PROMISING PRACTICES IN STATE SURVEY AGENCIES

Issue Brief: Achieving Better Outcomes Using Survey & Certification Enforcement Strategies

Introduction

Chapter 7 of the Centers for Medicare & Medicaid Services (CMS) State Operations Manual identifies a number of enforcement remedies that are available to State Survey Agencies (SAs) to address deficiencies in quality of care or safety standards in nursing homes (1). Examples include: provider agreement termination; civil money penalties; denial of payment for all (or new) Medicare and/or Medicaid admissions; state monitoring; directed plan of correction; directed in-service training; closure of facility; and transfer of residents.

The overall goal of the enforcement process is to help ensure that nursing homes maintain compliance with federal quality requirements. In addition, SAs have a strong interest in applying the remedies to other facility types, such as assisted living and community-based facilities as a means to increase efficiencies in the state licensure and survey workload. Achievement of this goal on a facility-by-facility basis presents an ongoing challenge for SAs. Despite the many remedies available, agencies at times struggle to identify the most appropriate and effective enforcement approaches to address specific care problems.

Enforcement of federal quality requirements, particularly in nursing homes, has been receiving national attention, with a recent report by the Government Accountability Office (GAO) indicating that the current enforcement system requires improvement (2). A May 2007 hearing of the U.S. Senate Special Committee on Aging featured GAO testimony that highlighted both the progress made in nursing home enforcement since the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) and the challenges that remain in this area – including the complexity of current enforcement policies and effectiveness of enforcement monitoring systems (3).

Given this heightened attention, the following examples of creative enforcement approaches used in various states are timely in highlighting some potential avenues that SAs may explore to help them confront the challenges of identifying and implementing the most effective enforcement options.

Summary of State Examples

This report describes effective enforcement strategies utilized by State Survey Agencies in Alabama, North Carolina, and Wisconsin to address serious and repeat violations in nursing homes, assisted living facilities, and community-based facilities. In North Carolina and Wisconsin, the SAs use directed plans of correction, while the Alabama SA uses facility consent agreements. The information presented is based on interviews with agency management staff, training consultants, and review of documentation supporting the various programs.

The key features of the three agencies' enforcement practices, their impact, and lessons learned are described in this section. Detailed information on each practice is presented in state-specific descriptions.

Key Features

The directed plan of correction and facility consent agreement practices utilized by these three states are designed to achieve the same overall goal – increased compliance with federal and/or state quality requirements and improved outcomes. However, each approach is unique in terms of its specific method for achieving compliance, the role of SA staff in implementing the practice, and the types of care issues addressed.

While Wisconsin's directed plan of correction practice for assisted living and community-based facilities does not fall under the CMS federal survey and certification requirements, it does provide improved state workload effectiveness and efficiencies. A dedicated agency staff member reviews statements of deficiency to determine whether a directed plan of correction is appropriate, and when deemed appropriate, prepares a customized directed plan for achieving compliance. North Carolina's directed plan of correction practice for nursing home providers involves a collaborative effort between the SA and the state's Quality Improvement Organization (QIO) to provide targeted consultative services for facilities demonstrating compliance problems in one of five targeted clinical care areas. And finally, Alabama's facility consent agreement practice targets facilities at risk of license revocation by offering them the option of signing an agreement to comply with certain requirements within a specified timeframe in order to avoid license revocation proceedings.

Impact

Agency management staff in the three featured states indicate that their respective enforcement practices have been effective in increasing compliance with federal and/or state quality requirements. North Carolina and Wisconsin report that provider feedback regarding their directed plan of correction programs has been particularly positive. Alabama has found that the majority of facilities comply with the terms of the facility consent agreements, resulting in a reduced need for license revocation proceedings, facility closure, and resident relocation.

Lessons Learned

For agencies implementing a directed plan of correction program, consideration should be given to whether staff resources can be made available for developing and implementing the program, as was the case in Wisconsin, or if options exist for collaboration with an outside entity, such as the state's QIO, as in North Carolina. The directed plan of correction approach also requires efficient and effective communication across the various parties involved, including survey teams, survey agency management staff, and outside consultants, if involved.

States interested in implementing a facility consent agreement process should bear in mind that it is highly recommended for the agency to be represented by legal counsel, preferably in-house counsel when feasible.

Conclusion

The three practices featured in this report demonstrate that innovative enforcement methods can be effectively utilized and implemented at minimal or no additional cost to the state.

References

1 – State Operations Manual, Centers for Medicare & Medicaid Services. Publication #100-07. http://www.cms.hhs.gov/Manuals/IOM/list.asp. Retrieved August 2007.

2 – United States Government Accountability Office, 2007. *Nursing homes: Efforts to strengthen federal enforcement have not deterred some homes from repeatedly harming residents.* Report to the Ranking Minority Member, Committee on Finance, U.S. Senate. GAO-07-241.

3 – Allen KG, 2007. *Nursing home reform: Continued attention is needed to improve quality of care in small but significant share of homes.* Testimony before the Special Committee on Aging, U.S. Senate. United States Government Accountability Office. May 2, 2007. GAO-07-794T.

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Alabama

Summary

To address serious compliance issues in nursing homes and other licensed facilities, the Bureau of Provider Standards at the Alabama Department of Public Health utilizes facility consent agreements as an enforcement technique aimed at reducing the need to issue license revocations. A facility consent agreement is a contract between the state and the facility under which the facility agrees to comply with certain stipulations in order to avoid license revocation and discharge of its residents. In addition to reducing the need for facility closure and transfer of residents, this program also often eliminates the need for resource-intensive revocation hearings and their associated costs.

Introduction

This report describes the structure and functioning of Alabama's facility consent agreement practice, its impact, and lessons learned that might benefit other agencies considering similar enforcement approaches. The information presented is based on interviews with agency management staff.

Background

Prior to implementing the facility consent agreement process, the Alabama Bureau of Provider Standards addressed serious compliance issues by issuing a notice of revocation. The notice led to a hearing in which a formal determination was made as to whether a facility's license would be revoked, often resulting in the need to discharge and transfer all of the facility's residents. The facility consent agreement practice is an effort by the Bureau of Provider Standards to reduce the need for revocation hearings, facility closure, and resident discharge or transfer by establishing agreements with facilities to address compliance issues before proceeding with (and with the goal of eliminating the need for) revocation.

Intervention

When state survey findings reveal a pattern of poor facility compliance over time, the Bureau of Provider Standards issues a letter notifying the facility that license revocation is being considered. Facility representatives are invited to attend a meeting with Bureau staff to discuss the issues of concern. At the meeting, the facility is given the option of signing a consent agreement – a document that details the requirements with which the facility must comply to avoid license revocation proceedings and a specific timeframe for doing so. The agreement indicates that failure to comply with the requirements and stipulations within the specified timeframe will result in the immediate institution of revocation proceedings. According to agency management staff, nearly all facilities sign the facility consent agreement when given the option. Once the agreement is signed by both the facility and the state, the agreement becomes a binding contract. At that point, contract law (rather than administrative law) comes into play, and the facility's license may be revoked as a result of its failure to meet the terms of the signed agreement. A facility that fails to meet the terms of the agreement has no further recourse for disputing the state's findings that predate the signing of the consent agreement.

Facility consent agreements typically include language stating that the state reserves the right to perform unannounced surveys at any time should they find that conditions warrant it, and that the provider license may be revoked as a result of those findings. The majority of facility

consent agreements in Alabama pertain to cases involving facilities with serious care problems and a history of poor compliance. Specific examples of care problems addressed include resident abuse, resident falls with fractures, medication re-supply deficiencies, operation of unlicensed facilities, and failure to meet specified staffing requirements. The goal in utilizing the facility consent agreement mechanism is to compel the facility to correct the problems or to mandate transfer of the facility to a new operator.

Implementation

The facility consent agreement process in Alabama evolved over time through a history of issuing revocation notices to providers with serious compliance issues and conducting hearings to determine the outcome. For most of these cases, a settlement was reached prior to actually going to hearing or trial; the agreement reached in these cases was typically referred to as a settlement agreement. A consent agreement is essentially a settlement agreement that is negotiated earlier in the process, before a revocation hearing is ordered, and sometimes even before the revocation letter is sent. A consent agreement is offered as an alternative to the time- and resource-intensive process of a revocation hearing. Alabama's facility consent agreement process evolved through the realization that a good deal of time and resources can be saved by settling revocation-level compliance issues before embarking upon and preparing for the revocation hearing process.

Impact

The Bureau of Provider Standards has found facility consent agreements to be a highly effective and efficient means of enforcement in cases involving serious compliance issues. By eliminating the need for a revocation hearing – and the associated surveyor and attorney time required to prepare for a contested case hearing – substantial state resources are saved. Furthermore, because the majority of facilities (approximately 75-80 percent) comply with the terms of the consent agreements, the need for facility closure and resident relocation is minimized. From the Bureau's perspective, facility consent agreements consistently result in positive outcomes – with either correction of care problems or transfer of the facility to a new operator.

Lessons Learned

A key factor in the success of the facility consent agreement process is the state's ability to convince the provider that the state is prepared to move forward with the revocation hearing if the consent agreement is not signed, and that strong evidence exists in favor of the need for revocation.

Another important consideration is that in order to issue facility consent agreements, the state agency needs to be represented by legal counsel, preferably in-house counsel, if feasible.

Contact Information

For further information regarding the facility consent agreement process, please contact Rick Harris, Director, Bureau of Provider Standards, Alabama Department of Public Health, by e-mail at rharris@adph.state.al.us or by phone at 334/206-5366.

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North Carolina

Summary

In 2006, the Division of Health Service Regulation (DHSR) at the North Carolina Department of Health and Human Services implemented a directed plan of correction program for nursing home providers in collaboration with The Carolinas Center for Medical Excellence (CCME), the Quality Improvement Organization for North and South Carolina. Under this program, the DHSR directs facilities with repeat and/or severe care problems to work with a CCME Quality Improvement Consultant to improve care in specified areas.

Introduction

This report describes the structure and functioning of North Carolina's directed plan of correction program, its impact, and lessons learned that might benefit other agencies considering similar enforcement approaches. The information presented is based on interviews with agency management staff as well as staff at The Carolinas Center for Medical Excellence.

Background

The directed plan of correction program in North Carolina evolved out of the state's recognition that certain facilities, particularly those with repeat and/or severe compliance issues, could greatly benefit from targeted consultative assistance in certain care areas. As a mechanism for providing such intensive consultation, DHSR contracted with CCME, the state's Quality Improvement Organization, to provide consultative services for five selected clinical areas: restraint use, pressure ulcers, medication management, urinary incontinence, and fall prevention. These five care areas were selected based on a number of factors, including state priorities, CMS goals for reducing pressure ulcers and use of restraints under the Government Performance and Results Act (GPRA) of 1993, and CCME's areas of expertise. Although a directed plan of correction had always been an available remedy for enforcement, this approach had not been utilized previously in North Carolina, mostly due to the perception that directed plans were primarily used for structural (e.g., life safety code) issues rather than those involving resident care. However, with the directed plan of correction remedy defined in the State Operations Manual (SOM) as a plan that the state develops "to require a facility to take action within specified time frames", DHSR chose to utilize this mechanism as a way of directing facilities to work with a CCME Quality Improvement Consultant in addressing their resident-focused quality of care problems.

Intervention

Under the directed plan of correction program, survey teams identify facilities that might benefit from CCME consultation upon completion of a survey by notifying DHSR management. DHSR management staff then promptly send a referral to the CCME Quality Improvement Consultant, who arranges for a one-day onsite visit with the facility.

Prior to the visit, the CCME consultant sends the facility a packet of information, including a letter of introduction that describes the purpose of the visit, an agenda, and recommendations for the types of facility staff who should be present at the visit. In preparation for the visit, the CCME consultant reviews the survey report to familiarize herself with the systems/care problems that led to the deficiency.

Once onsite, the CCME consultant meets with facility staff to conduct a root cause analysis of the problem. A discussion of the facility's previously proposed solutions and potential new solutions for consideration takes place, followed by a discussion of plans for implementation and evaluation. The CCME consultant provides the facility with a toolkit for the targeted care area, which contains general quality improvement information, as well as topic-specific information on best practices, recent literature reviews, clinical guidelines, and quality improvement tools. During the visit, the consultant also makes note of additional resources that may be helpful for facility staff in addressing specific problems, and sends those materials to the facility electronically upon completion of the visit.

Following the onsite consultation, the CCME consultant prepares a written report for the facility that includes the agreed upon action plan, which consists of all recommendations that were generated during the visit and proposed methods for implementation. Once complete, a copy of the report is sent to the facility.

Approximately three weeks following the visit, the CCME consultant conducts a one-hour conference call with the facility to assess the extent to which the recommendations documented in the report were implemented, any barriers encountered and solutions for addressing them, and progress achieved. A second one-hour call following this format is conducted approximately three weeks following the first call, or six weeks following the initial visit. These two progress monitoring calls also are used for contract evaluation purposes in assessing the effectiveness of the CCME's consultation intervention. In addition to the two scheduled calls, facilities are also invited to contact the CCME consultant as needed by phone or e-mail for additional advice.

Upon completion of this process, a member of the CCME staff (someone other than the CCME consultant) conducts a post-consultative services interview with the facility administrator or director of nursing to assess the facility's overall satisfaction with the consultation and to obtain feedback regarding the extent to which the facility staff's confidence in their ability to correct the identified care problems improved as a result of the consultation. During this interview, the facility contact also is asked to comment on aspects of the consultation that were most and least helpful and to provide suggestions for improving the consultation.

Funding for the North Carolina directed plan of correction program is provided through Civil Monetary Penalty (CMP) funds. Therefore, the CCME consultative services are provided at no direct cost to the facilities involved.

Implementation

The directed plan of correction program in North Carolina was generated through a longstanding collaborative relationship between DHSR and CCME focusing on quality improvement related to medication safety. DHSR initiated a contract with CCME to develop a new protocol for providing nursing homes individualized consultation in the five targeted clinical areas. The initial one-year contract covered a .75 full-time equivalent (FTE) CCME staff member to develop a toolkit for each of the five areas and to conduct both the onsite consultative visits and the conference calls at three and six weeks.

The current CCME Quality Improvement Consultant is a physical therapist with a background in research and public health who has worked in nursing home quality improvement for more than three years. Due to the initial resistance often encountered in facilities during the onsite visits, an important quality of the consultant is that he or she be adept at building rapport with facility staff, fostering a positive atmosphere, and facilitating discussion amongst staff in generating solutions.

Impact

Although this program has been in place for only one year (and limited to nine facilities), feedback received from providers thus far through the post-consultative services interview has been very positive. One suggestion received was that the visits be longer than one day to allow the CCME consultant more time in the facility to observe some of the changes that had been

implemented in the facility prior to the visit in response to the survey recommendations. Based on this feedback, and to allow for a more in-depth discussion of the issues, the program has been revised to allow for an expanded initial visit when needed.

Based on the progress monitoring calls conducted at six weeks following the onsite visit, most of the nine facilities were able to implement 80 to 90 percent of the recommendations generated through the consultation. Although progress beyond the six-week point is not formally monitored, one facility that became restraint-free following the onsite visit was found to have remained restraint-free for six months after the initial consultation.

The most definitive measure of this program's success will be the performance of the nine facilities during their next survey. With the program in place for only one year, most of the nine facilities visited to date have not yet had another survey visit. However, one facility that was surveyed the following year did not have deficiencies in the area addressed through the consultation. Overall, the North Carolina DHSR has been pleased with the progress of the program thus far, and has entered into another two-year contract with CCME to continue the program with additional consultative staff.

Lessons Learned

A key factor in the success of this program is the ability to move the process forward quickly so that the onsite consultation can take place before the facility's plan of correction is due. To achieve this, a strong communication system is required between both the survey teams and DHSR management staff to identify facilities in need of consultation, and between DHSR management staff and the CCME consultant to enable the consultant to schedule the onsite visit as expeditiously as possible.

It is essential to be able to adapt the intervention and resources provided during the consultation based on each facility's unique needs and problems. Also important is a process for soliciting facility feedback in terms of the most and least effective aspects and modifying the consultation based on that feedback.

Contact Information

For further information regarding the directed plan of correction program at the Division of Health Service Regulation, North Carolina Department of Health and Human Services, please contact Cindy DePorter, Program Manager, by e-mail at Cindy.Deporter@ncmail.net or by phone at 919/733-7461, or Beverly Speroff, Section Chief, by e-mail at Beverly.Speroff@ncmail.net or by phone at 919/855-4555. For further information regarding the CCME consultation and quality improvement toolkits, please contact Franzi Rokoske, Quality Improvement Consultant at The Carolinas Center for Medical Excellence, at FRokoske@thecarolinascenter.org.

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Wisconsin

Summary

In 2003, the Bureau of Assisted Living, Division of Quality Assurance (DQA) at the Wisconsin Department of Health and Family Services implemented a process for utilizing directed plans of correction as an enforcement strategy to address serious and repeat violations in assisted living and community-based facilities. This practice was initiated in response to concerns that financial penalties alone were not effective for all facilities in prompting and sustaining compliance. The directed plans of correction expand upon and clarify existing state codes and licensing requirements by prescribing concrete steps for facilities to achieve compliance and improve services. While this practice does not fall under the CMS federal survey and certification regulations, it does provide for improved state enforcement effectiveness and efficiencies in an area where many states find compliance issues are rapidly increasing.

Introduction

This report describes the structure and functioning of Wisconsin's directed plan of correction practice, its impact, and lessons learned that might benefit other agencies considering similar enforcement approaches. The information presented is based on interviews with agency management staff and review of documentation supporting the program.

Background

In addressing rising and increasingly serious complaints in Wisconsin's assisted living and community-based facilities, the DQA found that financial penalties alone were not an effective means of promoting compliance. Poor compliance in these facilities often was found to result from inadequate infrastructure and/or operational systems (e.g., lack of policies/procedures, poorly trained workforce, insufficient staffing), many of which would be only perpetuated by strictly monetary and/or punitive penalties. A key goal of the Wisconsin directed plan of correction program therefore was to move away from strictly punitive enforcement methods to a more constructive approach that encourages facilities to develop and implement durable, effective systems (e.g., policies, procedures, training, care planning) for improving and sustaining compliance. Although the DQA had the authority to direct plans of correction prior to 2003 – and did so on occasion primarily for straightforward environmental and structural issues – this enforcement method was adapted, expanded, and formalized for issues involving resident care and resident outcomes in 2003.

Intervention

Directed plans of correction expand upon and clarify existing state codes and licensing requirements by prescribing concrete steps toward achieving compliance and improving services. Under the directed plan of correction approach, all completed statements of deficiency (SOD) undergo a supervisory review to determine whether a sanction or other enforcement action may be warranted. Based on this supervisory review, citations that warrant further enforcement review are forwarded to the DQA's Enforcement Specialist, who determines whether a directed plan of correction might help the facility achieve compliance. In preparing the directed plan of correction, the Enforcement Specialist evaluates the SOD, following up with surveyors and regional supervisors as needed, to

determine the necessary remedial measures for inclusion. Such measures may include requirements for a facility to: 1) obtain specific training for staff; 2) hire a consultant to evaluate and develop systems; 3) obtain clinical assessments to address residents' needs, and/or 4) develop care plans to address residents' service needs.

The SODs and directed plans are sent to both the providers and involved stakeholders, some of whom may include the county human service agency, case managers, funding coordinators, ombudsmen, advocates, and other resident representatives. By including stakeholders in the distribution of SODs and directed plans, the DQA encourages and fosters communication and collaboration between the providers and the stakeholders. Stakeholders often get involved in the process by monitoring compliance, assisting with training when appropriate (in the case of ombudsmen), withholding provider funding pending compliance with orders, and/or terminating contracts with providers that fail to attain compliance.

Depending on the care issues involved, compliance with the directed plan is verified through submission of appropriate documentation by the provider and/or a follow-up visit by the survey team.

Of importance to note is that the directed plan of correction does not replace the facility's own written plan of correction. Providers are still required to submit a plan of correction within 30 days of the completed survey; this plan of correction may include the directed plan but must also address the problem from the facility's own operational perspective, taking into consideration its unique resident population, staffing structures, business practices, and other factors.

Although complying with a directed plan of correction typically involves some type of cost to the provider (e.g., provision of training, compensation for a consultant), these costs are re-invested into the facility's operation toward the goal of sustained quality improvement. This is in contrast to a fine whose proceeds go directly to the state, with no direct benefit to the facility.

Implementation

As a first step in implementing the directed plan of correction program, the DQA hired an Enforcement Specialist, who took a lead role in developing, refining, and implementing the program throughout the state. The Enforcement Specialist worked closely with the Bureau of Assisted Living Director to develop written procedures. Over time, feedback received from committees, regional office directors, and survey staff was incorporated to further refine and develop the process.

Implementation of the directed plan of correction program in Wisconsin was cost neutral in that it required no additional resources for implementation outside of the hiring of the Enforcement Specialist, whose position encompasses all enforcement-related issues, not just those pertaining to directed plans of correction.

Impact

Between 2002 (the year prior to implementation of the directed plan of correction program) and 2006, the total number of assisted living and community-based facilities in Wisconsin grew by approximately 16 percent (from 2,284 in 2002 to 2,731 in 2006); however, the number of complaints received during this time decreased by 22 percent (from 916 in 2002 to 718 in 2006). Although the number of sanctions increased 122 percent during this period, the percent of sanctions constituting forfeitures decreased from 64 to 22 percent and the percent of sanctions constituting directed plans of correction increased from 5 to 37 percent. Also, the percentage of surveys with enforcement that were appealed decreased from 18 percent to 10 percent. In addition, when sanctions were stipulated in the appeal process rarely were there any changes to the directed plan of correction. Finally, the number of facilities qualifying for abbreviated surveys during this period increased, reflecting more facilities with good compliance history. Although these trends cannot be unequivocally attributed to the implementation of the directed plan of correction program, agency management staff strongly believe the program

has played a major role in improving care and achieving compliance throughout the state.

Feedback from providers and provider associations regarding the directed plan of correction program has been generally supportive. A favorable and unanticipated benefit of the program is that some provider corporations with more than one facility have indicated that directed plans developed for an individual facility have been implemented in each of their licensed facilities in order to establish uniform compliance practices and avoid repeat violations.

Surveyors also have been supportive of the program. In December 2006, 28 of 29 assisted living facility surveyors participated in a survey to provide feedback about the effectiveness of directed plans of correction. Seventy-six percent of those surveyors indicated that directed plans of correction are an effective enforcement strategy in assisted living settings.

Lessons Learned

Agencies interested in implementing a directed plan of corrections program similar to the one implemented in Wisconsin should begin by reviewing their state's existing statutes to explore whether they have the authority to issue directed plans of correction. If implementing such a program, it is valuable to explore ways of maximizing the shared interests and responsibilities of stakeholders to support the development of systems and processes in facilities to improve and sustain quality of care.

Agency management staff believe that key factors in the success of the directed plan of correction program are the dedication, persistence, and efficiency of the DQA Enforcement Specialist, the close collaboration of the Enforcement Specialist with various components of the Bureau of Assisted Living, and the support of the Enforcement Specialist by senior DQA management.

Contact Information

For further information regarding the directed plan of correction program at the Bureau of Assisted Living, Division of Quality Assurance at the Wisconsin Department of Health and Family Services, please contact Kevin Coughlin, Bureau Director, by e-mail at CoughKJ@dhfs.state.wi.us or by phone at 920/448-5255; or Lynnette Traas, Enforcement Specialist, by e-mail at TraasLM@dhfs.state.wi.us or by phone at 608/266-8542.

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