COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

July 25, 2007

The Honorable Stephanie Takis, Chair
Legislative Audit Committee
Legislative Services Building
200 E. 14th Avenue
Denver, CO 80203

Dear Senator Takis:

This submission is in reference to the June 19, 2007 letter from Sally Symanski requesting follow-up on actions taken by the Department of Health Care Policy and Financing regarding the Nursing Facility Quality of Care Performance Audit released in February 2007.

Please see the enclosed response and if you have any questions, feel free to contact Laurie Simon, the Audit Section Coordinator at 303-866-2590.

Sincerely,

Joan Henneberry
Executive Director

JH:las

cc: Representative James Kerr, Vice-Chairman, Legislative Audit Committee
Representative Dorothy Butcher, Legislative Audit Committee
Senator Jim Isgar, Legislative Audit Committee
Representative Rosemary Marshall, Legislative Audit Committee
Representative Victor Mitchell, Legislative Audit Committee
Senator Nancy Spence, Legislative Audit Committee
Senator Jack Taylor, Legislative Audit Committee
Sally Synanski, Office of the State Auditor
Donna Kellow, Manager, Audit Section
Laurie Simon, Audit Coordinator, Audit Section

Enclosures

Department of Health Care Policy and Financing
Responses to Nursing Facility Quality of Care Report
July 25, 2007

Recommendation # 10a:

The Department of Health Care Policy and Financing should improve the oversight of nursing facility resident assessments and Minimum Data Set (MDS) data by:

a. Working with the Department of Public Health and Environment to conduct more systematic review and analysis of standard reports available in the electronic MDS system and data maintained by its contract auditor on resource utilization group classifications to identify those facilities that are at higher risk of submitting invalid assessments and, therefore, warrant further attention during rate-setting. (See also Recommendation 9b.)

Department of Health Care Policy and Financing Response for Recommendation # 10a:

Agree. Implementation Date: December 31, 2007.

The Department will work collaboratively with CDPHE's surveyors to identify and investigate problems noted with MDS assessments.

July 2007 Follow-up to Department of Health Care Policy and Financing's Response to Recommendation # 10a:

In progress.

The Department of Health Care Policy and Financing (the Department) met with representatives of the Colorado Department of Public Health and Environment (CDPHE) to develop a strategy and methodology to conduct a more systematic review and analysis of available Minimum Data Set (MDS) reports and data. Department staff has also taken MDS training through CDPHE and the Colorado Health Care Association. The Department is also making arrangements for a staff member to become a certified MDS coordinator. In addition, Department staff is contacting other states to develop a 'Best Practices' approach to MDS validation.

Recommendation # 10b:

The Department of Health Care Policy and Financing should improve the oversight of nursing facility resident assessments and Minimum Data Set (MDS) data by:

b. Working with the Department of Public Health and Environment (CDPHE) to require that MDS coordinators at all Medicaid-certified nursing facilities

Department of Health Care Policy and Financing Response for Recommendation # 10c:

Agree. Implementation Date: December 31, 2007.

The Department will work collaboratively with DPHE and policy-making bodies to evaluate options for the development and implementation of a state validation team to perform routine on-site reviews of nursing facilities' MDS assessments of Medicaid residents. The Department currently does not have resources dedicated to this task.

July 2007 Follow-up to Department of Health Care Policy and Financing's Response to Recommendation # 10c:

In progress.

The Department will continue to meet with CDPHE to discuss options for developing and implementing the most effective means for evaluating MDS data.

Recommendation # 12a:

The Department of Health Care Policy and Financing should improve its oversight of nursing facilities to ensure compliance with federal and state requirements for managing resident fund accounts. Specifically, the Department should:

a. **Develop and implement an audit program consistent with its existing authority to conduct more routine audits of resident fund accounts managed by nursing facilities participating in Medicaid. This audit program should be risk-based and consider factors that identify the need to audit resident fund accounts prior to a change in facility ownership.**

Department of Health Care Policy and Financing Response for Recommendation # 12a:

Agree. Implemented November 2006.

A risk-based audit program was developed and put into place in November 2006.

July 2007 Follow-up to Department of Health Care Policy and Financing's Response to Recommendation # 12a:

Completed.

A risk-based audit program was developed and put into place in November 2006. The Department has included in its risk-based audit program a step to audit 100 percent of the personal needs account balances. The Department's current staffing will allow all facilities to be audited every four years.

Department of Health Care Policy and Financing Response for Recommendation # 12c:

Agree. Implementation Date: March 31, 2007.

The Department will work with the Department of Public Health and Environment to coordinate and communicate information between the two departments to minimize any duplication of monitoring efforts.

July 2007 Follow-up to Department of Health Care Policy and Financing's Response to Recommendation # 12c:

In Progress.

Department staff met with CDPHE on July 17, 2007, and will meet in August. The two Departments will develop protocols for CDPHE to follow during the survey process to identify deficient resident fund account management practices. When deficient practices are noted, CDPHE will make referrals to the Department.

Recommendation # 16a & # 16b:

The Department of Health Care Policy and Financing should address problems related to nursing facility resident assessments and the implementation of a quality allowance as part of the feasibility study required by Senate Bill 06-131. At a minimum the Department should:

a. **Incorporate the intent and provisions of Recommendation No. 10 into any recommendations for a new reimbursement system where resident acuity is used as a factor in establishing nursing facility Medicaid reimbursement rates.**

b. **Review academic literature, other states' practices, and past experiences in Colorado to develop a methodology that addresses those factors critical to the successful implementation of a quality allowance when reimbursing nursing facilities under Medicaid. This should include developing measures of resident outcomes that are valid, reasonable, quantifiable, and auditable.**

Department of Health Care Policy and Financing Response for Recommendation # 16a and # 16b:

Agree. Implementation Date: July 1, 2008.

The Department will incorporate the recommendations in Recommendation No. 10 as part of the feasibility study.

As part of its ongoing commitment to develop a price-based reimbursement methodology, a workgroup consisting of nursing facility representatives, advocacy organizations and

STATE OF COLORADO

Bill Ritter, Jr., Governor
James B. Martin, Executive Director

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Colorado Department
of Public Health
and Environment

July 25, 2007

The Honorable Stephanie Takis, Chairperson
Legislative Audit Committee
c/o Office of the State Auditor
200 East 14th Avenue
Denver, CO 80203-2211

Subject: Status of Implementation of the Recommendations Set Forth in the Nursing Facility Quality of Care Performance Audit, Dated February 2007

Dear Senator Takis:

In response to the Office of the State Auditor's letter dated May 23, 2007, attached is the Colorado Department of Public Health and Environment's (the department) status report of our implementation of the recommendations, as set forth in the Nursing Facility Quality of Care performance audit, dated February 2007.

The attached status report includes all the auditor's recommendations to the department with our responses and implementation dates as presented in the audit report, together with the current implementation status of the auditor's recommendations.

Should you have any comments, questions, and/or concerns regarding our responses, please contact Howard Roitman, Director of Health Facilities and Emergency Medical Services Division (HFEMSD), at 303-692-2613 or our Internal Auditor, Scott Toland, at 303-692-2105.

Sincerely,

James B. Martin
Executive Director

Attachment

cc: Ned Calonge, MD, MPH, Chief Medical Officer
Howard Roitman, Director, HFEMSD, CDPHE
Chuck Bayard, Director, Administration and Financial Services Division (AFSD), CDPHE
Ann Hause, Director, Legal and Regulatory Affairs, CDPHE
Adam Eichberg, Director, Policy and External Affairs, CDPHE
Jessie Ulmer, Legislative Liaison, CDPHE
John Schlue, HFEMSD, CDPHE
Scott Toland, Internal Auditor, AFSD, CDPHE

Nursing Home Quality of Care Performance Audit
Status Report
As of July 25, 2007

Auditor Recommendation No. 1

The Department of Public Health and Environment should improve controls over the certification survey process to ensure that surveyors identify all deficient practices and cite deficiencies at a level that accurately and sufficiently identifies the scope and severity of the deficiency, in accordance with federal requirements. Specifically, the Department should:

a. Ensure that survey staff follow established quality review procedures, including use of a standard review form to document and track all changes made to deficiency citations prior to their release to the nursing facility or the public. Rationale for all changes as well as appropriate approval for changes should be documented on the review form.

b. Explore ways to expand quality review processes to ensure the completion of required survey forms, the sufficiency of documentation in support of deficiency citations, and the overall survey file organization.

c. Work with survey supervisors to ensure timely communication with survey teams throughout the survey process and increase the frequency with which supervisors are required to be on-site with survey teams.

d. Implement a standard format for organizing certification survey files and relevant supporting documentation. Only documentation supporting the deficiency citations or demonstrating compliance with required survey protocols and procedures should be maintained in the survey file.

e. Improve documentation standards and work with surveyors and supervisors to ensure that required forms are properly labeled and completed and that results from inquiries, team meetings, and the resolution of potential issues are clearly and sufficiently documented.

f. Provide surveyors with more training on general investigative skills and protocols, as well as on the regulatory and legal aspects of the survey process.

Department of Public Health and Environment's Response to the Auditor

a. Partially agree. Implementation date: Implemented October 2006. The CDPHE agrees that deficient practice should be cited at the most accurate scope and severity level; however, the CDPHE disagrees with the subjective evaluation criteria utilized by the Office of the State Auditor's hired contractor when reviewing past cited deficiencies. The CDPHE's citation of deficiencies against a facility is intended to notify the facility of a failure to meet standards and require a correction to get the facility back into substantial compliance with the federal standards. The citation of deficiencies against a certified facility typically results in the imposition of various remedies by CMS, up to and including termination of the facility's Medicare/Medicaid certification. The CDPHE cites the scope of the deficient practice as isolated, pattern, or widespread, and the severity as potential for minimal harm, potential for more than minimal harm, actual harm, and immediate jeopardy. It is important to note that the facility is required to rectify the deficient practice on a facility-wide basis, even when the deficiency cited was at an isolated or pattern level. Once the facility achieves substantial compliance with the standards as specified in their plan of correction and confirmed by the CDPHE surveyors on a revisit to the facility, any remedies imposed by CMS are retracted.

The CDPHE has modified the Protocol for Quality Review and the Quality Review Tool (QRT) Form for Long Term Care (LTC) Health Survey Deficiency Lists to include the recommendations made by the Office of the State Auditor. The standardized form is being utilized to document the review of all deficiency citations, including the tracking of changes made, the rationale for the changes, and how changes are communicated with the survey team. The protocol includes instructions for documenting additional citations, the movement of findings to different tag numbers, the reduction or increase in tag scope and severity, and the deletion of tags by the reviewer or team. The revised protocol and review form were put into effect in October 2006.

b. Agree. Implementation date: October 2007. The CDPHE will more closely examine its survey results and file organization to ensure that all Centers for Medicare and Medicaid Service (CMS) required forms are included and completed, and that appropriate documentation to support deficiency citations exists in the survey file.

c. Agree. Implementation date: July 2007. The CDPHE will continue to have each of the four supervisors provide on-site supervision for one full survey each quarter. In addition, each supervisor will spend one day in the field per month providing on-site supervision during a survey. The survey teams will be expected to make phone contact with a supervisor on the second day of survey to review preliminary survey findings.

d. Partially agree. Implementation date: October 2007. While the CDPHE agrees that enhanced file organization for linking written deficiency citations to supporting documentation is ideal, there are no specific CMS standards for file organization. This recommendation is beyond the Medicare/Medicaid certification requirements and must be prioritized in consideration of limited resources and workload needs. The CDPHE has a fixed federal budget for certification activities. Although enhanced file organization may be chargeable to that budget, doing so would require reducing the CDPHE's activities in some other certification tasks related to patient care and safety, such as performing on-site inspections or writing deficiencies. Implementation of this recommendation would require additional state funds. The CDPHE will take this recommendation into consideration when prioritizing future budget requests.

e. Agree. Implementation date: October 2007. While the CDPHE believes it has sufficient processes in place to maintain necessary documentation, we agree with the goal of improving documentation and will develop guidelines for documentation of the survey process in accordance with the CMS requirements. The guidelines will focus on improving documentation in the areas of investigations, interviews, and summaries of team meetings, consultations with supervisors, and whether potential issues identified have been resolved.

f. Partially agree. Implementation date: October 2007. The CDPHE currently ensures that all surveyors receive required CMS training, which is substantial. While the Department agrees that additional surveyor training on investigative skills and the regulatory and legal aspects of the survey process would be valuable, especially for newer surveyors, it is outside of the scope of CMS training requirements. Implementation of this recommendation will require additional state funds. CDPHE will investigate its options for implementing this recommendation, including assessing whether additional state funds might be available for it.

Nursing Home Quality of Care Performance Audit
Status Report
As of July 25, 2007

Implementation Status

a. Implemented October 2006.

b. In progress. The CDPHE will examine how best to include all CMS forms and appropriate documentation to support deficiency citations for implementation at the start of the 2007-2008 federal fiscal year, or October 2007.

c. In progress. Due to an unusually high staff turnover rate this year, which has resulted in the need to reorganize survey teams and require survey supervisors to participate in survey activities in an effort to meet federal workload requirements, this recommendation is not yet fully implemented. Specifically, the Health Facilities and Emergency Medical Services Division has lost 9 surveyors and 2 management positions to resignations, retirements and reassignments this year, of which 6 surveyor positions and 1 management position are still in the process of being filled. The CDPHE can address implementation of this recommendation in January 2008, after CMS workload has been met, supervisor work tasks and schedules have returned to normal and new survey staff has received some training.

d. In progress – dependent upon receiving additional state funds. The Health Facilities and Emergency Medical Services Division calculates that 1 hour of administrative support time and 3 hours of surveyor time would be necessary for each survey file to organize and ensure all appropriate forms and documentation are included. This level of work is above and beyond what is currently done by staff. Implementation of this recommendation will require additional state funds and resources, which continue to not be available.

e. In progress. The CDPHE plans to review processes and develop guidelines for CMS required documentation by October 2007.

f. In progress. The CDPHE is planning to train its Nursing Homes survey staff and management on investigative skills and the regulatory and legal aspects of the survey process in October 2007 after the 2006-2007 CMS workload has been completed.

Auditor Recommendation No. 2

The Department of Public Health and Environment should work to improve the unpredictability of certification surveys by:

a. Ensuring that predictability is routinely used as a key decision factor when scheduling certification surveys. This should include exploring ways to utilize staggered surveys and the full 15-month survey window to diminish the likelihood that nursing facilities can anticipate when they will be surveyed.

b. Including statistics in existing summary reports of survey interval data to monitor trends and assess performance related to survey predictability.

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: Implemented October 2006. According to the GAO-06-117 Nursing Home Quality and Safety Initiatives report, in 2005 Colorado's survey predictability was 15 percent versus the mean national average of 14.5 percent. CDPHE believes that survey predictability is only one factor in gaining an accurate picture of day-to-day care patterns and practices at facilities, but will strive to lower its survey predictability percentage. In October 2006, CDPHE modified its survey scheduling protocol to test against the three GAO predictability factors. Under the modified protocol, if scheduling the survey fails all three predictability factors that are typically due to uncontrollable circumstances (e.g., staffing issues, complaint investigation that trigger full surveys), a staggered survey is used to offset predictability. Any scheduled survey which meets one of these predictability factors must be approved by a program manager, with a written explanation of the scheduling issue, alternative used, and mitigating factors.

b. Agree. Implementation date: July 2007. CDPHE has various reports and computerized data that will help us with survey scheduling and being less predictable in conducting nursing facility surveys. The CDPHE will consolidate and update these various reports and tools into one computerized interface that will make it easier for nursing home supervisors and managers to plan and monitor survey predictability and performance. The program manager will review reports on a quarterly basis to monitor trends and provide performance feedback to nursing home supervisors.

Implementation Status

a. Implemented October 2006.

b. In progress. The CDPHE has a computerized tool to monitor trends and assess survey predictability performance on a look-back analyses basis. The CDPHE is working on a companion computerized tool to help with scheduling that will help avoid predictability looking forward. This computerized tool should be implemented in September 2007.

Auditor Recommendation No. 3

The Department of Public Health and Environment should work to improve the prioritization and timeliness of nursing facility complaint investigations by:

a. Reviewing and updating the point schedules programmed in the Complaint Priority Assessment System (COMPASS) to ensure the proper prioritization of nursing home complaints in accordance with current standards, practices, and relevant decision criteria. Such review should be done at least annually.

b. Establishing clear and consistent time frames within which each complaint investigation at a given priority level should begin.

c. Review reports of complaints data on a routine basis to determine if nursing home complaint investigation time frames are being met, and take action as appropriate.

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: April 2007. The COMPASS program is a decision support system designed to aid the complaints manager and staff with setting early prioritization on complaints; however, the Department ensures that the correct prioritization of complaints occurs by using human judgment as the final determinant of a complaint's prioritization. The CDPHE will annually update the COMPASS program to prioritize complaints according to current standards, practices, and relevant decision criteria.

b. Agree. Implementation date: April 2007. CDPHE will establish consistent time frames for beginning each of the complaint priority levels. CMS requires on-site investigation to start within 2 working days for Priority A complaints and to start within 10 working days for Priority B complaints. The CDPHE met CMS quality standards for 100 percent of Priority A and Priority B complaints in the draft federal fiscal year 2006 State Performance Standards Review Report. CMS does not specify when on-site investigations must start for Priority C, D, and E complaints. The CDPHE's practice has been to follow CMS policies when investigating certification complaints. Considering CMS workload requirements, complaint Priorities C, D, and E must be established to start investigations during the next on-site survey, which may be up to 15 months from when the complaint is alleged. Establishing and adhering to investigation start time frames sooner than 15 months for Priorities C, D, and E Medicare/Medicaid and comparable state priority complaints will require additional state funding and resources.

c. Agree. Implementation date: April 2007. CDPHE will review the complaints data report (aging report) on a regular basis. Each reviewed report will be initialed by the complaints manager or designee and kept in a file. The complaints manager will use the data to ensure that complaint investigation time frames are being met in accordance with federal minimum standards and CDPHE-established time frames by priority level.

Implementation Status

a. Implemented July 2007. Due to an unusually high staff turnover rate in the Long Term Care program this year, which has resulted in the need to reorganize survey teams and require survey supervisors to participate in survey activities in an effort to meet federal workload requirements, this audit recommendation was implemented in July, rather than April. The CDPHE re-analyzed its use of COMPASS as a tool for prioritizing complaints and decided to adapt and modify its complaint prioritization system to use the same evaluation methods and decision making criteria that CMS prescribes and that are currently being used day-to-day by complaints management and staff. The modified system uses CMS criteria, captures intake and decision choices, and tracks and audits changes by individual, date and time.

b. Partially implemented – dependent upon receiving additional state funding and resources to fully implement. The CDPHE revised the LTC Complaint Policy and implemented changes to reflect starting 2 and 10 day complaints by the 2nd and 10th days, respectively, and applied start dates for priority levels C, D and E to 15 months. Establishing and adhering to investigation start time frames sooner than 15 months for Priorities C, D, and E Medicare/Medicaid and comparable state priority complaints will require additional state funding and resources.

c. Implemented July 2007. Due to an unusually high staff turnover rate in the long term care program this year, which has resulted in the need to reorganize survey teams and require survey supervisors to participate in survey activities in an effort to meet federal workload requirements, this audit recommendation was implemented in July, rather than April.

Auditor Recommendation No. 4

The Department of Public Health and Environment should improve its occurrence reporting and investigation program by:

a. Strengthening standards for occurrence investigations to include specific time frames within which each occurrence investigation at a given priority level should begin.

b. Revising nursing facility occurrence reporting requirements set forth in state regulations to comply with federal regulations and guidance requiring notification within 24 hours.

c. Modifying the occurrences database and working with staff to ensure that all data relevant to occurrence reporting and investigation are captured accurately and tracked systematically and consistently.

d. Reviewing reports of occurrence data on a routine basis to determine if nursing home occurrence reporting and investigation time frames are being met, and taking action as appropriate.

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: Implemented January 2007. CDPHE modified its occurrence investigation policy in January 2007 to include specific time frames by priority level within which occurrence investigations should begin.

b. Agree. Implementation date: July 2007. The CDPHE's regulations will be modified to mandate reporting of occurrences within 24 hours.

c. Agree. Implementation date: July 2007. The occurrence database will be modified to track the date the incident occurred as well as the date the facility became aware of the incident. Additionally, the database will be reviewed to resolve any inconsistencies concerning investigation dates.

d. Agree. Implementation date: July 2007. The CDPHE currently reviews the occurrence data on a routine basis to monitor nursing home compliance with reporting and takes action as appropriate. CDPHE will reassess its tracking and review processes and make appropriate changes once the occurrence database modifications have been completed.

Implementation Status

a. Implemented January 2007.

b. In progress. The CDPHE will submit this regulatory change to the Board of Health in August for hearing in October 2007.

c. Implemented February 2007. The occurrence database was modified to track the date the incident occurred and the date the facility became aware of the occurrence.

d. Implemented January 2007. The CDPHE modified its tracking and review processes to use the date differences between when an occurrence happened and when the facility became aware of the occurrence happening, as a flag for a case-by-case review of timely occurrence reporting by the facility.

Auditor Recommendation No. 5

The Department of Public Health and Environment should ensure compliance with state and federal requirements governing informal dispute resolution (IDR) processes by:

a. Strengthening the intake and staff review of nursing facilities' IDR requests for compliance with established submission requirements. Requests that do not meet established requirements should be returned to the nursing facility for resubmission.

b. Revising policies to reflect current practice regarding primary and alternate voting members' participation on the IDR Committee.

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: Implemented September 2006. In September 2006 the Informal Dispute Resolution policy was revised to address the issue of how requests would be handled if facilities only challenge the classification (scope and severity). If the committee chair determines that the facility has not met the established requirements for submission, the requests are returned to the facility for revision. On September 15, 2006 the policy was made available on the Division's Web site and all facilities were notified of the policy changes by fax. A follow-up notification was also given at the November 7, 2006 Long Term Care Advisory Committee meeting and notice of the revisions were included in the Division's fall newsletter.

b. Agree. Implementation date: Implemented October 2006. CDPHE has implemented policy changes to reflect the Division's practice regarding utilization of the primary and alternate voting members on the IDR Committee. The revised policy states, "the voting member and the alternate member may elect to share their positions, rotating their attendance monthly or attending monthly, but dividing the IDR requests between them." These policy changes also went into effect October 2006 after all voting and alternate voting members were advised of the change.

Implementation Status

a. Implemented September 2006.

b. Implemented October 2006.

Auditor Recommendation No. 6

The Department of Public Health and Environment should improve mechanisms for nursing facilities to provide meaningful, appropriate, and relevant feedback regarding the survey process,

overall survey team performance, and individual surveyors. At a minimum, the Department should:

a. Designate a single individual, independent of the survey process, who is responsible for receiving and retaining completed post-survey feedback questionnaires, data entering the responses and written comments, and preparing summary reports and analysis to management and survey teams on a quarterly basis. Completed questionnaires should not be returned to the survey teams or to individual surveyors.

b. Inform nursing facilities and surveyors about procedures for handling post survey questionnaires and for communicating the data to management and survey teams. This should include instruction on informal and formal processes separate from the post-survey questionnaire available to nursing facilities for filing comments or complaints regarding individual surveyors.

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: July 2007. The CDPHE strives to obtain meaningful feedback from nursing homes concerning the surveyors and the survey process, and agrees that assignment of the recommended tasks to one individual should enhance the collection and review of this information.

b. Agree. Implementation date: July 2007. CDPHE will publish clear rules and guidelines for responses to post survey questionnaires and for reporting formal and informal complaints about surveyors to the CDPHE.

Implementation Status

a. In progress. The Long Term Care program manager receives all the Long Term Care program facility evaluation forms. Evaluation rating and comments are shared with all surveyors in an anonymous way during regular Long Term Care staff meetings. The names of facilities remain confidential. Completion of a written policy is estimated by August 2007.

b. In progress. The Long Term Care program manager calls facilities when they check the box on the evaluation form indicating they would like follow up call or if the average score is 3 (fair) or below. Completion of a written policy is estimated by August 2007.

Auditor Recommendation No. 7

The Department of Public Health and Environment should improve controls over its conflict-of-interest disclosure and monitoring process by:

a. Modifying and clarifying conflict-of-interest policies and disclosure requirements, to ensure that potential or perceived conflict of interest are identified and evaluated. This should include evaluating situations that fall outside of established time frames and circumstances defining an actual conflict of interest.

b. Requiring surveyors to provide more extensive details and factual information when disclosing actual or potential conflicts of interest to management. Management should

follow up with surveyors to obtain additional information as necessary to properly evaluate the conflict and determine an appropriate disposition.

c. Better documenting management's review of conflict-of-interest disclosure statements and their disposition. At a minimum, management should clearly document its review of the disclosure, whether a real or perceived conflict of interest exists, and how the conflict will be mitigated.

d. Ensuring that conflict-of-interest documentation is routinely reviewed when scheduling surveyors on survey teams.

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: October 2007. The CDPHE's policy will be modified to require disclosure of all potential conflicts and Division management will review this information and document its decisions with respect to potential conflicts of interest.

b. Agree. Implementation date: October 2007. The CDPHE will modify its conflict-of-interest policy to ensure that managers have sufficient information to make informed decisions concerning potential conflicts of interest.

c. Agree. Implementation date: October 2007. The CDPHE will maintain documentation of its decisions concerning potential conflicts of interest in accordance with Division records retention schedules.

d. Agree. Implementation date: October 2007. The CDPHE will document its review of conflicts of interest when scheduling surveyors.

Implementation Status

a. In progress. Implementation is planned for October 2007.

b. In progress. Implementation is planned for October 2007.

c. In progress. Implementation is planned for October 2007.

d. In progress. Implementation is planned for October 2007.

Auditor Recommendation No. 8

The Department of Public Health and Environment should strengthen its preemployment screening processes for surveyors. Specifically, the Department should:

a. Designate surveyors as security-sensitive positions and subject to criminal history check requirements prior to employment. This should include taking steps to periodically recheck criminal histories of employees after hire and developing guidelines regarding those offenses that would disqualify an applicant from employment as a surveyor.
b. Clarify with staff their responsibilities for conducting preemployment license checks, reference checks, and other screening.

c. Develop and implement a checklist to track and document completion of preemployment screening tasks by responsible parties throughout the hiring process. This checklist should be maintained in the employee's personnel file.

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: October 2007. The CDPHE will investigate its options for designating surveyors as security-sensitive positions, conducting criminal history checks prior to employment, and periodically rechecking such histories.

b. Agree. Implementation date: July 2007. CDPHE will implement this recommendation by July 2007.

c. Agree. Implementation date: July 2007. The CDPHE will maintain documentation concerning the preemployment screening conducted for all surveyors in the hiring process.

Implementation Status

a. In progress. The CDHPE has implemented name based criminal history background checks as a condition of employment for all new surveyors hired as of May 2007. The name based check is performed and reviewed by the Human Resources Department, who notifies the hiring/program manager of the results. Full implementation is planned for October 2007.

b. In progress. The Long Term Care program manager and supervisors complete reference, license and background checks on new employees. Completion of a written policy is estimated by August 2007.

c. In progress. The checklists for pre-employment screening have been completed and are in use. Completion of a written policy is estimated by August 2007.

Auditor Recommendation No. 9

The Department of Public Health and Environment should improve the oversight of nursing facility resident assessments and Minimum Data Set (MDS) data by:

a. Continuing to increase awareness among surveyors of the risk of problems with MDS assessments and ensure that surveyors investigate any problems noted with the MDS assessments, including problems with validity and reliability, during certification surveys. This should include citing the facility with a deficiency if warranted.

b. Working with the Department of Health Care Policy and Financing (HCPF) to conduct more systematic review and analysis of standard reports available in the electronic MDS system and data maintained by HCPF's contract auditor on resource utilization group classifications to identify those facilities that are at higher risk of submitting invalid assessments and, therefore, warrant further attention during certification surveys or require additional training. (See also Recommendation 10a.)

c. Working with the Department of Health Care Policy and Financing to require that MDS coordinators at all Medicaid-certified nursing facilities complete the State's MDS training or a comparable MDS training on a routine basis, as appropriate. Facility MDS

coordinators attending the State's training should be tracked and proof of comparable external training should be obtained to identify those facilities whose MDS coordinator has not completed the required training. (See also Recommendation 10b.)

d. Encouraging nursing facilities to identify and use best practices, such as standardized flow charts and checklists, to help collect data, improve communication, and better substantiate MDS assessments. This could include focusing facilities' attention on more critical MDS data elements, such as those used to calculate the case-mix adjustment to Medicaid payments, or those identified as having the most problems.

e. Working with the Department of Health Care Policy and Financing to evaluate options for the development and implementation of a state validation team to perform routine on-site reviews of nursing facilities' MDS assessments for Medicaid residents. This should include working with the federal Centers for Medicare and Medicaid Services, the General Assembly, and other policy-making bodies, as appropriate. (See also Recommendation 10c.)

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: Implemented and ongoing. As discussed in the audit report, CDPHE surveyors have cited MDS related deficiencies 564 times in the past 5 years against the 10 MDS related federal citation tags. Two of the 10 tags (20 percent) are related to data accuracy, for which surveyors cited 101 tags (18 percent). CDPHE has provided surveyors with ongoing MDS training and updates to assist surveyors in finding and making appropriate citations and will continue to do so.

b. Partially agree. Implementation date: July 2007. The CDPHE's existing electronic MDS standard reports will be used to help identify facilities and new MDS coordinators at higher risk of data accuracy problems who may need further survey attention and additional MDS training. The CDPHE will utilize any information provided by HCPF and its contract auditor with respect to RUGs data and reports as an additional tool to help CDPHE identify facilities prone to MDS data errors and, therefore, in need of additional training or survey activity. This recommendation is beyond the Medicare/Medicaid certification requirements and the current certification budget and must be prioritized in consideration of limited resources and workload needs. Implementation of this recommendation would require additional state funds. The CDPHE will investigate additional funding opportunities and options with HCPF for implementing this recommendation.

c. Partially agree. Implementation date: July 2007. CDPHE will support HCPF's efforts to require Medicaid certified nursing facility MDS coordinators to attend the State's or comparable MDS training. HCPF will be responsible for defining and establishing this requirement through their rules or statute. Enhancing additional mandated training requirements are beyond the existing Medicare/Medicaid certification budget and must be prioritized in consideration of limited resources and workload needs. Implementation of this recommendation will require additional state funds. The CDPHE will investigate additional funding opportunities and options with HCPF for implementing this recommendation.

d. Partially agree. Implementation date: July 2007. CDPHE will encourage nursing facilities to look for and use best practice forms, checklists, and documentation tools to improve MDS data collection and data item substantiation. CDPHE currently recommends and covers the need for such record keeping in its MDS training, but would need to expand on this topic in future training sessions. To implement this recommendation the CDPHE would need to expand its MDS training sessions to include information pertaining to critical MDS data elements that most affect RUGs scoring and case-mix adjustments. This recommendation is beyond the Medicare/Medicaid certification requirements and the current certification budget and must be prioritized in consideration of limited resources and workload needs. Implementation of this recommendation would require additional state funds. The CDPHE will investigate additional funding opportunities and options with HCPF for implementing this recommendation.

e. Disagree. CDPHE agrees that validation of MDS assessment is best determined by on-site record review; however, CDPHE does not believe that the development and staffing of a specialized state validation team is the most efficient or cost-effective means by which MDS data can be validated. Further, this recommendation exceeds what is required under Medicare/Medicaid certification requirements for MDS record review during survey. This recommendation cannot be prioritized or implemented with existing Medicare/Medicaid resources.

Implementation Status

a. Implemented and ongoing. The CDPHE continues to provide ongoing MDS training to surveyors on an as needed/as requested basis. The CDPHE provided a 1-day MDS training to all surveyors in March 2007 and the CDPHE requires all new surveyors to attend the 1-day MDS training module. A monthly MDS Q&A and tips email is sent to all surveyors.

b. In progress. This item corresponds with HCPF's item 10.a of this audit, which has an implementation date of December 2007. The CDPHE has met with HCPF to discuss how the two departments will work together to implement this recommendation. A second meeting between the CDPHE, HCPF and HCPF's contract auditor, Myers & Stauffer, is scheduled for late July 2007 to discuss the use of existing standard reports from the MDS system and RUGS and case mix reports created by Myers & Stauffer that may be used to identify facilities, MDS coordinators and case mix items that might be at a higher risk for data accuracy problems. The participants will also discuss at this meeting how to identify individuals who may be in need of additional MDS training and facilities that may need further survey attention. Once the CDPHE and HCPF have identified the necessary ongoing reports, analyses and resources to implement this recommendation the CDPHE will determine if this audit finding can be met with existing resources or if additional state resources and funds are needed.

c. In progress. July 2007 update: This item corresponds with HCPF's item 10.b of this audit, which has an implementation date of December 2007. The CDPHE has met with HCPF to discuss how the departments will work together to implement this recommendation. Details discussed included: HCPF rulemaking necessary to require facility MDS coordinators to attend qualified MDS training; HCPF methods for

validation and tracking of MDS training; use of the CDPHE MDS training syllabus by HCPF as a comparative means for evaluating other acceptable MDS training curriculums; CDPHE increasing facility MDS trainings from 5 to 8 per year; and how the CDPHE may include training tips on case mix reimbursement items in its MDS training. Once the CDPHE and HCPF have identified the necessary ongoing training requirements to implement this recommendation, the CDPHE will determine if this audit finding can be met with existing resources or if additional state resources and funds are needed.

d. In progress. In March 2007, the CDPHE began to team with the Colorado Quality Improvement Organization (QIO) on teleconference training calls to providers regarding MDS accuracy. The first call's accuracy subject was how to accurately access and code for pain; the second teleconference was held in June 2007 on the subject how to accurately access and code restraints; and a third call is planned for August 2007 on the topic of specialized MDS reports (the Quality Measure/Quality Indicator package). During its MDS training sessions, the CDPHE shares various MDS checklists and forms to assist facilities in comparing changes in various resident conditions from one assessment period to another; forms to help calculate accurate observation periods; and a reference sheet of informational facts about MDS for Colorado. When the CDPHE, HCPF and Myers & Stauffer meet in late July 2007 they will try to identify additional case mix and RUGS data accuracy training points, checklist and forms that will aid facilities with MDS accuracy. The CDPHE will also determine if this audit finding can be met with existing resources or if additional state resources and funds are needed.

e. Not implemented. The CDPHE disagreed with this recommendation.

Auditor Recommendation No. 11

The Department of Public Health and Environment should improve its oversight of nursing facilities to ensure compliance with federal and state requirements for managing resident fund accounts. Specifically, the Department should:

a. Ensure that surveyors are trained on the requirements and proper internal controls over resident fund accounts, as well as on common problems and risks associated with resident fund accounts.

b. Include specific questions about resident fund accounts in interviews with residents, family members, and facility staff. More in-depth review should then be done in accordance with CMS survey protocols depending on the results of these initial inquiries.

c. Work with the Department of Health Care Policy and Financing to improve communication and coordination and, to the extent possible, minimize the potential for duplication of resident fund account monitoring efforts.

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: July 2007. CDPHE will provide surveyors with refresher and updated training and guidelines on Medicare/Medicaid certification requirements for resident fund account oversight by July 2007.

b. Agree. Implementation date: July 2007. The CDPHE currently follows CMS Medicare/Medicaid certification guidelines and requirements for surveying resident fund accounts on triggered and sample resident bases. The CDPHE will use CMS guidelines and collaborate with HCPF to develop a surveyor checklist and protocol to better guide surveyor questions and review in this area, and help determine when to refer in-depth review of resident fund accounts to HCPF after citing the applicable deficiencies. The use of such tools and protocols and the potential inclusion of additional residents in the survey sample may increase surveyor time on resident fund account matters at the expense of other on-site survey tasks involving resident care and safety and must be prioritized in consideration of limited resources and workload needs. Implementation of this recommendation beyond current CMS requirements and guidelines will require additional state funds.

c. Agree. Implementation date: April 2007. CDPHE will increase its communication and coordinate with HCPF on resident fund account efforts and monitoring and collaborate on surveyor checklists, protocols and criteria for referral of cases needing in-depth analysis to HCPF.

Implementation Status

a. In progress. HCPF will provide the CDPHE surveyors with resident fund account training. This training is scheduled for surveyors during the CDPHE August 2007 staff meeting.

b. In progress. The CDPHE met with HCPF to discuss the creation of resident fund account checklists, protocols, monitoring and conditions for referral to HCPF for more in-depth analysis. A second meeting to develop these tools is planned by August 2007. The CDPHE has expanded its CMS guidelines and requirements for surveying residents fund accounts from a triggered basis to review of all comprehensive sampled residents for this area while on survey. This will be fully implemented after the August 2007 training. Completion of a policy for is estimated by October 2007. Once the CDPHE and HCPF have identified the necessary ongoing requirements to implement this recommendation, the CDPHE will determine if this audit finding can be met with existing resources or if additional state resources and funds are needed.

c. In progress. The CDPHE will disseminate the resident fund account checklists, protocols and analysis criteria with surveyors at the August 2007 training.

Auditor Recommendation No. 13

The Department of Public Health and Environment should work to improve preemployment screening efforts at nursing facilities. Specifically, the Department should:

a. Modify forms and checklists used by surveyors during certification surveys to include more detail on the factors that surveyors should use to review the preemployment screening for each facility employee, as well as guidelines on how the results should be evaluated by survey teams. At a minimum, such factors should include verifying documentation that the facility completed applicable criminal history, license, and reference checks prior to each employee's hire date.

b. Work with the General Assembly to revise and clarify statutory requirements for criminal history checks of nursing facility employees, including specifying the type of search required and those criminal offenses that disqualify individuals from employment at a nursing facility.

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: April 2007. CDPHE will develop recommended forms and protocols for surveyors to use during certification surveys to aid in determination of facility preemployment screening by April 2007.

b. Agree. Implementation date: Upon General Assembly request. The CDPHE will work with the General Assembly if it chooses to revise the statutory requirements for criminal background checks of nursing facility employees. Upon request from the General Assembly, the CDPHE will update and submit the analysis conducted as a result of a September 2001 performance audit on criminal history checks, which identified options for conducting background checks and proposed disqualifying crimes based on guidance established by existing statutes. During the 2003 Legislative Session, the Legislative Audit Committee sponsored Senate Bill 03-010 Concerning Criminal History Record Checks targeting persons who work with vulnerable persons. The bill was postponed indefinitely.

Implementation Status

a. Implemented October 2006. Upon further analysis of this recommendation, the CDPHE determined that forms and all staff training on facility pre-employment screening was put into place and conducted in October 2006.

b. Not implemented. The General Assembly has not requested a legislative initiative on criminal background checks for nursing facility employees. As stated in our initial response to the auditor, the CDPHE will work with the General Assembly if it chooses to revise the statutory requirements for criminal background checks of nursing facility employees.

Auditor Recommendation No. 14

The Department of Public Health and Environment should improve emergency and disaster planning efforts at nursing facilities by:

a. Training surveyors on the attributes of a well-organized and comprehensive emergency and disaster plan, as well as on common problems with emergency and disaster plans.

b. Developing testing forms and checklists to help surveyors conduct a more focused review of emergency and disaster plans and identify deficient practices.

c. Reviewing for appropriateness any emergency and disaster plan deficiencies that survey teams cite lower than a scope and severity of "F."

d. Facilitating information sharing and the dissemination of model disaster and emergency practices and procedures among nursing facilities. This should include assessing the

need to issue additional directives to nursing facilities on emergency and disaster planning.

e. Encouraging coordination between local emergency managers, local health departments, nursing facilities, and other agencies to ensure that the needs of nursing facilities are addressed in planning efforts for community-wide emergencies and disasters. Specific attention should focus on addressing the needs of nursing home residents during evacuations, including identifying viable evacuation locations and the arrangements necessary to relocate residents to these locations.

Department of Public Health and Environment's Response to the Auditor

a. Partially agree. Implementation date: January 2008. CMS recently shared a draft workgroup report on Emergency Preparedness Planning with State Survey Agencies (SSAs). SSAs may expect to receive Survey & Certification (S&C) written guidance and promising practices sometime during Federal Fiscal Years 2007-2008. CDPHE will use the CMS workgroup product and work with the CDPHE's emergency management section to identify the risk assessments and emergency planning elements facilities need to make and include in their plans. From these sources and conditioned upon receipt of additional federal and/or state resources, surveyor guidelines and training for assessing facility emergency management plans can be created.

b., c., d. Partially agree. Implementation date: October 2007. See CDPHE's response to 14a.

e. Partially agree. Implementation date: October 2007. While CDPHE agrees that this is an important next step to facility emergency planning, implementation of this recommendation is beyond Medicare/Medicaid certification requirements and our current certification budget and must be prioritized along with other resource and workload needs. Additional state or federal grant funding will be necessary to implement this recommendation. CDPHE will investigate the availability of such funding by October 2007.

Implementation Status

a. In progress and dependent upon availability of additional state and/or federal funding. CMS has circulated a draft Survey & Certification (S&C) letter on emergency preparedness and planning and the state survey agency's role and responsibility for ensuring facility compliance. The CDPHE will await the final S&C before implementing auditor recommendations for items 14 a.-e. Additional state or federal grant funding will be necessary to implement these recommendations. The CDPHE will investigate the availability of such funding by October 2007.

b. See CDPHE's status report to 14a.

c. See CDPHE's status report to 14a.

d. See CDPHE's status report to 14a.

e. See CDPHE's status report to 14a.

Auditor Recommendation No. 15

The Department of Public Health and Environment should work with the General Assembly and the Board of Health to evaluate policy options for licensing nursing homes and other types of health facilities, and consider the best direction for the State's health facility licensing program. This should include:

a. Reevaluating the licensing fee set in statute.

b. Exploring ways to revise licensing requirements, including conducting a side-by-side analysis of state and federal regulations to identify areas of overlap.

c. Seeking statutory and regulatory change, as appropriate.

Department of Public Health and Environment's Response to the Auditor

a. Agree. Implementation date: Ongoing. The CDPHE has been reevaluating the licensing fee in light of the program objectives as described in Recommendation 15b (see below). Currently, the statute establishes a uniform licensure fee ($360 annually) for all licensed facilities, except for assisted living residences and acute treatment units. Government entities do not pay any license fee. The Division is able to provide the issuance of a health facility license or certificate of compliance based on a cursory paper review of facility attestations to fitness and meeting regulatory licensing requirements; fire safety code attestation by local fire department jurisdictions; limited licensure technical assistance; and limited complaint investigations of the most egregious situations not covered by Medicare/Medicaid certification regulations for this $360 fee. However, the $360 annual license fee is insufficient to allow CDPHE to perform many of the mandated and often requested licensure activities including a comprehensive review of applicant's fitness to operate, specifically the applicant's past compliance performance, in addition to sufficient financial resources and insurance coverage; fire, safety and environmental construction plan review and technical support; on-site health, environmental and fire safety code inspections; and comprehensive state complaint investigations. The CDPHE has been closely examining this issue over the past several months and will work with the General Assembly and the Board of Health to seek options to improve the licensure program.

b. Agree. Implementation date: July 2007 start date, contingent upon additional resources. The primary goals of facility oversight include ensuring:
   - The organization's fitness to operate (e.g., do not have a history of egregious noncompliance in other states);
   - That the physical plant is sound (e.g., safe from fire and is built in such a way as to prevent the spread of infections—has walls and floors that are easily washable and installs appropriate ventilation); and
   - That health care is delivered by qualified staff and in a safe manner.

   Using these measures, the CDPHE will determine the extent to which there is overlap with the requirements established by other regulatory entities. The analysis will be conducted in phases and is contingent upon the receipt of additional resources and implementation of Recommendation 15a.

c. Agree. Implementation date: Ongoing. Based upon the reviews referenced in responses to 15a and 15b, the CDPHE will seek statutory and regulatory changes as needed to increase licensure funding and implement the program's objectives. Increased funding and resources are integral to implementing the recommendations of this audit and to meet the intended goals of the program. The CDPHE has been closely examining this issue over the past several months.

Implementation Status

a. In progress. HB 07-1221 deleted from statute the $360 license fee for hospitals, hospital units and other licensed facility types not otherwise statutorily covered and authorized the CDPHE to set new license fees through Board of Health (BOH) rule. In June 2007, the CDPHE requested and the BOH approved a default license fee of $360 for all facility types not otherwise covered under statute. The CDPHE will begin to work with stakeholders, the Board of Health, and the General Assembly to seek options to improve the licensure program as outlined in items 15 a-c.

b. See CDPHE's status report to 15a.

c. See CDPHE's status report to 15a.