APPENDIX 8

BUREAU OF QUALITY ASSURANCE

BQA POST SURVEY QUESTIONNAIRE

ANNOUNCEMENT AND RESULTS

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via: Sinikka Santala, Administrator, DDES

From: Otis Woods, Deputy Director, BQA

cc: Susan Schroeder, Director, BQA
BQA Section Chiefs

Subject: Jan -March 2004 Post Survey Questionnaire Results

Background

On November 25, 2003, the Bureau of Quality Assurance (BQA) issued BQA Memo 03-015 titled *Introducing the BQA Post Survey Questionnaire,* in which we notified all providers that beginning January 1, 2004, BQA would submit a post survey questionnaire following the survey's exit or issuance of the survey report. By implementing this program, BQA was interested in how providers experienced the survey and licensing processes and whether the provider fully understood how their particular survey and its results affect them.

During the quarter, BQA sent the post survey questionnaire to approximately 400 entities. Of these, 108, or 27%, were returned to BQA staff. The scoring system or scale we established, allowing the provider to numerically evaluate each survey function or staff interaction, was as follows:

1	Strongly Disagree
2	Disagree
3	Neutral
4	Agree
5	Strongly Disagree
NA	Not Applicable

Results

We are pleased to report that the overall results of the first quarter results are positive.

- Response range is from 1 (strong disagreement) to 5 (strong agreement).
- Onsite survey process = 4.46.

- Statements of Deficiency – 4.26.
- Approximately 98% were satisfied with manner in which standard survey tasks were performed by BQA surveyors.
- 3 scores fell below 4, but were still between satisfactory (3) and agreement (4).
- Results were consistent across BQA regions and sections.
- Highest scores on single items were in areas of surveyor conduct and surveyor interactions with staff and clients.

Future

While overall ratings were primarily positive, a greater than 27% response rate is more beneficial and desirable in terms of evaluating BQA staff performance and conduct during on site reviews. Of primary concern are the 73% who did not return the questionnaire and their reasons for not responding. To target receiving a greater response rate for subsequent quarter reports, BQA will explore implementing ways of affecting a greater return, including:

- Discussing with provider associations the results of data and ask for assistance to increase the response rate;
- Conducting telephone interviews/discussions with providers following surveys where outcomes were negative;
- Issuing survey questionnaires to Nurse Aide Training programs;
- Developing a system to track phone calls to supervisors in BQA relative to survey activity and any issues related to them; and
- Compiling all information for the next quarterly summary

Summary

The first quarter results confirmed that BQA staff conduct surveys in a professional manner; are knowledgeable of the survey and information needed to conduct survey; and are respectful in their interaction with entity staff and residents/patients. While the results reflect positively on BQAs on-site reviews, and the interactions therein, we are striving to achiever a greater response to the survey questionnaire than 27% and will plan to communicate with industry and providers our goal of a greater response rate.

Respectfully submitted

Otis L. Woods, Deputy Director
BQA

Enclosures

Appendix A Results Analysis and Data Reports
Appendix B Compilation of Providers' Written Comments, by Program
Appendix C BQA Program Sections Responses to Survey Results for Each Section's Providers
Appendix D BQA Memo 03-015

The BQA Post-Survey Provider Questionnaire:
Results from the First Quarter, 2004

The Bureau of Quality Assurance has been giving health care providers the opportunity to supply feedback regarding the on-site surveys conducted by the Bureau since January 1, 2004. Providers were notified of this opportunity via numbered memo on November 25, 2003. The memo included a copy of the post-survey questionnaire, and surveyors now give a copy to each surveyed provider during the entrance conference or at the time the survey is completed. Providers may also retrieve a copy of the questionnaire from the DHFS website. The format of the questionnaire is the same for all types of providers, and consists of thirty-three items intended to gather information about providers' experiences and perceptions in three main areas: the on-site review process, the statement of deficiency, and the conduct of standard survey tasks. The questionnaire also includes space for brief comments on each item, and more extensive comments on the survey process and suggestions for improving the survey experience. Identifying information collected on each questionnaire includes the provider name, address, and type, the BQA region, the date and type of the survey, and the date the questionnaire was completed. Completion of the questionnaire as a whole and individual items within it is voluntary, and providers are expressly notified that anonymous submissions are allowed.

Through March 31, 2004, the Bureau received and processed 108 completed questionnaires. Thirty questionnaires were returned by long term care providers (nursing homes and FDDs), thirty-seven were returned by non-long term care providers (hospitals, hospices, home health agencies, AODA and mental health treatment providers, ESRDs, ambulatory surgery centers, and rural health clinics), and forty-one were returned by assisted living providers (adult family homes, adult day care centers, CBRFs, and residential care apartment complexes). Approximately 400 surveys of all provider types were conducted during this period; the completed questionnaires thus represent a "response rate" of about 25%. (There is no limit to the amount of time providers are given to submit a questionnaire following a survey, so it is possible that the eventual response rate will be greater than this.)

Responses were tabulated for all 108 questionnaires in the aggregate, and were also broken out by BQA region, BQA section, and provider type. "Ratings" of the on-site review process and statements of deficiency were calculated by averaging responses to the individual items within those sections of the questionnaire. Responses range from 1, indicating strong disagreement, to 5, indicating strong agreement, with various statements about the on-site reviews (e.g. "The survey process was clearly explained.") and statements of deficiency (e.g. "Deficiencies clearly explained the basis for findings of noncompliance."). Satisfaction scores for survey tasks were determined by calculating the percentage of respondents who indicated that various survey tasks (e.g. entrance conference, sample selection) had been performed in accordance with the applicable survey guide.

As shown in Table 1, overall ratings of the survey process and statement of deficiency were typically quite positive. On a scale of 1 to 5, with 5 being the highest rating, providers gave the on-site survey process an average rating of 4.46 and gave statements of deficiency issued a rating of 4.26. Nearly ninety-eight percent indicated they were satisfied with the manner in which standard survey tasks were performed. Results were similar when considered at the level of individual regions, BQA sections, or provider types. Only three scores fell below 4—a rating of 3.83 in the Southern Region with respect to statements of deficiency, and ratings of 3.97 and 3.62 from FDDs with respect to the on-site survey process and statements of deficiency, respectively. Similarly, only one group of providers—RCACs—expressed a level of satisfaction with survey task performance that fell below 90 percent. FDDs also expressed a relatively lower level of satisfaction with survey task performance, at just over 93%. It should be noted that, like several other provider types, FDDs and RCACs accounted for only a few questionnaires, so these results could change significantly once responses from additional providers are tabulated.

Table 2 shows average responses for each individual item in the questionnaire for the Bureau as a whole. Tables 3, 4, and 5 show average responses to each item for specific regions, sections, and provider types, respectively. The lowest scores on single items, when all questionnaires are considered together, were given in the areas of documentation of deficiencies and client/patient/resident reactions to the survey. However, most respondents still indicated that they at least agreed, if not strongly, with the statements "Deficiencies were documented by accurate information" and "Client/resident/patient reaction to the survey was positive." Responses to the items regarding survey task performance also suggest that client/patient/resident reactions to surveys may be an area deserving attention. A smaller proportion of providers—85 percent—indicated that client/patient/resident interviews were conducted according to the Survey Guide than said this about any other task. Whether this helps explain a relatively lower level of agreement among providers that clients, patients, and residents react positively to surveys cannot be determined from the questionnaire, but it is one possibility.

The highest scores on single items were given in the areas of surveyor conduct and surveyor interactions with staff and clients. Respondents indicated the strongest level of agreement (4.69 on a scale of 1 to 5) with the statements "The survey was conducted in a professional manner" and "Surveyor(s) interacted respectfully with facility staff and clients." Assuming these results hold up over time, they suggest that the great majority of providers do not have a problem with the demeanor of BQA surveyors, and that reports of negative interactions are either based on isolated occurrences or indicative of problems that are largely confined to the past.

When questionnaire responses are considered at the level of BQA regions and sections or individual provider types, the picture is largely the same. The lowest ratings were given in the areas of documentation of deficiencies and/or client/patient/resident reactions to the survey in four of five regions (Northeast, Southern, Southeastern, and Western), and in all three sections. The largest number of the different provider groups gave these areas their lowest ratings as well. The exception appears to be the Northern Region. The lowest ratings in this region were given to provider staff views of the survey, rather than client/patient/resident reactions, and to the extent to which deficiencies explained the basis for a finding of non-compliance, not whether they were accurate. The Northern Region also stands out for having the highest ratings given in areas other than surveyor demeanor and interactions. In the Northern Region, respondents agreed most strongly that surveyors explained the survey process and conducted it in a manner that did not interfere with delivery of care. In the other four regions, respondents continued to express the greatest agreement with the statements concerning surveyor professionalism and interactions with facility staff and clients. These areas also received the highest ratings across all three BQA sections and among seven of eleven different provider groups.

As providers continue to submit the post-survey questionnaires, BQA will have the opportunity to assess the durability of these preliminary results. It is certainly possible that the overall picture emerging during the first three months of this initiative could change. For now, however, it seems safe to say that providers have a generally favorable view of the way in which BQA performs surveys, and that they may be most particularly impressed with the conduct of surveyors themselves. If problems exist, they may involve documentation of deficiencies and client/patient/resident reactions to the survey. Even in these areas it is apparently a matter of providers being less positive than they are with respect to some other areas, not that they hold negative views.

Table 1: Bureau of Quality Assurance Post-Survey Provider Questionnaire First Quarter Summary Results, 2004				
		Overall Ratings*		
	Questionaires Returned	On-Site Survey Process	Statement of Deficiency	Percent Satisfied with Survey Task Performance
Aggregate Results	108	4.46	4.26	97.80
Northeastern Region	29	4.57	4.55	98.55
Northern Region	10	4.43	4.10	96.08
Southeastern Region	21	4.35	4.17	98.99
Southern Region	19	4.35	3.83	97.94
Western Region	29	4.49	4.46	96.77
Assisted Living Section	41	4.52	4.31	97.62
Health Services Section	37	4.50	4.25	96.81
Resident Care Review Section	30	4.32	4.23	99.02
Acute Care Hospitals	2	4.50		100.00
Adult Day Care	1	4.92	4.86	100.00
Adult Family Homes	9	4.76	4.44	99.03
AODA/MH	28	4.56	4.24	95.45
CBRF	27	4.45	4.24	98.68
ESRD	4	4.26	4.10	100.00
FDD	3	3.97	3.62	93.33
Home Health Agencies	2	4.27	4.29	100.00
Hospices	1	4.31	4.86	100.00
Nursing Homes	27	4.35	4.31	99.64
RCAC	4	4.35	4.00	86.36

* 1 = lowest, 5 = highest

Table 2: Post-Survey Questionnaire Responses, First Quarter, CY 2004			
Number of completed questionnaires	108		
	Average response (on a scale from 1 = Strongly Disagree to 5 = Strongly Agree)		
SECTION A. ON-SITE REVIEW PROCESS			
A1 Survey process was clearly explained.	4.53		
A2 Survey did not interfere with the delivery of patient/client/resident care.	4.50		
A3 Survey assisted in your understanding of rules/regulations.	4.19		
A4 Survey Guide was easy to understand and helpful during survey.	4.30		
A5 Survey was completed in a reasonable amount of time.	4.50		
A6 Survey time frames and plan of correction process were explained.	4.37		
A7 Provider/facility staff comments on the survey were positive.	4.31		
A8 Client/patient/resident reaction to the survey was positive.	4.09		
A9 Communication with surveyor(s) was ongoing during survey.	4.59		
A10 Provider/facility had opportunity to discuss preliminary survey findings with the surveyor/ supervisor.	4.65		
A11 Received knowledgeable response from BQA surveyor/supervisor if provider/facility requested clarification during survey process.	4.52		
A12 The survey was conducted in a professional manner.	4.69		
A13 Surveyor(s) interacted respectfully with facility staff and clients.	4.69		
SECTION B. POST-SURVEY STATEMENT OF DEFICIENCY			
B1 Deficiencies clearly explained the basis for findings of noncompliance.	4.43		
B2 Deficiencies identified who, what, when, where and how, if applicable.	4.44		
B3 Deficiencies included specific actions, errors or lack of actions to explain findings of noncompliance.	4.31		
B4 Deficiencies were documented by accurate information.	4.09		
B5 Deficiencies clearly and concisely explained noncompliance with rules/ regulations.	4.24		
B6 Documentation in deficiencies helped provider/supplier develop a plan of correction.	4.18		
B7 Changes in policies and/or procedures were made as a result of survey findings.	4.15		
SECTION C. SURVEY TASKS EVALUATION Were the following survey tasks carried out in accordance with the Survey Guide? Check Yes, No or NA for each task.	Yes	No	NA
CA Entrance conference	100	1	7
CB Sample selection	90	0	18
CC Technical Assistance	79	0	29
CD Observation	88	0	20
CE Home visits	30	1	77
CF Orientation tour	73	3	32
CG Assessment of applicable regulations	93	1	14
CH Environmental quality	78	2	28
CI Life Safety Codes	72	0	36
CJ Clinical record reviews	99	0	9
CK Staff interviews	89	4	15
CL Patient/client/resident interviews	64	11	33
CM Exit conference	101	1	6

Table 3: Post-Survey Questionnaire Responses by BQA Region, First Quarter, CY 2004	Northeast			Northern			Southeast			Southern			Western		
Number of completed questionnaires	29			10			21			19			29		
SECTION A. ON-SITE REVIEW PROCESS	Average response (on a scale from 1 = Strongly Disagree to 5 = Strongly Agree)														
A1 Survey process was clearly explained.	4.68			4.89			4.62			4.26			4.38		
A2 Survey did not interfere with the delivery of patient/client/resident care.	4.62			4.80			4.52			4.33			4.38		
A3 Survey assisted in your understanding of rules/regulations.	4.48			4.20			4.05			3.95			4.17		
A4 Survey Guide was easy to understand and helpful during survey.	4.37			4.30			4.05			4.18			4.50		
A5 Survey was completed in a reasonable amount of time.	4.62			4.30			4.38			4.53			4.52		
A6 Survey time frames and plan of correction process were explained.	4.48			4.33			4.25			4.17			4.48		
A7 Provider/facility staff comments on the survey were positive.	4.52			4.10			4.10			4.33			4.32		
A8 Client/patient/resident reaction to the survey was positive.	4.19			4.13			3.84			3.91			4.26		
A9 Communication with surveyor(s) was ongoing during survey.	4.66			4.60			4.52			4.53			4.62		
A10 Provider/facility had opportunity to discuss preliminary survey findings with the surveyor/supervisor.	4.67			4.50			4.57			4.58			4.79		
A11 Received knowledgeable response from BQA surveyor/supervisor if provider/facility requested clarification during survey process.	4.59			4.33			4.48			4.53			4.54		
A12 The survey was conducted in a professional manner.	4.86			4.50			4.57			4.63			4.69		
A13 Surveyor(s) interacted respectfully with facility staff and clients.	4.72			4.63			4.65			4.63			4.72		
SECTION B. POST-SURVEY STATEMENT OF DEFICIENCY															
B1 Deficiencies clearly explained the basis for findings of noncompliance.	4.67			4.20			4.46			4.07			4.53		
B2 Deficiencies identified who, what, when, where and how, if applicable.	4.67			4.20			4.23			4.33			4.53		
B3 Deficiencies included specific actions, errors or lack of actions to explain findings of noncompliance.	4.61			4.20			4.38			3.71			4.47		
B4 Deficiencies were documented by accurate information.	4.50			4.20			4.08			3.43			4.24		
B5 Deficiencies clearly and concisely explained noncompliance with rules/ regulations.	4.56			3.60			4.08			3.93			4.47		
B6 Documentation in deficiencies helped provider/supplier develop a plan of correction.	4.50			3.80			4.08			3.57			4.56		
B7 Changes in policies and/or procedures were made as a result of survey findings.	4.35			4.50			3.86			3.73			4.44		
SECTION C. SURVEY TASKS EVALUATION Were the following survey tasks carried out in accordance with the Survey Guide? Check Yes, No or NA for each task.	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
CA Entrance conference	26	1	2	9	0	1	18	0	3	18	0	1	29	0	0
CB Sample selection	25	0	4	8	0	2	15	0	6	15	0	4	27	0	2
CC Technical Assistance	19	0	10	7	0	3	15	0	6	16	0	3	22	0	7
CD Observation	22	0	7	8	0	2	17	0	4	15	0	4	26	0	3
CE Home visits	6	0	23	2	0	8	4	0	17	9	0	10	9	1	19
CF Orientation tour	15	0	14	8	0	2	15	0	6	16	0	3	19	3	7
CG Assessment of applicable regulations	25	0	4	7	0	3	18	0	3	17	1	1	26	0	3
CH Environmental quality	18	0	11	7	1	2	17	0	4	15	0	4	21	1	7
CI Life Safety Codes	18	0	11	8	0	2	13	0	8	12	0	7	21	0	8
CJ Clinical record reviews	29	0	0	10	0	0	17	0	4	17	0	2	26	0	3
CK Staff interviews	23	1	5	9	1	0	17	0	4	13	1	5	27	1	1
CL Patient/client/resident interviews	19	2	8	5	2	3	12	2	7	10	1	8	18	4	7
CM Exit conference	27	0	2	10	0	0	18	0	3	17	1	1	29	0	0

First Quarter, CY 2004	Assisted Living			Health Services			Resident Care Review		
Number of completed questionnaires	41			37			30		
	Average response (on a scale from 1 = Strongly Disagree to 5 = Strongly Agree)								
SECTION A. ON-SITE REVIEW PROCESS									
A1 Survey process was clearly explained.	4.55			4.44			4.60		
A2 Survey did not interfere with the delivery of patient/client/resident care.	4.63			4.51			4.33		
A3 Survey assisted in your understanding of rules/regulations.	4.27			4.30			3.97		
A4 Survey Guide was easy to understand and helpful during survey.	4.41			4.26			4.19		
A5 Survey was completed in a reasonable amount of time.	4.46			4.59			4.43		
A6 Survey time frames and plan of correction process were explained.	4.38			4.35			4.37		
A7 Provider/facility staff comments on the survey were positive.	4.40			4.42			4.04		
A8 Client/patient/resident reaction to the survey was positive.	4.26			4.00			3.93		
A9 Communication with surveyor(s) was ongoing during survey.	4.68			4.68			4.37		
A10 Provider/facility had opportunity to discuss preliminary survey findings with the surveyor/ supervisor.	4.65			4.75			4.52		
A11 Received knowledgeable response from BQA surveyor/supervisor if provider/facility requested clarification during survey process.	4.53			4.63			4.37		
A12 The survey was conducted in a professional manner.	4.76			4.73			4.53		
A13 Surveyor(s) interacted respectfully with facility staff and clients.	4.74			4.82			4.47		
SECTION B. POST-SURVEY STATEMENT OF DEFICIENCY									
B1 Deficiencies clearly explained the basis for findings of noncompliance.	4.45			4.47			4.37		
B2 Deficiencies identified who, what, when, where and how, if applicable.	4.48			4.35			4.48		
B3 Deficiencies included specific actions, errors or lack of actions to explain findings of noncompliance.	4.19			4.32			4.41		
B4 Deficiencies were documented by accurate information.	4.21			4.05			4.04		
B5 Deficiencies clearly and concisely explained noncompliance with rules/ regulations.	4.35			4.30			4.11		
B6 Documentation in deficiencies helped provider/supplier develop a plan of correction.	4.26			4.15			4.15		
B7 Changes in policies and/or procedures were made as a result of survey findings.	4.24			4.14			4.08		
SECTION C. SURVEY TASKS EVALUATION Were the following survey tasks carried out in accordance with the Survey Guide? Check Yes, No or NA for each task.	Yes	No	NA	Yes	No	NA	Yes	No	NA
CA Entrance conference	40	0	1	31	1	5	29	0	1
CB Sample selection	36	0	5	30	0	7	24	0	6
CC Technical Assistance	36	0	5	25	0	12	18	0	12
CD Observation	37	0	4	23	0	14	28	0	2
CE Home visits	19	1	21	7	0	30	4	0	26
CF Orientation tour	35	2	4	20	0	17	18	1	11
CG Assessment of applicable regulations	36	0	5	31	0	6	26	1	3
CH Environmental quality	35	2	4	21	0	16	22	0	8
CI Life Safety Codes	34	0	7	17	0	20	21	0	9
CJ Clinical record reviews	37	0	4	34	0	3	28	0	2
CK Staff interviews	38	1	2	23	3	11	28	0	2
CL Patient/client/resident interviews	28	5	8	9	6	22	27	0	3
CM Exit conference	40	0	1	32	0	5	29	1	0

First Quarter, CY 2004

	Acute Care Hospitals	Adult Day Care	Adult Family Homes	AODA/MH	CBRF	ESRD	FDD	Home Health Agencies	Hospices	Nursing Homes	RCACs
Number of completed questionnaires	2	1	9	28	27	4	3	2	1	27	4
SECTION A. ON-SITE REVIEW PROCESS	Average response (on a scale from 1 = Strongly Disagree to 5 = Strongly Agree)										
A1 Survey process was clearly explained.	5.00	5.00	4.67	4.48	4.52	4.25	4.33	4.00	4.00	4.63	4.33
A2 Survey did not interfere with the delivery of patient/client/resident care.	5.00	5.00	4.75	4.61	4.56	4.25	3.67	4.00	3.00	4.41	4.75
A3 Survey assisted in your understanding of rules/regulations.	4.50	4.00	4.56	4.39	4.26	3.75	4.00	4.00	4.00	3.96	3.75
A4 Survey Guide was easy to understand and helpful during survey.	4.00	5.00	4.89	4.39	4.27	3.67	4.33	4.00	4.00	4.17	4.00
A5 Survey was completed in a reasonable amount of time.	4.50	5.00	4.78	4.71	4.33	4.25	4.00	4.00	4.00	4.48	4.50
A6 Survey time frames and plan of correction process were explained.	5.00	5.00	4.56	4.36	4.33	4.25	4.00	4.00	4.00	4.41	4.00
A7 Provider/facility staff comments on the survey were positive.	4.00	5.00	4.78	4.52	4.27	4.25	3.33	4.00	4.00	4.12	4.25
A8 Client/patient/resident reaction to the survey was positive.	3.00		4.43	4.08	4.20	4.25	3.67	3.50	4.00	3.96	4.50
A9 Communication with surveyor(s) was ongoing during survey.	4.50	5.00	4.78	4.68	4.63	4.75	4.00	4.50	5.00	4.41	4.75
A10 Provider/facility had opportunity to discuss preliminary survey findings with the surveyor/ supervisor.	4.50	5.00	4.89	4.74	4.58	4.75	3.67	5.00	5.00	4.62	4.50
A11 Received knowledgeable response from BQA surveyor/ supervisor if provider/facility requested clarification during survey.	4.50	5.00	4.89	4.70	4.44	4.00	4.00	4.50	5.00	4.40	4.00
A12 The survey was conducted in a professional manner.	5.00	5.00	4.89	4.75	4.74	4.25	4.33	5.00	5.00	4.56	4.50
A13 Surveyor(s) interacted respectfully with facility staff and clients.	5.00	5.00	5.00	4.81	4.67	4.75	4.33	5.00	5.00	4.48	4.67
SECTION B. POST-SURVEY STATEMENT OF DEFICIENCY											
B1 Deficiencies clearly explained the basis for findings of noncompliance.	5.00	4.83	4.54	4.29	4.00	3.33	4.50	5.00	4.50	4.00	
B2 Deficiencies identified who, what, when, where and how, if applicable.	5.00	4.83	4.29	4.31	4.67	3.67	4.50	4.00	4.58	4.00	
B3 Deficiencies included specific actions, errors or lack of actions to explain findings of noncompliance.	5.00	4.20	4.31	4.14	4.00	4.00	4.50	5.00	4.46	4.00	
B4 Deficiencies were documented by accurate information.	5.00	4.20	4.14	4.17	3.33	3.00	4.00	5.00	4.17	4.00	
B5 Deficiencies clearly and concisely explained noncompliance with rules/ regulations.	5.00	4.80	4.29	4.15	4.00	3.00	4.50	5.00	4.25	4.00	
B6 Documentation in deficiencies helped provider/supplier develop a plan of correction.	4.00	4.20	4.14	4.33	4.00	4.00	4.00	5.00	4.17	4.00	
B7 Changes in policies and/or procedures were made as a result of survey findings.	5.00	4.00	4.00	4.27	4.67	4.33	4.00	5.00	4.05	4.00	

SECTION C. SURVEY TASKS EVALUATION Were the following survey tasks carried out in accordance with the Survey Guide? Check Yes, No or NA for each task.	Acute Care Hospitals			Adult Day Care			Adult Family Homes			AODA/MH			CBRF			ESRD			FDD			Home Health Agencies			Hospices			Nursing Homes			RCACs		
	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
CA Entrance conference	1	0	1	1	0	0	9	0	0	23	1	4	26	0	1	4	0	0	3	0	0	2	0	0	1	0	0	26	0	1	4	0	0
CB Sample selection	1	0	1	1	0	0	8	0	1	23	0	5	24	0	3	3	0	1	2	0	1	2	0	0	1	0	0	22	0	5	3	0	1
CC Technical Assistance	0	0	2	1	0	0	8	0	1	19	0	9	24	0	3	3	0	1	2	0	1	2	0	0	1	0	0	16	0	11	3	0	1
CD Observation	0	0	2	1	0	0	9	0	0	16	0	12	24	0	3	4	0	0	3	0	0	2	0	0	1	0	0	25	0	2	3	0	1
CE Home visits	0	0	2	0	0	1	6	0	3	3	0	25	11	0	16	1	0	3	2	0	1	2	0	0	1	0	0	2	0	25	2	1	1
CF Orientation tour	1	0	1	1	0	0	9	0	0	12	0	16	23	1	3	4	0	0	1	0	2	2	0	0	1	0	0	17	1	9	2	1	1
CG Assessment of applicable regulations	1	0	1	1	0	0	8	0	1	23	0	5	24	0	3	4	0	0	1	1	1	2	0	0	1	0	0	25	0	2	3	0	1
CH Environmental quality	0	0	2	1	0	0	9	0	0	14	0	14	23	1	3	4	0	0	2	0	1	2	0	0	1	0	0	20	0	7	2	1	1
CI Life Safety Codes	0	0	2	1	0	0	7	0	2	10	0	18	23	0	4	4	0	0	3	0	0	2	0	0	1	0	0	18	0	9	3	0	1
CJ Clinical record reviews	1	0	1	1	0	0	7	0	2	26	0	2	25	0	2	4	0	0	3	0	0	2	0	0	1	0	0	25	0	2	4	0	0
CK Staff interviews	1	0	1	1	0	0	8	0	1	15	3	10	26	0	1	4	0	0	2	0	1	2	0	0	1	0	0	26	0	1	3	1	0
CL Patient/client/resident interviews	0	0	2	1	0	0	5	1	3	2	6	20	20	2	5	4	0	0	2	0	1	2	0	0	1	0	0	25	0	2	2	2	0
CM Exit conference	1	0	1	1	0	0	9	0	0	24	0	4	26	0	1	4	0	0	2	1	0	2	0	0	1	0	0	27	0	0	4	0	0

DIVISION OF DISABILITY AND ELDER SERVICES

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Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DATE: November 25, 2003 **DDES-BQA – 03-015**

TO:

Ambulatory Surgery Center	ASC	03
Adult Day Care	ADC	03
Adult Family Homes	AFH	04
Ambulatory Surgery Centers	ASC	03
Certified Mental Health and AODA	CMHA	03
Community-Based Residential Facilities	CBRF	04
End Stage Renal Disease	ESRD	03
Facilities for the Developmentally Disabled	FDD	06
Home Health Agencies	HHA	05
Hospice Agencies	HSPCE	07
Hospitals	HOSP	08
Facilities for the Developmentally Disabled	FDD	06
Nursing Homes	NH	09
Outpatient Physical Therapy/Speech Pathology Services	OPT/OSP	02
Resident Care Apartment Complex	RCAC	04
Rural Health Clinic	RHC	02

FROM: Otis Woods, Deputy Director
Bureau of Quality Assurance

VIA: Susan Schroeder, Director
Bureau of Quality Assurance

Introducing the BQA Post Survey Questionnaire

OVERVIEW: This memo describes the new provider post survey questionnaire under which health-care facilities provide feedback to the Bureau of Quality Assurance (BQA) regarding their experience with the on-site reviews BQA conducts. FACILITIES MAY RESPOND ANONYMOUSLY. This procedure will take effect **January 1, 2004.**

In 2000, the Health Services Section within BQA began conducting post survey reviews to measure non-long term care providers' experiences with on-site survey processes and their outcomes. Results from these reviews have been informative. They provide an opportunity for BQA to address improvements necessary to ensure that providers understand survey processes and how surveys impact them. They also

indicate needed improvements to the Bureau's surveyor training programs. BQA will be expanding this continuous quality improvement methodology to all regulated providers beginning January 1, 2004.

The Bureau is very interested in how providers experience survey and licensing processes and whether the provider fully understands how their particular survey and it's results affect them. Questionnaire results will be kept separate according to each Bureau operating unit. BQA will also determine aggregate scores on a bureau-wide basis. Completing the survey questionnaire will be voluntary. We strongly encourage providers to complete and return the questionnaire to BQA.

Included with this memorandum is a copy of the post survey questionnaire that we will give to each provider. The method of delivery could be at the entrance conference initiating the on-site survey, or within a period of time following completion of an initial, annual or complaint survey conducted by BQA surveyors. The questions are not specific to a particular provider type and some may not pertain to your facility. When this occurs, please check the "N/A" box and proceed to the next question or group of questions. Also provided is an opportunity to comment on a specific area(s) of the survey. We welcome your narrative comments.

BQA is committed to continuous quality improvement. We expect it from the providers we regulate and we expect it of ourselves. We will use the information facilities submit to us through this questionnaire to review, revise and improve BQA systems and practices. Your participation is vital; we need to hear from you!

Enclosures

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2579 (Rev. 1-04)

STATE OF WISCONSIN
Bureau of Quality Assurance

POST SURVEY QUESTIONNAIRE

Completion of this form is voluntary. A copy of this questionnaire is available at http://www.dhfs.state.wi.us/forms/DDESNum.htm

Facility Name	Survey Date
Facility Address	Date Questionnaire Completed
BQA Region ☐ Southern ☐ Southeast ☐ Northern ☐ Northeast ☐ Western	Provider Type

SECTION A. ON-SITE REVIEW PROCESS

Use the following scale and check the number that applies.
5 = Strongly Agree 4 = Agree 3 = Neutral 2 = Disagree 1 = Strongly Disagree NA = Not Applicable

	5	4	3	2	1	NA	Comment if 1 or 2 is checked.
1. Survey process was clearly explained.	☐	☐	☐	☐	☐	☐	
2. Survey did not interfere with the delivery of patient / client / resident care.	☐	☐	☐	☐	☐	☐	
3. Survey assisted in your understanding of rules/regulations.	☐	☐	☐	☐	☐	☐	
Survey Guide was easy to understand and helpful during survey.	☐	☐	☐	☐	☐	☐	
Survey was completed in a reasonable amount of time.	☐	☐	☐	☐	☐	☐	
Survey time frames and plan of correction process were explained.	☐	☐	☐	☐	☐	☐	
Provider / facility staff comments on the survey were positive.	☐	☐	☐	☐	☐	☐	
Client / patient / resident reaction to the survey was positive.	☐	☐	☐	☐	☐	☐	
Communication with surveyor(s) was ongoing during survey.	☐	☐	☐	☐	☐	☐	
Provider / facility had opportunity to discuss preliminary survey findings with the surveyor / supervisor.	☐	☐	☐	☐	☐	☐	
Received knowledgeable response from BQA surveyor / supervisor if provider / facility requested clarification during survey process.	☐	☐	☐	☐	☐	☐	
The survey was conducted in a professional manner.	☐	☐	☐	☐	☐	☐	

	5	4	3	2	1	NA	Comment if 1 or 2 is checked.
13. Surveyor(s) interacted respectfully with facility staff and clients.	☐	☐	☐	☐	☐	☐	

SECTION B. POST-SURVEY STATEMENT OF DEFICIENCY

1. Deficiencies clearly explained the basis for findings of noncompliance.	☐	☐	☐	☐	☐	☐	
2. Deficiencies identified who, what, when, where and how, if applicable.	☐	☐	☐	☐	☐	☐	
3. Deficiencies included specific actions, errors or lack of actions to explain findings of noncompliance.	☐	☐	☐	☐	☐	☐	
4. Deficiencies were documented by accurate information.	☐	☐	☐	☐	☐	☐	
5. Deficiencies clearly and concisely explained noncompliance with rules / regulations.	☐	☐	☐	☐	☐	☐	
6. Documentation in deficiencies helped provider / supplier develop a plan of correction.	☐	☐	☐	☐	☐	☐	
7. Changes in policies and/or procedures were made as a result of survey findings.	☐	☐	☐	☐	☐	☐	

SECTION C. SURVEY TASKS EVALUATION

Were the following survey tasks carried out in accordance with the Survey Guide? Check Yes, No or NA for each task.

SURVEY TASK	Yes	No	NA	COMMENT
A. Entrance conference	☐	☐	☐	
B. Sample selection	☐	☐	☐	
C. Technical Assistance	☐	☐	☐	
D. Observation	☐	☐	☐	
E. Home visits	☐	☐	☐	
F. Orientation tour	☐	☐	☐	
G. Assessment of applicable regulations	☐	☐	☐	
Environmental quality	☐	☐	☐	

SURVEY TASK	Yes	No	NA	COMMENT
I. Life Safety Codes	☐	☐	☐	
J. Clinical record reviews	☐	☐	☐	
K. Staff interviews	☐	☐	☐	
L. Patient/client/resident interviews	☐	☐	☐	
M. Exit conference	☐	☐	☐	

Additional comments or information about the onsite survey process

commend one change that would improve the survey experience

pe of on-site survey conducted (please identify all that apply)

Medicare / Medicaid Certification ☐ Health
State Licensure / Certification ☐ Complaint Investigation
LSC / Physical Environment ☐ Other

DIVISION OF DISABILITY AND ELDER SERVICES

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Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

November 26, 2003

Dear Administrator:

Attached is the Bureau of Quality Assurance (BQA) Post Survey Questionnaire. The purpose of the questionnaire is to obtain data for a review of the survey system. Collecting the data will enable the Assisted Living Section to:

- evaluate provider/supplier experience with state and/or federal survey or complaint investigation processes,
- improve provider/supplier understanding of the regulatory process,
- ensure consistency in the application of rules and regulations, and
- foster positive oversight relationships.

Comments and responses to the questions will be used to evaluate and improve the quality of the survey process. Data provided in response to the questionnaire will not influence state licensure or certification status. The identity of the provider/supplier and survey staff will remain anonymous throughout analysis and interpretation of the data. Although every effort will be made to maintain anonymity, please be aware that the BQA Post Survey Questionnaire responses are subject to disclosure under the Open Records Law.

The Bureau believes your feedback is valuable. Please take a few moments to complete the questionnaire. After completing the questionnaire, please mail or fax it to:

Assisted Living Section
Attn: Colette Anderson
Bureau of Quality Assurance
2917 International Ln, Suite 210
Madison, WI 53704
FAX: (608) 243-2389

This survey tool is a bureau wide quality improvement effort. All questions may not apply to all provider types.

For additional information concerning the questionnaire contact the Bureau of Quality Assurance, Assisted Living Section at 608-243-2359. Thank you for taking time to respond and assist the Assisted Living Section to improve the survey process.

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF SUPPORTIVE LIVING

BUREAU OF QUALITY ASSURANCE
2917 INTERNATIONAL LANE,SUITE 300
MADISON WI 53704

Telephone: 608-243-2024
FAX: 608-243-2045
www.dhfs.state.wi.us

November 26, 2003

Dear Administrator:

Attached is the Bureau of Quality Assurance (BQA) Post Survey Questionnaire. The purpose of the questionnaire is to obtain data for a review of the onsite survey system. Collecting the data will enable the Health Services Section to:

- evaluate provider/supplier experience with state and/or federal survey or complaint investigation processes,
- improve provider/supplier understanding of the regulatory process,
- ensure consistency in the application of rules and regulations, and
- foster positive oversight relationships.

Comments and responses to the questions will be used to evaluate and improve the quality of the survey process. Data provided in response to the questionnaire will not influence state licensure or certification status. The identity of the provider/supplier and survey staff will remain anonymous throughout analysis and interpretation of the data. Although every effort will be made to maintain anonymity, please be aware that the BQA Post Survey Questionnaire responses are subject to disclosure under the Open Records Law.

The Bureau believes your feedback is valuable. Please take a few moments to complete the questionnaire. After completing the questionnaire, please mail or fax it to:

Health Services Section
Attn: Sandy Frank
Bureau of Quality Assurance
2917 INTERNATIONAL LANE, Suite 300
Madison, WI 53704
FAX: (608) 243-2026

This survey tool is a bureau wide quality improvement effort. All questions may not apply to all provider types.

For additional information concerning the questionnaire contact the Bureau of Quality Assurance, Health Services Section at (608) 243-2024, TTY: (608) 266-7376, or e-mail: PlichIthcareprov@dhfs.state.wi.us. Thank you for taking time to respond and assist the Health Services Section to improve the onsite survey process.

DIVISION OF DISABILITY AND ELDER SERVICES

BUREAU OF QUALITY ASSURANCE
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Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

November 26, 2003

Dear Administrator:

Attached is the Bureau of Quality Assurance (BQA) Post Survey Questionnaire. The purpose of the questionnaire is to obtain data for a review of the onsite survey system. Collecting the data will enable the Resident Care Review Section to:

- evaluate provider/supplier experience with state and/or federal survey or complaint investigation processes,
- improve provider/supplier understanding of the regulatory process,
- ensure consistency in the application of rules and regulations, and
- foster positive oversight relationships.

Comments and responses to the questions will be used to evaluate and improve the quality of the survey process. Data provided in response to the questionnaire will not influence state licensure or certification status. The identity of the provider/supplier and survey staff will remain anonymous throughout analysis and interpretation of the data. Although every effort will be made to maintain anonymity, please be aware that the BQA Post Survey Questionnaire responses are subject to disclosure under the Open Records Law.

The Bureau believes your feedback is valuable. Please take a few moments to complete the questionnaire. After completing the questionnaire, please mail or fax it to:

Resident Care Review Section
Attn: John Hess
Bureau of Quality Assurance
1 W. Wilson, Room 1150
PO Box 2969
Madison, WI 53701-2969
FAX: (608) 267-0352

This survey tool is a bureau wide quality improvement effort. All questions may not apply to all provider types.

For additional information concerning the questionnaire contact the Bureau of Quality Assurance, Resident Care Review Section at 608-266-8476. Thank you for taking time to respond and assist the Resident Care Review Section to improve the survey process.

Wisconsin Association of Homes and Services for the Aging, Inc.
204 South Hamilton Street • Madison, Wisconsin 53703 • 608-255-7060 • FAX 608-255-7064

June 24, 2004

To: State Senator Carol Roessler, Co-Chair
State Representative Suzanne Jeskewitz, Co-Chair
Members, Joint Legislative Audit Committee

From: John Sauer, Executive Director
Tom Ramsey, Director of Government Relations

Subject: Follow-up to Audit Report 02-021, Regulation of Nursing Homes and Assisted Living Facilities

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of 186 not-for-profit corporations principally serving the elderly and persons with a disability. WAHSA members own/operate 190 nursing facilities, including 45 county-operated facilities, 19 facilities for the developmentally disabled (FDD), 65 community-based residential facilities (CBRF), 48 residential care apartment complexes (RCAC), 12 HUD Section 202 Supportive Housing for the Elderly apartment complexes, and 103 apartment complexes for seniors who are able to live independently. WAHSA members offer over 300 community service programs ranging from homecare, hospice, Alzheimer's support and adult/child daycare to Meals on Wheels. Our members employ over 38,000 dedicated caregivers and support staff.

For background purposes, we have attached a February 5, 2003 memo providing WAHSA's response to Audit Report 02-21, which we presented to this Joint Committee at its 2/5/03 public hearing on this audit report. In addition, we have attached a March 18, 2003 letter to Representative Jeskewitz which we wrote jointly with the Wisconsin Health Care Association, that offers a list of suggested statutory changes which both organizations believe would improve the quality of care in our state's nursing homes and assisted living facilities.

Much has taken place since the legislative Audit Bureau (LAB) released its report on the regulation of nursing homes and assisted living facilities in December of 2002. And much of that has been positive. For instance:

- Responding to the demographics of elderly services and to the findings contained in Audit Report 02-21, the Bureau of Quality Assurance (BQA) in late 2002 created a new section whose primary focus is the oversight of assisted living providers (CBRF, RCAC, adult family homes and adult daycare).

- BQA Assisted Living Section Chief Kevin Coughlin and his staff meet every other month with assisted living providers, advocates and staff trainers to discuss issues of mutual interest. The BQA uses the participants of the Assisted Living Forum as a sounding board for future policy directives.

- With the creation of an Assisted Living Section in the BQA and the transfer to that section of eight nurses who formerly served as nursing home surveyors, many assisted living providers feared that the new assisted living section would be tainted with nursing home enforcement attitudes, philosophies, processes and regulations. In an effort to alleviate those fears, Kevin Coughlin agreed in 2003 to permit the new assisted living nurse surveyors to tour various assisted living facilities throughout the state and sit down with staff to discuss the differences they perceive between the nursing home regulatory environment and that found in assisted living.

- On January 1, 2004, the BQA Assisted Living Section began to implement a new survey process, one which focuses the Section's limited resources on poor performing facilities without neglecting the BQA's responsibility to residents in all assisted living facilities. This approach, we believe, could be invaluable on the nursing home side.

- WAHSA assisted living providers continue to cast a skeptical eye on any actions which might be construed as seeking to impose the nursing home regulatory environment on assisted living. We don't see those actions or efforts coming from the BQA; rather, they are being suggested by some within the Department of Health and Family Services (DHFS) who are working on reforming the overall long-term care delivery system. Some individuals believe many people currently living in nursing homes could be served effectively and more economically in assisted living. Most WAHSA not-for-profit members provide both nursing care and assisted living care so their concern in this possible shift is not based on fear of competition. Their fear is that many assisted living facilities are not equipped to adequately care for that higher acuity resident and if breaches in care follow, so, too, will nursing home-like regulations.

On the nursing home side, most of the changes suggested in the 3/18/03 letter to Representative Jeskewitz and sought by members of both nursing home trade associations were contained in 2003 Assembly Bill 842, authored by Representatives Pettis and Rhoades. They worked painstakingly for over a year with representatives from the two nursing home associations and the DHFS to craft a bill which each ultimately was able to support. (A copy of a February 19, 2004 WAHSA memo in support of AB 842 is attached). Some argued that AB 842 (a copy of the bill is attached) "deregulates" nursing homes and would weaken state regulations. However, that drew this response from Linda Dawson, deputy chief legal counsel of the DHFS, who told members of the Assembly Aging and Long-Term Care Committee at its 2/19/04 hearing on AB 842:

"We don't think it undermines our regulatory authority in any way."

Although AB 842 failed to reach the Assembly floor, we eagerly anticipate working on similar legislation with Representatives Pettis and Rhoades and with Linda Dawson and other representatives of the DHFS in the next session of the Legislature.

AB 842 really is a small example of a much larger issue, an issue where we may be on opposite sides from the LAB. And that is whether monetary penalties, whether called forfeitures, civil monetary penalties or the term of your choosing, can compel compliance or provide the necessary disincentive to ensure quality. WAHSA members argue they are not, especially at a time when over half the state's nursing homes are in some form of financial distress. How can a notice of a forfeiture assessment which arrives at a facility anywhere from 65 months to 2 years after the notice of violation has been received compel compliance? The vast majority of nursing home violations are based on human error. And, as was clearly pointed out by a number of caregivers at the February 19th hearing on AB 842, good care comes from people who care, not by those who are motivated by fear of sanctions.

Thank you for this opportunity to discuss once again Audit Report 02-21.

Wisconsin Association of Homes and Services for the Aging, Inc.
204 South Hamilton Street • Madison, Wisconsin 53703 • 608-255-7060 • FAX 608-255-7064

February 5, 2003

To: State Senator Carol Roessler, Co-Chair
State Representative Suzanne Jeskewitz, Co-Chair
Members, Joint Legislative Audit Committee

From: John Sauer, Executive Director
Tom Ramsey, Director of Government Relations

Subject: Wisconsin Legislative Audit Bureau Report 02-21, "Regulation of Nursing Homes and Assisted Living Facilities"

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of 198 not-for-profit corporations principally serving elderly and disabled persons through programs ranging from nursing home care to assisted living to hospice and homecare. On behalf of our not-for-profit members, we would like to commend the Legislative Audit Bureau (LAB) for its thorough handling of this complex subject. We are especially grateful to Kate Wade of the LAB and her team for their professionalism and for something so simple yet so important, their willingness to listen. The value of the report comes primarily from its balanced approach and that balance is a result of the LAB's drive to seek out and give voice to all sides of a given issue. From our perspective, a job well done.

We would like to present our response from two perspectives: First of all, to respond to what was in the report, to its recommendations; Secondly, we would like to respond to what was not in the report, or to issues the report touched upon but either provided no recommendations or refrained from taking a position.

Before getting into the specifics of the report, we would like to begin with one simple statement: The quality of care provided in the overwhelming majority of Wisconsin's nursing homes and assisted living facilities is excellent. The job of all of us is to do whatever we can to ensure that excellent care is provided in all long-term care (LTC) facilities. The failure of our current system is that it treats the good facilities the same as the bad and squanders scarce resources by so doing. Applying the same enforcement activities and actions on compliant facilities as are applied to non-compliant facilities is an inefficient use of those scarce resources and must be substantially modified if excellence in quality is to be achieved by all LTC providers.

LAB Recommendations in Report 02-21

1) **Assisted Living Survey Revisions:** On Page 37 of the report, the LAB writes that if the Legislature is not satisfied with the current regulatory process for assisted living facilities, it could: A) Establish standards for the frequency with which assisted living facilities should be inspected; B) Establish minimum qualifications for assisted living facilities inspectors; and C) Increase the number of staff assigned to inspect assisted living facilities by seeking additional federal funds, increasing facility licensure fees, or directing the Department of Health and Family Services (DHFS) to reallocate its existing resources OR direct the DHFS to develop technical assistance training programs to better enable assisted living facilities (ALF) to comply with regulations.

   WAHSA Response: Although WAHSA would not oppose these recommendations, it must be noted the DHFS Bureau of Quality Assurance (BQA) already has begun implementing these proposed changes. The internal directive of the BQA is to visit each ALF at least once every 24 months; their long range goal is to increase that to once every 18 months but that goal currently is unachievable because they do not have the staff to do so. It would be hypocritical of the Legislature to demand more frequent ALF compliance visits by the BQA without providing the funds necessary, or ensuring that the needed funds are available, to meet this demand. The BQA also has created a new Assisted Living Section with staff dedicated to assisted living. Among those new staff are nine nurses, eight from the Resident Care Review (nursing homes) Section and one funded through federal funds, which will provide both more and better qualified ALF surveyors. Finally, one of the new positions in the Assisted Living Section has been filled by a former ALF licensing specialist whose new responsibilities include the development of technical assistance training programs for both ALF surveyors and providers. The BQA appears to already be moving where the LAB suggests it be going.

   WAHSA members believe current statutes and codes provide the BQA with all the regulatory and enforcement tools they need to do their jobs. What the BQA does not have are enough people currently assigned to properly utilize those tools.

2) **Written Procedures for ALF Forfeitures:** On Page 48 of the report, the LAB recommends the DHFS establish a written procedure to guide the assessment of forfeitures for ALFs. The LAB argues ALF forfeitures are not based on written criteria such as statutes, administrative code or the DHFS' formal written policies. Rather, the LAB says regional and central office staff confer to determine forfeiture amounts based on a facility's compliance record and the DHFS' treatment of other facilities for similar violations. The LAB concludes that such a practice, which relies exclusively on the individual judgments of staff, could lead to inconsistencies.

   WAHSA Response: We disagree with the LAB's conclusion. Indeed, we believe current inconsistencies in citing practices often times are attributable to different interpretations of written procedures and the current DHFS system provides greater flexibility to assess ALF forfeitures more on a case-by-case basis.

3) **Diversion of ALF Forfeitures to the DHFS:** On Page 46 of the report, the LAB recommends the DHFS report to the Joint Legislative Audit Committee by March 1, 2003 on the number and percentage of FY 2000-01 and FY 2001-02 state nursing home citations eligible for forfeiture and awaiting review and for the percentage of a forfeiture that represents a reasonable estimate of the

DHFS' administrative costs related to assessing a forfeiture. A positive response to these queries could lead to the Legislature permitting a portion of the nursing home and ALF forfeitures to be directed to the DHFS rather than to the Common School Fund and allowing resources that currently support forfeiture assessment functions to be redirected to the regulation of long-term care.

WAHSA Response: We are neutral on this recommendation. On the one hand, we are leery of providing the DHFS with a perverse incentive to increase its own coffers by assessing more and larger forfeitures. On the other hand, we see absolutely no value to LTC residents to have LTC forfeitures deposited in the School Fund. We also oppose further funding of DHFS enforcement activities through increased licensure fees, which is simply a tax by another name of providers who can ill afford to divert their already scarce resources to non-resident care uses.

4) **Restrict Nursing Home Admissions:** On Page 50 of the report, the LAB quotes DHFS staff as saying that restricting new admissions to nursing homes or ALFs can be an effective enforcement option. The DHFS stated it has not imposed admissions restrictions on nursing homes because s.50.04 (4)(d), Wis. Stats., limits its ability to do so in a timely manner. The LAB recommends permitting the DHFS to restrict nursing home admissions in a more timely manner.

WAHSA Response: Before taking a position, we would have to see the definition of "in a more timely manner." The intent of the current statute was to ensure that a penalty as severe as restricting admissions was applied only for serious violations of state code or statutes. It must be kept in mind that this penalty is severe enough on the provider but it could be particularly devastating on the prospective resident seeking admission to the facility of his/her choice, especially in a rural setting where the next closest facility may be 50 miles from home and family. Further, in some cases the DHFS has sought severe penalties against nursing facilities for alleged deficiencies, only later to have the related citations overturned by appeal.

5) **Improvements in the Informal Dispute Resolution (IDR) Process:** On Page 59 of the report, the LAB notes that the DHFS has met its goal of making an IDR decision within 21 days of issuing a statement of deficiency in only 32.5% of its decisions between FY 1997-98 and FY 2000-01. In order to improve the timeliness of IDR decisions by the DHFS, the LAB recommends that the Department report to the Joint Legislative Audit Committee by July 1, 2003 on the effect of timeliness of returning responsibility for the IDR decision-making to regional managers, on the number of cases resolved through the IDR, and on the number of cases resolved through the IDR that were subsequently appealed.

WAHSA Response: WAHSA supports any actions which will improve the timeliness of IDR decision-making. Our concern is with who is making those decisions. The current system, with regional managers reviewing the decisions of their peer regional managers, certainly raises issues of objectivity. Instead, we support Recommendation #210 of Department of Health and Human Services (DHHS) Secretary Tommy Thompson's Advisory Committee on Regulatory Reform, which would require IDR programs to be conducted through an independent third party not connected to the state survey agency or to the nursing facility. The LAB notes on page 61 of the report that a pilot program utilizing this approach currently is being conducted in Iowa and Texas. Alternatively, if a truly independent process is not immediately implemented, WAHSA recommends that DHFS assign staff to administer the IDR process who do not directly supervise or oversee BQA surveyors or regional operations.

6) **60-Day Timeframe for Provider Appeals:** On Page 62 of the report, the LAB noted that Wisconsin law allows nursing home and assisted living providers ten days to file an appeal after receiving a statement of deficiency or a forfeiture assessment for violations of state regulations. However, 79.1% of the appeals filed in FY 1998-99 through FY 2000-01 were closed before those appeals hearings were held. In order to save those needless administrative expenses, the LAB recommends creating a 60-day timeframe for providers to file appeals after receiving statements of deficiency for state violations.

WAHSA Response: We support the LAB recommendation, which would parallel the federal appeals process.

What LAB Report 02-21 Did Not Say

In her December 13, 2002 issuance letter of this report to Senator George and (then) Representative Leibham, State Auditor Janice Mueller wrote: "Although both nursing homes and assisted living facilities are inspected by state staff, there are significant differences in the oversight provided. Nursing homes are inspected under a well-established process that is dictated by federal regulations designed to ensure quality, occurs frequently, and employs teams of inspectors that include registered nurses who evaluate resident care. In contrast, the regulatory system for assisted living facilities, which is controlled entirely by the State, is less-established, and each inspection typically involves a single inspector who is not required to have medical credentials."

On Page 19 of the report, a similar point is made: "Nursing home inspections typically involve a greater number of staff, with more education and prior long-term care experience, who are on-site for a longer period of time. Nursing homes also are inspected more frequently than assisted living facilities."

Inadequacies of the Nursing Home Survey System

The message, that the assisted living inspection and enforcement system should more closely mirror the nursing home system, certainly can be inferred from the LAB report. The problem is that very few of the individuals who are directly involved in the nursing home enforcement system – the regulators, providers and consumer advocates – are satisfied with that system.

Listed below are a few examples of that dissatisfaction:

- In an April 4, 2002 letter to DHHS Secretary Tommy Thompson seeking to pilot a modified nursing home survey process in Wisconsin, the signatories wrote: "The current survey process limits states' ability to allocate necessary resources to nursing homes experiencing significant problems. Our proposal allows Wisconsin the flexibility needed to improve the quality of care and quality of life for vulnerable nursing home residents to a greater extent than we are presently able to do so." The signatories included former Governor Scott McCallum; BQA Director Susan Schroeder; George Potaracke, the executive director of the Wisconsin Board on Aging and Long-Term Care; Tom Moore, the executive director of the Wisconsin Health Care Association; and WAHSA Executive Director John Sauer.

- A study of the federal survey process in New York State (a process similar to Wisconsin's because both are based on the same federal regulations) says the process- and paperwork-oriented survey

process threatens the care of New York's nursing home residents because caregivers and providers: A) Have trouble attracting and retaining staff, many of whom often quit rather than deal with the negative-focused, morale-eroding survey process; B) Cannot adequately compensate staff due to low government reimbursement levels; C) Have difficulty innovating and improving quality of care when burdened by an incoherent and inflexible regulatory system; and D) Have no hope of success when faced with a subjective and process-oriented, rather than an outcome-based, survey system. (The report, "Bad Medicine – How Government Oversight of Nursing Homes is Threatening Quality Care," was published in August 2001 by the New York Association of Homes and Services for the Aging, our New York State affiliate.)

- In a research paper supported by the Commonwealth Fund, "Regulating U.S. Nursing Homes: Are We Learning From Experience?" Kieran Walshe, a senior research fellow at the Health Services Management Centre at the University of Birmingham in the United Kingdom, outlined the failings of the U.S. nursing home survey system in a 2001 article in Health Affairs. In describing the characteristics of a survey system which "may have detracted from its effectiveness and contributed to its disappointing results," Walshe wrote: "At present, nursing home regulation exhibits few, if any, of the features of responsive regulation. Nursing homes are surveyed annually and treated similarly, regardless of whether they are good or poor performers – a 'cookie-cutter' approach that neither adequately rewards good-quality care nor deals forcefully enough with poor-quality care. Nursing home regulators have little scope to use their discretion and professional judgment in applying the highly prescriptive regulations and are actually prevented by the regulations from giving nursing homes advice or assistance."

- In a March 20, 2001 letter to DHHS Secretary Tommy Thompson on behalf of the Association of Health Facility Survey Agencies (AHFSA), the professional association of health facility licensure directors, H. Michael Tripple, the president of AHFSA and director of the Facility and Provider Compliance Division of the Minnesota Department of Health, listed a series of recommendations on ways to improve the DHHS' Nursing Home Initiative. One of those recommendations called for a deliberate discussion of nursing home regulation and alternatives to the current nursing home survey process. Tripple wrote: "Several states have been directed to look at alternatives to the current federal regulatory process. Minnesota and other states have requested waivers to create more effective survey procedures and have been denied due to the lack of waiver authority at both the Medicare and Medicaid levels. We realize that these discussions will be controversial. However, these discussions must start in order to better utilize resources as well as to encourage innovations at the state level. We are seeing increasing dissatisfaction among providers and consumers as to the scope and intensity of the current survey process. This dissatisfaction is often expressed to our Legislatures and there is increasing state pressure to change the survey process in ways that challenge and potentially conflict with current federal provisions. A deliberate discussion of the overall direction of regulation is essential."

- The issue is clearly laid out on Page 36 of the LAB report: "The Department, nursing home providers, and resident advocates have concerns that the nursing home inspection process, as prescribed by the federal government, limits the State's ability to focus resources on nursing homes that have histories of noncompliance with regulations or high rates of complaints. From FY 1997-98 through FY 2000-01, 49.6% of nursing home inspections and complaint investigations in Wisconsin resulted in no citations. Under current federal inspection requirements, states are to allocate the same

resources to compliant nursing homes as they allocate to nursing homes with long histories of noncompliance."

The federal nursing home survey process measures a facility's compliance with a set of minimum standards at a point in time; a deficiency-free survey simply means you are in compliance at that point in time with those minimum standards, not that you are providing quality care. It's a process that has been described above as ineffective, inflexible, inefficient, and paper- and process-oriented rather than outcome-based. It limits the ability of nurse surveyors to "be nurses," to share their expertise and experience to improve quality, by forcing them to become a form of healthcare police. Worst of all, it destroys the morale of the overworked, underpaid compassionate long term caregiver. Imagine a process in which the best you can possibly do is to be told you didn't mess up. Not that you're doing an excellent job in providing quality care, but that you didn't mess up "this time." Is it any wonder nursing homes are having difficulty in recruiting and retaining competent and compassionate staff? And why would we contemplate applying the tenets of the nursing home survey process to assisted living?

Our ability to change the federal nursing home survey process is admittedly limited but we will continue to do all in our power to bring about those needed changes. What we implore of the members of the Joint Legislative Audit Committee is to not allow the mistakes we've made in regulating nursing homes to be duplicated in assisted living. We need to use the flexibility of state regulation of assisted living to permit the efficient use of limited resources by focusing those resources on the poor performing assisted living providers and we need a regulatory environment in assisted living which focuses on collaboration and technical assistance for all other ALFs, using punitive compliance penalties only as a last resort.

Compelling Compliance and the Fixation on Forfeitures

The LAB report is replete with references to forfeitures and various ways to improve their assessment and collection. But the analysis never categorically states that the assessment of forfeitures and the imposition of other punitive measures is an effective tool to compel or entice compliance. Our assertion is there's no such empirical evidence and, at the very least, the question is open to debate.

In Kieran Walshe's paper mentioned above ("Regulating U.S. Nursing Homes: Are We Learning From Experience?"), Walshe notes that regulatory theorists often use two terms – "deterrence" and "compliance" – to describe the paradigms within which regulators work. "Deterrence regulators see the organizations they regulate as 'amoral calculators,' out to get what they can and willing to break the rules if they need to get away with it. As a result, their approach to regulation is formal, legalistic, punitive, and sanction-oriented," Walshe states. In other words, the nursing home survey process.

(Note: In a 2000 article in the University of California Press ("Regulatory Encounters: Multinational Corporations and American Adversarial Legalism"), Robert Kagan and Lee Axelrod argue that regulation is very much a product of the political, social, and economic environment and that approaches to regulation vary considerably among countries. "The United States is perhaps the foremost proponent of deterrence regulation and use this approach in many fields in which other countries use compliance approaches successfully," wrote Kagan and Axelrod, who categorize the American tradition of deterrence regulation as "adversarial legalism" and assert that it has high costs, a divisive and corrosive effect on relationships between organizations, and few compensating benefits.)

Walshe says, in contrast, "compliance regulators see organizations as fundamentally good, well-intentioned, and likely to comply with regulations if they can. Their approach to regulation is generally

more informal, supportive, and developmental, and they use sanctions only as a last resort." It is the compliance-regulator approach that WAHSA members would prefer to see used in assisted living, both because we believe it can work to ensure quality in LTC facilities and because we are certain the punitive nature of the current nursing home survey system has resulted in the failure of that system to ensure quality.

The point here is not to debate regulatory theorism; the point is there are differing viewpoints on the effectiveness of the type of deterrence regulation currently used to regulate nursing homes.

From the theoretical to the practical, the concerns we have with the reliance on forfeitures as a tool to compel compliance is there's no direct benefit to residents and it's forcing facilities in financial distress to pay fines they can't afford.

As the LAB report notes, forfeitures paid by nursing homes and ALFs are deposited in the Common School Fund; they cannot be used to help cure the ills that caused their imposition and cannot be used to improve the quality of care provided to residents. They are strictly and solely imposed as punitive measures; we see no empirical data, and the LAB report showed none, either, which indicates that the assessment of such forfeitures serves as a deterrent to acts of noncompliance. On the contrary, the imposition of forfeitures denies facilities resources they should be applying (and indeed should be forced to apply) to improve resident care.

These forfeitures, in many instances, are being assessed on facilities which have a limited ability to pay them. As noted on Page 44 of the LAB report, $1.3 million of the nearly $2 million in unpaid nursing home forfeitures as of May 7, 2002 were assessed against nursing homes which have filed for bankruptcy. In addition, the DHFS conducted an internal analysis at the end of last year which identified 192 nursing homes out of the 379 facilities analyzed as being at "financial risk:" 138 facilities were operating at a net loss, 111 facilities were operating with negative working capital, and 57 facilities were operating both at a net loss and with negative working capital. With their current financial status tied to an inadequate Medicaid reimbursement system and a perilous 2003-05 budget awaiting them, nursing homes simply can't afford to pay forfeitures to the state school fund at a time when their scarce resources are desperately needed to improve care at their facilities.

Resource Allocation Inefficiencies

We've discussed the inefficient use of scarce resources in a nursing home survey system which treats the good provider the same as the poor-performing provider. What we would like to see, and what the LAB report did not include, is what percentage of BQA surveyor resources were spent at what percentage of facilities. Were the dollars fairly evenly spent on a per facility basis or was a large percentage of those scarce surveyor dollars being spent on relatively few facilities?

Other Responses to the Report

1) On Page 4 of the report, the LAB states that 92.7% of the federal nursing home citations that were issued against Wisconsin nursing homes from FY 1997-98 through FY 2000-01 identified a "potentially" harmful situation "before any residents were harmed." Another way of stating this is only 7.3% of the citations issued during that time period were for situations that resulted in harm to residents, a figure that still is unacceptably high but indicative of the fact that the vast majority of citations are issued for situations where a resident was not harmed.

2) On Page 5, the LAB report states that the increases in the number of complaints against ALFs, the rate at which complaints are substantiated, and the relative infrequency of ALF inspections suggest that in contrast to nursing home regulation, the regulatory system for ALFs has reached a critical juncture. Once again, this assumes the nursing home regulatory system ensures quality, an assumption we do not accept. In addition, it seems to imply that compliance can be assured by "the numbers," i.e., the number of complaints and the number of inspections. Numbers can't define or determine quality; they don't tell how a resident is doing. What needs to be determined is the outcome of the care that a given resident is receiving and numbers alone can't tell that story.

3) If the assessment and collection of forfeitures is so needed to deter noncompliance, why did the BQA leave the forfeiture specialist positions vacant in 2000-01?

4) Table 20 on Page 58 of the report indicates 50.5% of the IDR decisions resulted in no change in the citation. Stated differently, the IDR process resulted in a change in the original citation 49.5% of the time. In school, that would be an "F."

5) In Appendix 4, the LAB determined there is no statistically significant relationship between the percentage of allowable costs reimbursed and a number of factors identified as being related to a nursing home's ability to provide quality care. That would be a logical conclusion since establishing any statistically significant relationship must be difficult when only 9.9% of the state's nursing homes were fully reimbursed for their allowable Medicaid costs in FY 2000-01, as noted on page 4-2 of Appendix 4 of the LAB report.

   Appendix 4 concludes by stating that data indicate that homes with more serious citations were generally reimbursed a higher percentage of their allowable Medicaid costs, indicating that the percentage of allowable costs reimbursed may not be the most important factor in determining whether a facility is able to provide the level of care that remains in compliance with federal regulations. Might the problem be that, for some of the 9.9% of facilities fully reimbursed for their Medicaid costs, they are able to comply with federal regulations but, for whatever reasons, have chosen not to? Or that they are fully reimbursed for their Medicaid costs but they need to spend more to ensure quality and they are either unwilling or unable to procure those additional funds? In these rare cases, full reimbursement for incurred MA costs is not the issue.

   For the vast majority of homes, the issue is how long can they continue to expend more revenues than Medicaid reimburses them. They are doing so now primarily by adjusting the rates they charge their private payors to subsidize that Medicaid underfunding. The question is: Is it fair to place that burden on private citizens paying for their own care and how much longer can those individuals continue to subsidize MA nursing home underfunding until they can provide that subsidy no longer? And when that time comes, what then of quality?

Regulating U.S. Nursing Homes: Are We Learning From Experience?

Nursing home regulation does not work very well, but we need to understand the reasons for its failings in order to improve it.

by Kieran Walshe

ABSTRACT: The quality of care in U.S. nursing homes has been a recurrent matter of public concern and policy attention for more than thirty years. A complex regulatory system of state licensure and federal certification is in place, but problems of poor quality and neglect and abuse of patients still appear to be endemic. This paper describes how the current system of regulation developed, examines its impact, and draws on the wider literature on regulation to outline some characteristics that may have detracted from its effectiveness and contributed to its disappointing results. Future regulatory reform should pay more attention to the lessons of regulation in other settings and make more use of research and formative evaluation.

FOR MORE THAN THIRTY YEARS the quality of care in nursing homes has been a recurring matter of public concern and debate in the United States. In the 1970s and 1980s researchers presented compelling evidence that the frail and vulnerable recipients of nursing home care were too often neglected, mistreated, or abused and that the system of nursing home regulation and licensure was largely ineffectual, failing to protect residents and to prevent quality problems.[1] In 1986 the Institute of Medicine (IOM) published an influential report that set out detailed recommendations for reforming the regulation of nursing homes, intended to bring about a major improvement in quality of care.[2] Those recommendations were largely accepted by Congress, enacted through the Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act (OBRA) of 1987, and have since been gradually implemented by the Centers for Medicare and Medicaid Services (CMS, formerly HCFA).[3]

It seems that the same quality problems that spurred calls for greater regulation in the 1970s and 1980s are still endemic in many

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nursing homes today.[4] Nursing home regulation remains the constant subject of policy attention, most recently via the Senate Special Committee on Aging, the Clinton administration's nursing home initiative, and the U.S. General Accounting Office (GAO), which has issued a stream of reports.[5] The IOM has just revisited nursing home regulation as part of a wider review of long-term care and has concluded that while regulation has brought some limited improvements in nursing home care, further reform is still needed.[6]

This paper briefly describes how nursing home regulation has developed in the United States from 1986 to the present and summarizes what is known about the impact of regulation on nursing home care. It then draws on the wider literature on regulation and its impact to outline some characteristics of nursing home regulation that may have detracted from its effectiveness and contributed to its rather disappointing results. The paper concludes that fundamental regulatory reform is needed but that greater attention should be paid to the lessons of regulation in other settings, and more use should be made of research and formative evaluation to improve the effectiveness of nursing home regulation.

The Development Of Nursing Home Regulation

More than 1.6 million Americans live in nursing homes, most of them elderly, frail, and vulnerable persons who are likely to live out the remainder of their lives there. Because of their physical or mental infirmity and their dependence on their caregivers, they are often not able to act as assertive, well-informed consumers. In 1999 the United States spent about $90 billion on nursing home care (about $55,900 per resident), and 60 percent of the cost was borne by states and the federal government through the Medicaid and Medicare programs.[7] The great majority of nursing homes (93 percent) are operated in the private sector, 67 percent of them by for-profit organizations, including a growing number of large corporations whose facilities house thousands of residents.[8]

Concern about quality of care in nursing homes can be traced back at least to the 1950s. Before the establishment of Medicare and Medicaid in 1965, there were essentially no federal standards regulating nursing homes, regulation was left up to the states, and standards varied widely. Although federal regulations were enacted once Medicare and Medicaid began to pay for nursing home care, they were inadequate in design, poorly implemented, and often unenforced by the federal and state agencies that shared regulatory responsibility. A succession of studies in the 1970s and early 1980s highlighted continuing serious problems with nursing homes' quality of care and were one reason that Congress asked the IOM in 1984

to investigate and recommend reforms.[9]

The IOM's 1986 report outlined proposals for a comprehensive and radical reform of regulatory arrangements.[10] The standards for nursing homes were to be revised to make them more focused on quality of care, more detailed and comprehensive in their coverage, and more explicit about the rights of residents. The survey or inspection process used to check compliance with the standards also was to be reformed, to make it less oriented toward paper records and structures and more focused on direct observation of care and communication with residents. A much broader range of enforcement mechanisms was to be introduced, including financial penalties, blocks on payment for new admissions or all residents, provisions to take over the management of failing homes, and ultimately termination of participation in Medicare/Medicaid. These reforms passed Congress with broad bipartisan support and were enacted as the Nursing Home Reform Act, part of OBRA 1987.

It took the CMS (then HCFA) three years to put into operation the regulations to implement OBRA 1987 and seven years to implement the regulations needed to put its regulatory enforcement mechanisms in place. Over that time political support for the OBRA 1987 reforms slackened, and although a number of proposals were brought forward in Congress in the mid-1990s aimed at repealing or weakening nursing home regulation, none were successful.[11] Even once the reforms were in place, a succession of GAO reports highlighted continuing quality-of-care problems in nursing homes and major flaws in OBRA's implementation and the management of nursing home regulation by the CMS. In response, the Clinton administration launched a nursing home initiative in 1998 aimed at improving the effectiveness of regulation.

The current regulatory arrangements are administratively complex but conceptually straightforward. The CMS is responsible for producing and maintaining federal regulations with which all homes that wish to participate in Medicare and Medicaid must conform. The state survey, licensing, and certification agencies are responsible for surveying or inspecting nursing homes to check their compliance with the regulations, investigating complaints, and reporting the results to the CMS. When deficiencies are identified, state agencies and the CMS regional offices share responsibility for taking enforcement action to make sure that nursing homes deal with the problems and come back into compliance. The CMS funds most of the costs of Medicare/Medicaid certification and oversees the performance of state survey agencies to make sure that the federal regulations are implemented appropriately. States also have their own licensing requirements, with which all homes (not just

those participating in Medicare and Medicaid) must conform. State regulations may parallel or exceed federal requirements and generally have separate provisions for licensing nursing homes, undertaking surveys or inspections, investigating complaints, identifying deficiencies, and taking enforcement action.

Impact Of Regulation On Performance

Although numerous studies have examined the implementation of nursing home regulation and the management of regulatory arrangements, these reports are of limited help in determining what impact regulation has had on nursing home performance and the quality of nursing home care.[12] The impact of regulation has not been much researched, in part perhaps because it presents several methodological challenges. First, the absence of any control or comparison group (since virtually all nursing homes are regulated) means that one can really only study changes in quality over time and attempt to determine whether those changes can be attributed to regulatory interventions.

Second, much of the data available on the quality of care in nursing homes are the product of the regulatory process itself, which means that changes in the process affect the data and are difficult to distinguish from underlying changes in quality. For example, changes in the deficiency rates found in nursing home surveys over time or variations in these rates across states may result from differences in the stringency, scope, or implementation of the survey process or from real differences in quality of care, and it is not possible to disentangle the two.[13] Third, the reliability, validity, completeness, and timeliness of much of the routinely available data (such as the Minimum Data Set data collected on every nursing home resident and the Online Survey Certification and Reporting, or OSCAR, database of survey findings) have been questioned, and some caution is needed in using such data.[14]

■ **Residents' physical condition.** Nevertheless, there is some evidence that the quality of care in nursing homes has improved greatly in many areas over the past ten to fifteen years and that at least some of that improvement has been brought about by the OBRA 1987 regulatory reforms.[15] For example, the inappropriate use of physical and chemical restraints has declined, as have rates of urinary incontinence and catheterization. Hospitalization rates also have fallen (which may be a good proxy for quality of care if poor care increases the risk of hospitalization). On the other hand, pressure sore rates have not changed; malnutrition, dehydration, and other feeding problems remain relatively common; and rates of bowel incontinence have risen slightly.

"The increasing dominance of the industry by major corporations may have been accelerated by nursing home regulation."

■ **Industry changes.** Nursing home regulation also may have had effects on the nursing home industry. For example, in other settings it has been found that regulation favors larger, multisite corporations over smaller, single-site, owner-operated businesses, because larger organizations can spread the fixed costs of regulation across a greater business volume and are more able to develop in-house skills in regulatory compliance.[16] Over the past decade the nursing home industry has become increasingly dominated by major corporations, the largest of which control hundreds of nursing homes and many thousands of beds. This trend may reflect the economics of nursing home provision but also may have been accelerated by nursing home regulation.

■ **Costs of regulation.** The costs of nursing home regulation are difficult to quantify. The CMS and the states spent $382.2 million in 2000 on running the state licensing and certification agencies that implement both federal and state nursing home regulations. This is only 0.4 percent of all spending on nursing home care and equates to about $22,000 per nursing home or $208 per nursing home bed.[17] However, these costs are probably only a small part of the overall costs of regulation, most of which fall on nursing homes themselves. First, nursing homes incur costs in dealing with the regulatory agencies, preparing for and hosting survey visits, gathering and providing data, responding to complaint investigations, and so on. Second, nursing homes incur costs when they are required to make changes to comply with the regulations. The experience of other sectors suggests that these interaction and compliance costs are probably greater than the regulatory agency costs outlined above, but there are no data available to allow these costs to be quantified.[18]

■ **Stakeholders' debate.** Most stakeholders in nursing home regulation—such as the CMS and state survey agencies, nursing home providers, consumer groups, researchers, and independent governmental evaluators—would concur that the OBRA 1987 reforms have brought some improvements in the quality of nursing home care, but beyond that, opinions fall broadly into two camps.[19] Some think that because many quality problems still exist, regulation should be tightened with tougher standards and more aggressive enforcement, and they argue for more frequent inspections, more use of sanctions and penalties, and more uniform and rigorous application of existing regulations. Others believe that the current

regulatory burden is already too great and that regulation has created a punitive, adversarial climate that is hostile toward quality improvement. They argue that regulation should be simplified and reduced, focused mainly on a smaller number of "problem" nursing homes, and reoriented toward a model based on cooperation and partnership between regulators and regulated organizations. There is little consensus among stakeholders about whether the benefits of nursing home regulation over the past decade outweigh its considerable costs. The debate has become polarized and politicized and, in the absence of robust empirical evidence on the effectiveness of regulation, is likely to remain so.

Learning From Regulation In Other Settings

A substantial literature exists on the use of regulation in a wide range of settings outside health care, including manufacturing industries, financial services, public utilities, and government agencies.[20] Although much research on regulation has been specific to particular countries, industries, or settings, a generic understanding of regulatory issues has begun to develop that offers many transferable concepts, models, and ideas.[21] However, it has been noted that most regulation tends to develop in isolation from similar regulatory initiatives or approaches in other settings, with little sense of a regulatory community able to share findings across sectors.

Over recent years a fast-growing literature has developed on regulation in health care, including the regulation of hospitals, managed care organizations, and the health care professions.[22] It appears that there is scope to make more use of this wider literature on regulation in health care and in other settings, both to review the progress of nursing home regulation to date and to influence its future development. To that end, I draw on this literature to outline six major problems in nursing home regulation and to explore how regulatory reform could improve the effectiveness of regulation in assuring and improving quality.

Problems Of Nursing Home Regulation

■ **Deterrence, compliance, and responsive regulation.** Regulatory theorists often use two terms—*deterrence* and *compliance*—to describe the paradigms within which regulators work.[23] In brief, deterrence regulators see the organizations they regulate as "amoral calculators," out to get what they can and willing to break the rules if they need to and can get away with it. As a result, their approach to regulation is formal, legalistic, punitive, and sanction-oriented. In contrast, compliance regulators see organizations as fundamentally good, well-intentioned, and likely to comply with regulations if they

can. Their approach to regulation is generally more informal, supportive, and developmental, and they use sanctions only as a last resort. Each approach has different advantages and disadvantages.

For example, deterrence regulation is likely to achieve change more quickly and may be more suited to situations in which the regulator is dealing with large numbers of heterogeneous organizations. However, it is usually more costly and can provoke defensive behavior by regulated organizations, which subverts the objectives of regulation. On the other hand, compliance regulation is cheaper, may achieve more change in the longer term, and may work better when dealing with a smaller number of more homogeneous regulated organizations. However, it can be easily undermined or circumvented by regulated organizations if they are determined to do so.

In practice, regulators often make use of a mixture of deterrence and compliance approaches. Robert Kagan and Lee Axelrad argue that regulation is very much a product of the political, social, and economic environment and that approaches to regulation vary considerably among countries.[24] The United States is perhaps the foremost proponent of deterrence regulation and uses this approach in many fields in which other countries use compliance approaches successfully.[25] Kagan and Axelrad characterize the American tradition of deterrence regulation as "adversarial legalism" and assert that it has high costs, a divisive and corrosive effect on relationships between organizations, and few compensating benefits.

Before 1987, American nursing home regulators were much criticized for doing too little to deal with persistent poor performance and widespread, long-standing quality problems. While approaches varied from state to state, many used a compliance model in which education and persuasion were seen as the main tools for improvement.[26] As a result, it was argued, some nursing homes flouted the regulations with impunity, regulators did not have sufficient powers to deal with such offenders, and so the whole process of regulation was brought into disrepute. Since the implementation of the OBRA 1987 reforms, nursing home regulation has developed most of the features of deterrence regulation, with great stress placed on developing and applying formal, written regulations; undertaking inspections or surveys; recording deficiencies and issuing citations; and enforcing regulation through the use of sanctions such as civil money penalties, denials of payment, or decertification. It is therefore not surprising that it suffers the problems of deterrence regulation, such as strained relationships between the various players in regulation, a defensive and uncooperative response to regulation from nursing home providers, and high regulatory costs. Despite its overt deterrence orientation, U.S. nursing home regulation still seems

"Responsive regulation might not reduce regulatory costs overall, but it would be a much better use of resources."

to be ineffective at dealing with many problems of persistent poor performance. It is interesting to note that nursing home regulation in other countries is generally less deterrence oriented, as is the regulation of other types of health care organizations in the United States.[27]

A number of regulatory theorists have argued in recent years for a more contingent or adaptive approach to regulation, and their ideas may have some relevance to the regulation of nursing homes. Called "responsive" or "smart" regulation, this approach seeks to find a more effective regulatory paradigm that combines some of the benefits of both deterrence and compliance regulation.[28] The main principle of responsive regulation is that regulatory methods and approaches should be adapted in response to the behavior of individual regulated organizations. A broad, graduated hierarchy of regulatory interventions and enforcement actions is used, and while most regulation takes place at lower levels, the regulator has the capacity and the will to use higher-level interventions and actions if need be. In this way, most of the benefits of compliance regulation—such as cooperation, information sharing, negotiated agreement, and low regulatory costs—are retained, but the powerful incentives and sanctions of deterrence regulation are still available.

At present, nursing home regulation exhibits few, if any, of the features of responsive regulation. Nursing homes are surveyed annually and treated similarly, regardless of whether they are good or poor performers—a "cookie-cutter" approach that neither adequately rewards good-quality care nor deals forcefully enough with poor-quality care. Nursing home regulators have little scope to use their discretion and professional judgment in applying the highly prescriptive regulations and are actually prevented by the regulations from giving nursing homes advice or assistance. It seems that there is considerable scope to make use of the ideas of responsive regulation to create regulatory arrangements for nursing homes that would be less focused on deterrence, more capable of monitoring and discriminating between nursing homes on the basis of their performance, and more able to tailor regulatory interventions to the performance needs of individual nursing homes. This might not reduce regulatory costs overall, and would mean investing more in regulating poor-quality nursing homes, but it would be a much better use of regulatory resources.

■ **Regulatory fragmentation.** Regulation is sometimes fragmented, with different agencies responsible for different functions or performance areas and even some direct overlap of oversight. Regulatory fragmentation may result in duplication, an increased regulatory burden and higher regulatory costs, and some conflict or confusion between the requirements of different regulators. It also may weaken regulatory oversight, because no one agency has either all of the information needed to assess performance or complete responsibility for dealing with performance problems.[29]

The regulation of nursing homes is fragmented in three ways. First, although federal responsibility rests with the CMS, it is split between the central agency and its regional offices, which deal separately with developing and promulgating regulations and setting guidance for state survey agencies, on the one hand, and with financing, contracting with and overseeing state survey agencies, and enforcing regulations, on the other. These responsibilities are only brought together at the level of the CMS administrator, and there is good evidence that this fragmentation causes communication problems and reduces the effectiveness of regulation.

Second, regulatory responsibility is split between the CMS and the state survey agencies, and the relationship does not appear to be an easy one, marked more by bureaucratic direction and dissonance than by real interagency dialogue or collaboration. The CMS sets out in excruciating detail in its *State Operations Manual* what it expects state agencies to do, but those agencies struggle to fulfill their mandate in the real world within the resources that the CMS allocates to them.[30] State survey agencies have a dual accountability—to the CMS and to their state government—so conflicts can and do arise. The CMS is meant to oversee the performance of state agencies but has done little to monitor them and in any case has limited powers to do anything about performance problems.

Third, there is really not one system of regulation, but two—federal certification and state licensure—running side by side. This results in some duplication, occasional conflicts, and considerable confusion. For example, when state survey agencies find a deficiency at a nursing home, they may choose to pursue it through state or federal enforcement mechanisms, or both.

The current level of fragmentation creates unnecessary complexity for regulators and for nursing homes, probably reduces the effectiveness of regulation, and certainly increases its costs. These regulatory structures are an accident of history; they reflect the gradual and piecemeal development of state and federal regulatory arrangements since 1965. A simpler regulatory structure with one regulator would probably be much more efficient and effective. However, im-

provements could be made to the current system of regulation by simplifying and bringing together responsibility within the CMS and taking steps to develop a more proactive and productive relationship between the CMS and the state survey agencies.

■ **Clarity and priority of the regulatory mission.** While some regulators are agencies established for the purposes of regulation, others undertake regulation as one of a number of related activities. There can be some benefits to integrating the regulatory function with other responsibilities, but the main disadvantage is that the clarity and priority of the regulatory mission may be compromised when the agency trades off regulatory objectives against other objectives. Regulatory organizations for which the regulatory mission is not clouded by a host of other competing nonregulatory objectives (such as the Food and Drug Administration or the Occupational Safety and Health Administration) may be more likely to be effective regulators because they can focus on a clear regulatory mission.

Nursing home regulation is only one responsibility among many for the CMS and for the state government departments in which the state survey agencies are located. It competes for attention with a multitude of other policy priorities, and it tends to be seen as a rather unexciting, unglamorous, and low-profile function. In these circumstances, it is likely that nursing home regulation will always struggle to secure resources and gain sustained policy attention unless it is forced up the policy agenda by external influences such as pressure from consumer groups or independent evaluators.[31] This problem of prioritization may be one of the reasons why the implementation of the OBRA 1987 reforms proceeded so slowly (with the CMS taking seven years to introduce some regulations). Reorganizing responsibility for nursing home regulation within the CMS could help to provide greater clarity of mission, but putting nursing home or long-term care regulation in the hands of a separate agency would probably be the most effective way to ensure that the issue gets the attention it deserves. The same problems may exist at the state level, especially when nursing home regulation is one relatively small function of a much larger entity. It might not be feasible to have a separate state agency for nursing home regulation except in the largest states, but it would be possible to reorganize responsibility for nursing home regulation to give it greater visibility and policy attention.

■ **Balancing independence and accountability.** Regulators have to be held accountable for what they do, and public regulatory agencies are generally made accountable by reporting, directly or indirectly, to an elected legislative body. However, regulators sometimes need to take actions that may be politically unpopular or that may arouse the opposition of important stakeholder groups, and in

these instances they need some degree of freedom to act without interference. In any case, a regulator's credibility with stakeholders may depend upon its perceived independence from sectional interests and its ability to act as a nonpartisan "honest broker." Regulatory governance arrangements therefore need to provide a balance of accountability and independence.

Nursing home regulation has become highly politicized, and various stakeholders attempt to influence the regulators and to shape the legislative framework for regulation. For example, nursing home providers have made large political contributions; in some states nursing home providers are prominent in the local political party hierarchies; and some state and federal legislators have substantial financial interests in nursing home care. On the other hand, there are powerful, well-organized national and state consumer and citizen groups that often run influential campaigns. Legislators at both the state and federal levels have taken a close interest in the work of nursing home regulators, held hearings and commissioned reports from evaluators, and sought to influence both, either directly through new legislation or indirectly by controlling the resources made available to run the regulatory agencies. While this kind of attention may be an inevitable result of the political process, it does not necessarily make for effective regulation. Regulators working in the glare of political and public attention tend to be highly cautious, risk-averse, and overinfluenced by the likely political and public response to their actions. Although it is perfectly legitimate and desirable that providers, consumers, legislators, and other stakeholders should be involved in shaping the regulatory process, nursing home regulators need to be freed up to do their jobs without undue interference.

Regulatory accountability is also an important guard against having the regulatory process be "captured" by any one sectional group or interest, most commonly the organizations that are being regulated. However, it can be argued that nursing home regulation has been captured, not by the providers but by the payers for nursing home care. The CMS and state governments act both as regulators of nursing homes and as funders (through Medicare and Medicaid) of 60 percent of the costs of nursing home care. If the CMS, as regulator, makes changes in the regulations that will cost money to implement, then the CMS, as funder, comes under pressure to increase reimbursements. The current debate about whether federal regulations should be amended to set minimum staffing ratios for nursing homes is an illustration of this problem. Some estimates suggest that federal minimum staffing ratios could increase the costs of nursing home care by $3–$15 billion a year, depending on where the mini-

"Regulatory alignment might be improved if measures were taken to increase competition on quality grounds."

mum staffing level is set, and the nursing home industry has been quick to assert that Medicare and Medicaid should be ready to increase reimbursement levels accordingly.[32] While affordability is an important issue, and the costs and benefits of any regulatory changes should be carefully analyzed, it is probably unhealthy for the regulatory process to be so completely in the hands of a single interest group. A more balanced model of regulatory accountability might involve the separation of regulatory and funding responsibilities in state and federal government agencies and the provision of a formal role for a wider range of stakeholders such as consumer groups, provider associations, educators, and researchers in holding nursing home regulators accountable for their performance.

■ **Regulatory alignment.** Regulation is most effective when the requirements or objectives of regulatory agencies are aligned with other influences on the behavior of regulated organizations. For example, regulatory compliance with environmental health standards among food producers is generally good, because the producers recognize that any major food-related disease outbreak can result in great harm to their commercial interests, such as loss of market share and damage to their public image and reputation. Alain Enthoven argues for a "procompetitive" approach to health care regulation in market situations, in which, as far as possible, the regulatory regime is designed to reinforce or complement existing market incentive structures or influences on regulated organizations.[33]

However, for nursing homes, the pressures of the marketplace are not well aligned with the objectives of regulation.[34] While nursing home regulation attempts to promote high quality of care, the market does not seem to reward nursing homes that provide such care. First, restrictions on nursing home developments have weakened competition by constraining supply in many areas, even though occupancy statistics now suggest that there is some excess capacity overall.[35] Second, nursing home consumers (potential residents, their families, and caregivers) are poorly equipped with information to compare quality among nursing homes. Thus, their choices are often driven mainly by the proximity of the home to family members. Once they are residents of a home, their dependence on it makes it difficult to speak out about quality problems, and it is difficult for them to move if the quality of care does not meet their expectations. Third, the financial pressures on nursing homes from

low rates of Medicaid reimbursement have driven many to reduce their spending to sustain their profits.

When regulatory objectives and market pressures collide, as they do for nursing homes, organizations will often attempt to reconcile the conflicting pressures, but ultimately the stronger market pressures are likely to prevail. For nursing homes, regulatory alignment might be improved if measures were taken to increase competition on quality grounds and to provide greater financial incentives to provide good-quality care. Regarding competition, initiatives that offer nursing home consumers much more information about the facilities when they are making their initial choice would be helpful, and some examples already exist. It also would be useful to make it easier for residents to change nursing homes. Regarding incentives, some measures of quality need to be incorporated into the complex prospective payment system for Medicare and Medicaid so that a proportion of reimbursement is dependent on the quality of care. This is not an easy task, but it is disappointing that past experiments with quality-based reimbursement have never been implemented widely, despite their promising results.[36]

■ **Regulatory tripartism.** The relationship between a regulator and a regulated organization is not simply bilateral. Many other stakeholders have an interest or involvement in the organization's performance, and it has been argued that regulatory arrangements should be designed to make use of or co-opt these other groups for the purposes of regulation—an approach that is called *tripartism.* For example, workers in a manufacturing firm have a strong self-interest in good workplace safety arrangements, and so occupational safety and health regulations often require manufacturers to have some kind of formal employee involvement and representation in workplace safety structures and processes. In this way, workers and their representatives are brought into the regulatory process, where they can be an important source of information to the regulator and can help to promote regulatory compliance. Regulatory agencies have very limited resources in comparison with the organizations they regulate, and even the most intensive approaches to regulatory oversight are unlikely to involve regulators in inspecting more than a small proportion of the activities they oversee. Tripartism provides a mechanism by which regulators can extend their oversight by using other stakeholders as informants and can secure greater regulatory compliance by using those stakeholders to pressure regulated organizations to change.

Many formal and informal nursing home stakeholders have an interest in the regulatory process. Residents and their families hold perhaps the greatest stake in assuring good quality of care, but

consumer and citizen groups, staff unions and associations, provider groups (including nursing home associations and corporate owners of chains or networks of nursing homes), and other health care organizations and professions (such as hospitals, social workers, and physicians) also interact with nursing homes, and a federally funded network of long-term care ombudsmen oversees nursing home care.[37]

Current nursing home regulatory arrangements are mainly structured bilaterally, around the relationship between the regulator and the nursing home, and they make relatively little use of these other interest groups. While nursing home regulators do interview residents and staff as part of their regular surveys and will respond to and investigate complaints from any source, there is no formal regulatory requirement for any other stakeholder involvement. Regulators could make more use of tripartism by requiring nursing homes to have strong resident and family councils and providing more support for them; by providing more resources for the admirable but chronically underfunded long-term care ombudsman program and doing more to link it up with resident and family groups in nursing homes; by requiring nursing homes to have forums in which workers can raise quality problems and by safeguarding "whistleblower" employees who express legitimate concerns about quality; and by incorporating more extensive consultation with stakeholders into the nursing home survey process.

NURSING HOME REGULATION IS CLEARLY NECESSARY, but not all regulation is good and effective. It seems that although the OBRA 1987 nursing home reforms have achieved some important quality improvements, there is too little evidence to be able to determine whether the benefits justify the costs. The current regulatory arrangements could be improved, and regulatory experience in other settings may offer some valuable insights. Even so, there is clearly a need for more research aimed at developing a better understanding of the costs and effects of different regulatory methods and so informing regulatory policy.

For the future, further regulatory reform for nursing homes is probably inevitable. The IOM has recently recommended a number of changes, including a greater focus on providers that are chronically poor performers (by using more frequent surveys and increasing penalties); more CMS monitoring of the regulatory process to ensure that regulations are applied consistently; and more research into whether regulation has sufficient resources.

However, it can be argued that more fundamental reforms to the current regulatory arrangements are needed that are less focused on

changing the regulations and more concerned with reforming the regulators themselves and changing the culture of the regulatory process. For example, future reforms could include a shift toward a more responsive approach to regulation; changes to the structure of the CMS and the state survey agencies to reduce fragmentation, focus their regulatory mission, and improve regulatory governance; the alignment of regulatory and other incentives for nursing home providers; and the incorporation of a wider range of stakeholders into the regulatory process. Whatever changes are made, it is important that they be properly evaluated.

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NOTES

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