey process is not the right place for it.

State 4
Yes.

State 5
Recognition occurred under federal direction in the late 80s early 90s. But they were criticized heavily for it by the State Ombudsman office who was investigating a complaint about the survey agency. This ended positive recognition.

State 6
Yes. This is in agreement with the consultation role that a surveyor should have.

State 7
The survey process is punitive. An avenue to compliment staff would be good, but not during the survey process. Positive feedback may be possible through the state QIOs. During the survey process, if the team compliments a provider, provider's staff may only pick up on the compliment and not on the areas of concern (i.e. "people hear what they want to hear").

6. **Do you find the current IDR process useful and/or effective in resolving disputed deficiencies? What aspects do you find least/most useful/effective?**

Common Themes

- Some states satisfied with IDR process

State Responses

State 1
The IDR process can be useful and effective; however, the process is too loosely structured; sometimes it is not particularly useful to the SA.

State 3
Don't know.

Providers did not like previous IDR process. The Michigan group was brought in as an IDR option. The Department has not heard any complaints recently.

State 4
This state's system is the envy of many other states that have the survey people hear the appeal. We have an outside entity that is objective. Compared to other states, we have a lot more attorney involvement than do other states. It more closely resembles a formal hearing.

State 5
This state has an effective IDR process. It is not the best because the mediator is on the state Regulations and Licensure staff, but the current employee is as close to a neutral party as possible. The informal process is encouraged where providers can present their positions without needing to have legal counsel present.

State 6
Other states have approached the state on its IDR model. The state is pleased with its IDR process.

After the IDR, the IDR panel and supervisors will meet with survey team to discuss why something was changed, what documentation was missing or needed. This helps the survey teams with future citations; they have a better understanding of what they need to keep a citation.

Approximately 15% of the IDRs overturn deficiencies and the number of IDRs in this state has decreased over the years. Also, CMS has overturned many of the IDRs.

State 7
State has a good IDR process and has partnered with providers to make it better. (*Interviewer note*: We have a Surveyor Provider Forum in this State that is very strong and one of the projects we have worked on together is IDR and the Innovative Practice award.)

7. **Assuming that some form of IDR will continue to be required, do you have suggestions for making it more useful and/or effective?**

State Responses

State 2
No.

State 3
The IDR process is great, objective, and without need for change.

State 4
Need to be able to change a G to another level instead of eliminating or keeping it with no other option. Adjustments: Uphold, Delete or Change

Scope and Severity should be allowed to be changed during the IDR process (currently a drop/keep process). Often deficiencies are mistakenly rated wrong, and perhaps were deficient practices, but the challenge at the IDR process is due to poor rating.

State 5
The mediator should be a truly neutral party.

State 6
Make it more structured. Possibly only allow IDRs in certain situations.

8. **Do you believe that joint training of providers and surveyors would be a constructive approach to resolving some of the communication concerns and/or questions about compliance determinations? If so, do you have suggestions as to how this training could be best accomplished in this state and/or region?**

Common Themes

- Yes; however,
    - Often with stipulations

State Responses

State 1
No problem seen regarding joint training. The concern with joint training is that surveyors and providers are on different sides; this may cause surveyors not to ask some specific questions with providers in the room. The benefit is that all would learn from the same presenter. The question is, how will both sides interpret the information?

State 2
Joint training is beneficial – however it would be difficult if the State agency and the Providers are not already working collaboratively. (*Interviewer's note*: No suggestions for how this could be accomplished were offered.

State 3
Joint training is not a bad idea, but consideration must be given to the time that surveyors are spending in training.

State 4
It depends on the type of training. Some joint training could be advantageous such as learning new regulations. Would not favor training jointly when teaching about internal survey processes.

State 5
Yes, it is supported and has been done for years.

State 6
It is very well used and beneficial; supportive of joint training.

QIS training is very intensive and used for new surveyors instead of training on the old system. This is especially the case in regions where new surveyors are being hired.

State 7
The Division takes a strong position that joint training is desirable. The Division has started some joint training by inviting a few representatives from the long-term care trade associations; however, funding (or lack of) and space requirements prevents further expansion. That is something the Division is definitely pursuing. The State has provider/surveyor workshops on an annual basis that help toward that goal.

9. **Do you have other suggestions for improving communications between the State Agency/surveyors and providers?**

State Responses

State 1
In the past, associations met quarterly with the different state agencies. This was discontinued a few years ago, based on the state feeling it was conflict of interest. The Director would like to see the quarterly meetings start up again and indicated the associations should push for this.

Opportunities for providers and surveyors to meet outside of the nursing homes would benefit all.

State 2
Do what Oregon did – establish a Surveyor Provider Forum that meets regularly – members serve for a full year.

State 3
Periodic updates to the certification/survey/enforcement process via email, via internet, via the professional associations, etc. Resources to do this are always an issue.

State 5
No. The SA and provider associations hold quarterly meetings to discuss any issues.

State 6
Continue with communication channels.

State 7
Newsletters through the internet are available to providers. The Division maintains a good relationship with the long-term care trade associations; providing them with regulatory updates. Regional offices have varying degrees of interaction with the providers, but for the most part, are available and willing to communicate with individual providers.

Appendix C
Comparison of State Surveyor Position Descriptions*

State	Position Title	Salary	Education, Experience, Minimum Qualifications	Excerpts from Position Descriptions
AL	Licensure and Certification Surveyor	$43,900 – 66,700	Bachelor's Degree in Nursing (BSN) plus 2 years direct patient care Or Associate's Degree in Nursing (ASN) plus 5 years direct patient care	
AZ	Federal / State Licensing Surveyor	NA	Degree required (not specified) "Nursing background [is] a plus" *Prefer:* ASN and "general nursing experience" Or Bachelor's in an appropriate [health services] field and experience in related field	
GA	Nurse Surveyor	$34,500 – 60,500	Registered Nurse (RN) plus 3 years experience in health care or long-term care *Prefer:* 1. Surveyor experience 2. More than three years RN experience 3. BSN 4. Supervisory / management experience 5. Computer skills 6. Bilingual	

State	Position Title	Salary	Education, Experience, Minimum Qualifications	Excerpts from Position Descriptions
KS	Health Facilities Surveyor I	$18 – 25/hour	RN For some positions, RN must have "three years of experience in adult care situation such as nursing homes."	
MD	Health Facilities Surveyor Nurse I	$48,700 – 67,000	BSN Two years of RN experience may substitute for BSN	This position is at the intermediate level.
MI	Health Care Surveyor Levels 9, 10, P11	$19 – 30/hour	**Level 9:** No minimum amount or type of experience required **Level 10:** One year experience as Level 9 surveyor **Level P11:** Two years experience as surveyor including one year as Level 10 Education: BSN or health care field Equivalent combinations of education and experience will be considered	Surveyors must orient in facilities for 10 days. For health care license renewal, 50% of CEU must be in geriatric care.

State	Position Title	Salary	Education, Experience, Minimum Qualifications	Excerpts from Position Descriptions
NV	Health Facilities Surveyor II – Nurse	$47,700 – 71,000	BSN Three years experience with two or more years of direct patient care, one year experience as a surveyor Or One year experience as Surveyor I – Nurse in Nevada Or Two years supervisory / managerial experience in nursing Or RN with an equivalent combination of education and experience	
ND	Health Care Facility Surveyor II	$2,800 – 3,200/ month	RN or BSN Two years professional experience Or Passed SMQT	State car provided.
OH	Healthcare Facilities Surveyor – Entry Level	$22/hour	RN plus two years experience in long-term care Orientation: One year orientation includes training on survey tasks; protocols; procedures; duties of survey team leader and office-based reviewer; extensive reading and program briefings regarding laws, rules and guidelines pertinent to assigned discipline (i.e. RN). Six weeks of orientation in Columbus, Ohio.	Must provide own transportation.

State	Position Title	Salary	Education, Experience, Minimum Qualifications	Excerpts from Position Descriptions
OK	Clinical Health Facility Surveyor Level I Level II	Level I: $2,300 – 3,800/month Level II: $2,500 – 4,200/month	**Level I:** RN with three years clinical experience Or BSN with two years clinical experience **Level II:** All requirements of Level I surveyor plus "knowledge of federal and state laws, regulations and policies, of what constitutes immediacy of threat to a client, and of the requirements for determining culpability of a facility."	Level II requirements include ability to "gather and present findings within a hostile facility environment while maintaining professional tone and demeanor; analyze non-verbal and verbal communications to determine if an interview subject is omitting information or is being deceptive, and employ techniques for identifying omissions and deception in written statement;…"
OR	Client Care Surveyor	$3,600 – 5,200/month	Three years experience in health care field AND Bachelor's in health or human services field OR RN license	

State	Position Title	Salary	Education, Experience, Minimum Qualifications	Excerpts from Position Descriptions
TX	Generalist Surveyor	$2,800 – 3,400/month	"Applicants with a degree preferred" Initial Selection Criteria: • Experience with elderly patients/clients • Experience in institutional health care, hospital care, or in surveying/inspecting long-term care facilities	Requires initial "Academy training" that requires weekly blocks of overnight travel, additional overnight survey travel, and/or additional training overnight travel. Knowledge of nursing principles and acceptable professional standards of resident/client care.… Must be willing to work overtime."
WV	Health Facilities Surveyor II	NA	BSN or other health-related field Four years full-time or equivalent part-time paid professional experience in a health care field may substitute for required training. If employed in the NH Program, must have a current WV Nursing Home Administrator's license in good standing, excluding life safety code surveyors and licensed or registered dieticians.	This is the advanced level. Surveyor II is expected to act as a team leader of a multi-disciplinary team and/or as a lead worker.

*Notes:

1. For brevity, this table contains salary, education, experience, and minimum qualifications specified in the position description. Additional knowledge, skills, and abilities are often listed in position descriptions, but generally not included in

this table. Components of position descriptions that pertain to the interests of the Survey and Certification Task Force are quoted or summarized in the far right column.

2. This table is restricted to position descriptions specific to nurse surveyors or generalists and excludes descriptions for surveyor social workers, dieticians, therapists, etc.

3. Position descriptions varied in language describing job responsibilities: job responsibilities toward facilities were described in antagonistic terms (investigate abuse and neglect), consultative or technical assistance terms (provide consultative and technical assistance), or objective terms (observe care, interview staff, review records).

4. States vary on qualifications and position responsibilities for entry- and higher-level positions.

5. States varied on providing state cars for travel purposes.

6. States varied on travel time required (ranged from 60 – 90%).

7. States varied on days and hours scheduled. Some states explicitly said that hours are regular 8 – 5, Monday – Thursday, all federal holidays apply. Other descriptions listed hours as including nights, weekends, holidays.

8. Few descriptions included an explanation of orientation and training post-hire.

Appendix D

State IDR Process

Information collected by AAHSA, 2007

State	Who Conducts			How			Timeframe for Results	Attorney Allowed	Comments
	S & C	*State*	*Other*	*Phone*	*Desk*	*Person*			
AL							Not Specified	Not Specified	Administrative Procedures Act*
AK	Dept – not specified					X	Not Specified	Not Specified	Very rarely used (3 times in 15 years) as cited in OIG report
AZ							Not Specified	Not Specified	Administrative Procedures Act*
AR	Dept – not specified			X	X	X	Not Specified	Not Specified	
CA		Neutral 3rd Party		X	X	X	Not Specified	Yes	
CO			IDR Committ [7 voting]		X		7 days	Not Specified	Seems to work pretty well
CT									
DE		Not Specified		X	X	X	Not Specified	Not Specified	
DC									
FL	X – If SQC, MD or RN with Geriatric Experience				X				In general, have heard that when providers are familiar with the process, it can be successful. However, many providers are not familiar and thus, they do not appeal.
GA	LTC Section; Ofc of Reg. Servs				X	On Request	Not Specified	Not Specified	
HI							Not Specified	Not Specified	Administrative Procedures Act*
ID		State Hearing Officer			X	X	30 days	Yes	
IL	Dept – not specified				X		Not Specified	Not Specified	
IN			MPRO or paper only option		X	X	20 days	Not Specified	Detailed instructions on 2-page submission sheet

State	Who Conducts			How			Timeframe for Results	Attorney Allowed	Comments
	S & C	***State***	***Other***	***Phone***	***Desk***	***Person***			
IA	Bureau Chief + ALJ Review		Face-to-face by the ALJ	X	X	X	10 days	Yes	NH has 30 mins to present its case; the Dept has 20 mins to respond; NH has 10 mins for rebuttal. If / how much documentary evidence not provided to surveyors at exit can be intro'd at the IDR is under dispute. There is skepticism over the outcomes, i.e., the rate of removal is low (20%); the rate has remained steady even though NHs are more reluctant to appeal because the likelihood of overturning is low.
KS			Independent Review Panel [1 SA]		X		Not Specified	Not Specified	The process is less than desirable; Conflict of interest inherent in the panel because a KS Dept. of Aging Reg Manager has traditionally been a member of a 3-person panel, effectively sitting in judgment of his/her peers & lacking objectivity; insufficient instruction regarding options Review Panel has in making its determination, e.g., removal of a deficiency, etc. Given the above and the way they have been

State	Who Conducts			How			Timeframe for Results	Attorney Allowed	Comments
	S & C	***State***	***Other***	***Phone***	***Desk***	***Person***			
									conducted, our members just don't use it. They feel it is a waste of time, an exercise in futility—and also fear retribution for asking for an IDR. Have a 2-tiered IDR for LSC by the SFM; **In-person** on request; results of 1st -tier w/in 10 days of disposition; appeal to 2nd tier is a 3-person panel appt'd by the SFM.
KY	IDR Coord. in Office of OIG	Panel – 2 SA +LTC Provider	On Req	X	*On Request: Panel Review G or higher / SQC; OIG for reconsid	35 days	Not Specified		
LA	Employee who did not participate in survey				X	X	3 days	Not Specified	
ME	Licensing Division Director					X	Not Specified	Not Specified	
MD	Ofc of Health Care Quality (AHCQ)						Not Specified	Yes	
MA			14 Member IDR Comm [7 voting/1 SA]		X		5 business days	Not Specified	Both provider associations have a vote on the IDR Committee. MA Aging has a member designee and another member who serves as an alternate.

State	Who Conducts			How			Timeframe for Results	Attorney Allowed	Comments
	S & C	***State***	***Other***	***Phone***	***Desk***	***Person***			
MI			MPRO or BHS		X	X	20 days	Not Specified	Explanation process is helpful and titled "Informal Deficiency Resolution."
MN	IDR – No $ to Provider		IIDR – ALJ $ / SA and Provider based on F-tags lost	IIDR	IDR / IIDR	IIDR	Not Specified	Y – for IIDR	IIDR statute developed based on an arbitration clause in the SA's contract with the hosp rate review program; called arbitration, but more like major league baseball (the player and team each present a number, and the arbitrator picks one), not arbitration as in classic labor/manage-ment; no mediation involved; each side presents its case and the arbitrator decides; not perfect, but way better than the traditional process
MS			3 person panel	X	X	X	10 days	No	
MO	Dir – Division of Sr. Services & Regulation			X	X	X	Not Specified	Yes + audio-taped	
MT		Ofc of Fair Hearing		X	X	X	Not Specified		
NE	Dept – not specified			X	X	X	20 days	Not Specified	
NV									
NH									
NJ	Dept – Supervisory staff				X	X	7 days	Not Specified	
NM	Dept – not specified					X	30 days	Yes	

State	Who Conducts			How			Timeframe for Results	Attorney Allowed	Comments
	S & C	***State***	***Other***	***Phone***	***Desk***	***Person***			
NY			3 member panel including 1 SA		X		10 days	Not Specified	Originally a 2-step process with the regional office review & 2nd review available at central office. 2003, became 1-tier, with G or above reviewed at the CO, F & below at the RO. Face/face was dropped in 2006, with only a desk review by a panel of DOH CO reps, NAB, & Ombudsmen. The panel process is intended to resolve provider concerns about lack of objectivity by DOH. Providers are disappointed over loss of face/face; the letter informing of a failed IDR does not tell why.
NC			Panel – not specified	X	X	X	10 days	Not Specified	
ND	Dept – not specified					X	Not Specified	Not Specified	
OH	1st level	2nd level			X		5 days each – 1st /2nd levels	Yes	Our process seems to be working fairly well.
OK	Impartial Decision-Maker			X	X	On Request		No	We have a high success rate with IDR; the problem is providers are hesitant to use it for fear of future retaliation in the survey process.
OR	Dept – not specified					X	Not Specified	Not Specified	
PA	X			X	X	X	Not Specified	Not Specified	Roughly 20% success rate in getting cited

State	Who Conducts			How			Timeframe for Results	Attorney Allowed	Comments
	S & C	*State*	*Other*	*Phone*	*Desk*	*Person*			
									deficiency overturned. PANPHA sponsored legislation for 2 consecutive sessions for an independent IDR; the federal prohibition on making it truly 'independent' led to little support from our SA or legislature. Members feel there is little use in going through IDR.
RI									
SC	X				X	On Request	50 days from survey	Not specified	
SD									
TN	X		3-member Independent Panel / from pool of 9 profess w/ knowledge of LTC appointed by the Commiss of Health [not SA or current provider]	All but SQC, harm, IJ	All but SQC, harm, IJ	For SQC, harm and IJ–indep panel for CMPs more than $25,000; SA or Indep panel for less than $25,000	5 days	May assist, attend, but not present at IDR	
TX		Neutral 3rd Party		On Req	X	On Request	30 days	Yes	
UT							Not specified	Not specified	Administrative Procedures Act*
VT	Commiss on designee				X		Not specified	Not specified	
VA		Adjudica tion Officer		X	X	X	Not specified	Yes	Believe the IDR process for the most part is going very well.
WA	X			X	X		Not specified	Not specified	Centralized IDR process at dept headquarters, One goal was more

State	Who Conducts			How			Timeframe for Results	Attorney Allowed	Comments
	S & C	***State***	***Other***	***Phone***	***Desk***	***Person***			
									consistency i.e., having 1 person conduct all IDRs. Not aware of systemic complaints with the process; not hearing dissatisfaction.
WI			MPRO	X	Desk only for A,B,C	X	24 days	Yes + taping allowed	WAHSA members have had limited success since the Division of Quality Assurance still has the final say in the process.
WV						X	Not specified	Not specified	
WY						X	Not specified	Not specified	Administrative Procedures Act*

***Administrative Procedures Act: cited in the statute or regulation as the remedy available is to follow their state APS; usually includes a hearing and decision by a state official.**