REPORT OF

THE

STATE AUDITOR

NURSING FACILITY QUALITY OF CARE

Performance Audit
September 2000

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STATE OF COLORADO

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Members of the Legislative Audit Committee:

This report contains the results of the performance audit of Nursing Facility Quality of Care, managed by the Departments of Public Health and Environment and Health Care Policy and Financing. The audit was conducted under the authority of Section 26-4-410 (2) (c.5) (IX) (A), C.R.S., which requires the State Auditor to audit the procedures implemented to monitor the financial accountability of the nursing facility Quality Care Incentive Payment (QCIP) program.

This report presents our findings, conclusions, and recommendations, and the responses of the Departments of Public Health and Environment and Health Care Policy and Financing.

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OFFICE OF THE STATE AUDITOR **REPORT SUMMARY**

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State Auditor

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Performance Audit
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Authority, Purpose, and Scope

This audit was conducted under the authority of Section 26-4-410 (2) (c.5) (IX) (A), C.R.S., which requires the State Auditor to audit the procedures implemented to monitor the financial accountability of the nursing facility Quality Care Incentive Payment (QCIP) program. Clifton Gunderson L.L.C., a contracted auditing firm, reviewed the Health Facilities Division's oversight of quality of care as measured through its surveys and complaint investigations. The Office of the State Auditor reviewed the effectiveness of QCIP financial incentives in improving nursing facility quality of care. The audit was conducted in accordance with generally accepted auditing standards. We gathered information through interviews, data analyses, document reviews, and site visits. We gratefully acknowledge the assistance and cooperation extended by management and staff at the Departments of Health Care Policy and Financing and Public Health and Environment, Health Facilities Division, as well as staff at Colorado nursing facilities.

Overview

Colorado has 231 licensed nursing facilities that provide long-term care to about 17,000 people who are elderly or who have intensive long-term care needs. Two state departments—the Departments of Health Care Policy and Financing and Public Health and Environment—are responsible for overseeing various aspects of Colorado's nursing facilities. The Department of Health Care Policy and Financing is primarily responsible for financing activities such as rate-setting and auditing billing practices, cost reports, and personal needs funds. The Department of Public Health and Environment is responsible for standards and quality of care, including licensure, certification, and complaint and occurrence investigation.

In 1994 the General Assembly created the Quality Care Incentive Payment program (QCIP) to improve quality of care at nursing facilities. The purpose of QCIP is to reward nursing facilities with financial incentives for delivering high-quality care. The Department of Health Care Policy and Financing (Department) administers the program. The Department of Public Health and Environment, Health Facilities Division, assesses quality of care at nursing facilities to establish a basis for determining QCIP incentive payments.

For further information on this report, contact the Office of the State Auditor at (303) 866-2051.

Our audit determined that financial accountability for QCIP is lacking. There is no evidence that QCIP has improved quality of care. Further, QCIP lacks adequate measures to assess quality of care and criteria for incentive payments are too lenient. In total, the Department has spent over $19 million in incentive payments without demonstrating that quality of care has improved. A summary of our findings and conclusions follow.

Oversight of Nursing Facility Quality of Care

One of the primary ways the Health Facilities Division (Division) oversees quality of care at nursing facilities is through investigations termed, "surveys," mandated by the federal Health Care Financing Administration (HCFA). All nursing facilities that participate in either the federal Medicaid or Medicare programs receive unannounced surveys by the Division at least once every 15 months. Our audit reviewed the Division's oversight of nursing facility quality as evaluated through surveys and complaint investigations. We found that, in general, the Division is conducting surveys and complaint investigations in accordance with the federal standards. We also noted the following quality of care concerns at nursing facilities:

- **Division surveys sometimes overlook important quality of care issues.** During on-site evaluations for two Division surveys, our three nurse consultants found that Division surveyors: 1) did not identify a significant medical treatment issue for further investigation, 2) did not appropriately assign scope and severity to a housekeeping and maintenance deficiency, 3) overlooked problems with administering pain medication, 4) did not thoroughly investigate infection control issues, and 5) did not consistently comply with HCFA documentation requirements. HCFA has also found problems with the survey process in Colorado and the Division's investigation of quality of care issues. This is not surprising since Division surveyors are not citing as many deficiencies as HCFA surveyors or surveyors in other states. HCFA conducted four comparative surveys (where HCFA resurveys the nursing facility within 60 days of the Division's survey) between February 1999 and March 2000. Our audit found that HCFA surveyors cited eight times the number of deficiencies cited by Division surveyors. Additionally, between Fiscal Years 1997 and 1999, the Division's surveyors identified substantially fewer deficiencies than other states nationally and regionally (51 and 36 percent respectively). These issues raise concerns about the Division's effectiveness in citing deficiencies and uncovering quality of care problems at Colorado nursing facilities.

- **Additional quality of care measures are needed.** Currently, the Division relies primarily on the federally mandated certification surveys and complaint investigations to evaluate quality of care. However, other states have developed additional measures, such as consumer satisfaction surveys, staff turnover rates, staff expertise, and financial stability measures to evaluate quality of care. The Division is also developing a database that captures risk factors to identify potential quality of care concerns. This database, along with researching measures

in use in other states, could form the foundation for additional, comprehensive measures for assessing quality of care.

- **Oversight of complaints and occurrences should be improved.** Our review of a sample of 40 complaints and 41 occurrences found: 1) complaint investigation results are not reported timely and there are delays in completing occurrence investigations; 2) complaint documents are not maintained in one location; 3) dispositions of complaints reported on the Division's hotline are not recorded consistently; 4) follow up on reporting of abuse occurrences to local law enforcement is not consistent; and 5) abuse occurrences are not reported timely to the Medicaid Fraud Control Unit.

Our recommendations address improving oversight of nursing facility quality of care by increasing focus on quality of care issues during surveys, developing additional quality of care measures, and improving systems for monitoring and recording complaints and occurrences. A summary of our recommendations and the Division's responses can be found in the Recommendation Locator.

Financial Incentives for Quality of Care

The Department of Health Care Policy and Financing (Department) has developed a two-part Quality Care Incentive Program (QCIP) for nursing facilities based on: 1) survey incentives–which are intended to improve quality of care through the survey process overseen by the Health Facilities Division; and 2) Resident-Centered Quality Improvement Plan (or ResQUIP) incentives–which are intended to promote quality of life for residents through resident choice and involvement. During Fiscal Year 2000, the Department spent about $4.4 million in state and federal Medicaid funds on QCIP. Of this amount, about $1.3 million (30 percent) was spent on survey incentives and $3.1 million (70 percent) on ResQUIP incentives.

According to statutes, the purpose of QCIP is to provide financial incentives to encourage nursing facilities to improve quality of care. Our audit concluded that QCIP is not adequately measuring quality of care. As a result, QCIP lacks a sufficient basis for determining incentive payments. The QCIP program needs to be overhauled to better address statutory intent and increase accountability for QCIP funds. Specifically, we found the following:

- **QCIP quality of care measures are insufficient.** Neither the survey nor ResQUIP incentive portions of the QCIP program adequately measure quality of care at nursing facilities as required by statutes. Surveys are overlooking key health and medical issues related to quality of care. ResQUIP incentives are not based on quality of care measures. Facilities can receive ResQUIP payments without meeting even minimum quality of care standards. In July of 1999, there were 55 facilities that received $470,000 in ResQUIP incentive payments without meeting minimum quality of care standards assessed through surveys.

- **QCIP criteria are too lenient.** During Fiscal Year 1999, 76 percent of all nursing facilities received at least one survey incentive payment. During the same year 99 percent of all facilities that submitted ResQUIP plans received at least one ResQUIP incentive payment. Facilities receive survey incentives as long as they have no more than two deficiencies, some of which can be serious. Facilities receive ResQUIP incentives if, by required deadlines, they submit a plan that is resident-centered. Since so many facilities receive incentive payments, the dollar value of these payments is relatively insignificant to the facilities (on average $22,000 per facility or 0.5 percent of the average facility's revenue). This raises questions about whether the incentive payments play a sufficient role in motivating facilities to provide better care.

- **Additional quality of care measures are needed.** We interviewed nine other states and found that eight either have or are implementing quality of care incentive programs. None of the eight states we interviewed are relying on surveys alone as the basis for awarding quality of care incentive payments. Other states are using an array of measures including staff turnover, staff expertise, consumer satisfaction, financial stability, and complaint frequency, to assess quality of care.

- **ResQUIP incentive payments lack an accountability basis.** There are no measures to assess the effectiveness of ResQUIP incentives in improving quality of care and no information to assess how ResQUIP incentives are spent. We found that many residents are not informed that incentive money is available for implementing their ResQUIP plans. Additionally, nursing facilities are not required to use ResQUIP incentive payments for implementing residents' plans. In one plan we sampled, residents were expected to use their own personal needs funds and donations to fund their plan activities even though the facility was awarded a ResQUIP incentive payment of over $18,000.

Our recommendations address improving the QCIP program through establishing valid quality of care measures and strict eligibility criteria sufficient for distributing incentive payments to nursing facilities. In addition we point out the need for proposing legislative amendments for ResQUIP. The legislation could establish a fiduciary ResQUIP fund at nursing facilities to be controlled by residents. Oversight of these funds could be handled through annual audits of nursing facilities, eliminating about $70,000 in current administrative costs for overseeing ResQUIP. A summary of our recommendations and the Department of Health Care Policy and Financing's and the Health Facilities Division's responses can be found in the Recommendation Locator.

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	19	Increase focus on quality of care and deficiency citing through training, supervision, and team building.	Health Facilities Division	Agree	3/31/01
2	21	Develop additional quality of care measures to assess nursing facility quality of care. Research quality of care measures in other states along with data maintained in the profiling database.	Health Facilities Division	Agree	11/30/00
3	24	Develop a checklist for monitoring complaints through COMPASS. Track key communications and include an audit trail to the complaint hotline phone log.	Health Facilities Division	Agree	1/15/01
4	24	Record and track the disposition of all calls and complaints entering through the complaint hotline.	Health Facilities Division	Agree	1/15/01
5	25	Limit access to COMPASS through logins and passwords. Permanently record complaint prioritization in the COMPASS system and track any changes through an audit trail. Establish controls to make sure complaint notes cannot be deleted or changed by staff once entered into the system.	Health Facilities Division	Agree	11/30/00

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
6	27	Evaluate the need for intermediate sanctions to encourage reporting occurrences timely, proposing legislation as indicated. Establish time frames for completing occurrence investigations and for referring abuse occurrences to the Medicaid Fraud Control Unit. Follow up on abuse occurrences that must be reported to local law enforcement. Monitor occurrences through a single, integrated tracking system.	Health Facilities Division	Agree	a. 12/15/00 b. 01/01/01 c. 11/30/00 d. 02/01/01 e. 12/01/00
7	29	Improve oversight of employee conflicts of interest.	Health Facilities Division	Agree	Implemented
8	30	Review personnel files annually and require staff to update qualifications.	Health Facilities Division	Agree	10/31/00
9	38	Establish a comprehensive quality of care incentive program by improving surveys, developing an array of quality of care measures, establishing more stringent eligibility criteria and larger incentive payments, and evaluating funding levels and non-financial incentives.	Department of Health Care Policy and Financing Health Facilities Division	Agree Agree	06/30/01 11/30/00
10	41	Propose legislation establishing statutory authority for ResQUIP, including recommending the percentage of QCIP funds to be allocated for ResQUIP, establishing a separate statutory ResQUIP fund at nursing facilities to be controlled by residents, and requiring fund oversight through annual audits of nursing facilities.	Department of Health Care Policy and Financing	Agree	06/30/01

Overview of Nursing Facilities

Introduction

Colorado has 231 licensed nursing facilities that provide long-term care to about 17,000 people who are elderly or who have intensive long-term care needs. Of these, seven facilities are private-pay only. The remainder serve people who are eligible for Medicare, Medicaid, or both. The number of facilities and people served for Fiscal Year 1999 is displayed in the chart below.

People Served in Nursing Facilities in Colorado
Fiscal Year 1999

Type of Facility[1]	Number of Facilities	Number of Residents
Accepts only Private-Pay	7	295
Accepts Medicare	27	1,067
Accepts Medicaid	23	1,376
Accepts both Medicare and Medicaid	174	14,547
TOTAL	**231**	**17,285**

Source: Information provided by the Department of Public Health and Environment.

Note: [1] Facilities that are certified to accept Medicare or Medicaid may also serve private-pay residents.

Two state departments—the Departments of Health Care Policy and Financing and Public Health and Environment—are responsible for overseeing various aspects of Colorado's nursing facilities. Their respective responsibilities are detailed below.

State Responsibilities for Overseeing Nursing Facilities	
Health Care Policy and Financing	**Public Health and Environment**
• Reimburse nursing facilities for resident care. • Determine eligibility. • Audit nursing facility billings and their cost reports.	• License nursing facilities according to state law. • Certify nursing facilities according to federal Medicaid/Medicare requirements. • Evaluate quality of care. • Investigate complaints and occurrences.
Source: Compilation of information provided by the Departments of Health Care Policy and Financing and Public Health and Environment.	

As can be seen from the chart, the Department of Health Care Policy and Financing is primarily responsible for financing activities while the Department of Public Health and Environment is responsible for standards and quality of care.

Oversight of Nursing Facilities by the Department of Public Health and Environment

The federal government requires all states to evaluate the quality of health care services provided to its citizens. In Colorado, this responsibility rests with the Health Facilities Division (Division) within the Colorado Department of Public Health and Environment. According to its mission statement, the Division "assures that patients and residents receive quality care from health facilities and programs which are licensed and/or certified and promotes health and safety through on-site inspections and complaint investigations." The Division oversees nursing facilities primarily through the functions described below:

- **Licensure.** According to state law, all nursing facilities that operate in Colorado must be licensed. The Division conducts on-site inspections and reviews building plans, ownership information, company by-laws, and other key documents to determine whether a facility has the legal capacity, financial resources, and competence necessary to function as a licensed provider. Licenses are valid for one year and must be renewed annually. The Division has 5 FTE that license various types of health care facilities, including nursing facilities. The Division estimates that, during Fiscal Year 2000, it spent a total of about $240,000 (primarily State General Fund) on licensing activities.

- **Certification Surveys and Complaint and Occurrence Investigations.** The federal Health Care Financing Administration (HCFA) requires the Health Facilities Division to "certify" the 224 nursing facilities in Colorado that participate in federal Medicare or Medicaid programs. The Division accomplishes this through unannounced inspections, known as surveys, conducted according to federal standards at least once every 15 months. Additionally, the Division provides ongoing monitoring through complaint and occurrence investigations. A complaint can be alleged by anyone and, once classified, will result in an investigation. An occurrence is an incident (such as death, abuse, serious injury, or a missing resident) that a nursing facility is required to self-report to the Division. Depending on the severity of the incident, the Division will conduct either an on-site or paper review of the occurrence. Problems identified through surveys, complaints, and occurrences result in deficiencies and sanctions, which are reported to and tracked by the federal government. The Division has about 86 FTE that conduct Medicare/Medicaid certification activities for all certified health care providers in Colorado, including nursing facilities. The Division estimates that, during Fiscal Year 2000, it spent about $6.5 million for all certification functions. Of this amount, about $4.8 million were federal funds and $1.7 million was State General Fund.

Oversight of Nursing Facilities by the Department of Health Care Policy and Financing

The Department of Health Care Policy and Financing is responsible for providing financial oversight of and payments to nursing facilities that serve Medicaid recipients. There are 197 nursing facilities in Colorado certified to serve Medicaid recipients, representing 85 percent of all nursing facilities in the State. The Department estimates that, during Fiscal Year 2000, the State spent about $350 million in Medicaid funds on nursing facility care to Medicaid recipients. Of this amount, about half is from the State General Fund. About five Department FTE are responsible for financial oversight of nursing facilities. Oversight is accomplished through rate-setting, change-of-ownership audits, and cost report audits, as described below.

- **Rate-setting.** The Department pays each nursing facility a per diem rate based on its audited costs. During the 1997 legislative session, the General Assembly authorized the Department to develop a new reimbursement methodology based on case mix. The new methodology was effective July 2000. Under the new methodology, nursing facility payments are adjusted based on the acuity of the population served. Property and administration expenses are reimbursed based on costs. During 1997 the General Assembly

also set annual limits on nursing facility rate increases. Administrative cost increases are limited to 6 percent per year.

- **Change-of-ownership, billing practices, and personal needs fund account audits**. The Department has one staff who audits nursing facility billing practices and personal needs funds accounts (accounts which are held and managed by nursing facilities for the benefit of the resident) on a limited basis. Audits are directed primarily toward nursing facilities that have recently had a change of ownership.

- **Cost report audits.** Nursing facilities report their costs to the Department annually on Med-13 cost reports. The Department hires a contracted audit firm to audit the cost reports annually and develop reimbursement schedules.

The Quality Care Incentive Payment (QCIP) Program

In 1994 the General Assembly created the Quality Care Incentive Payment program (QCIP) to improve the quality of care at nursing facilities. The purpose of QCIP is to reward nursing facilities with financial incentives for delivering high quality of care. The Department of Health Care Policy and Financing (Department) administers the program. The Health Facilities Division (Division) at the Department of Public Health and Environment assesses quality of care at nursing facilities to establish a basis for determining QCIP incentive payments.

Audit Scope

This audit reviews quality of care measures and financial incentives for QCIP as required by Section 26-4-410 (2) (c.5) (IX) (A), C.R.S. Clifton Gunderson L.L.C., a contracted auditing firm, reviewed the Division's oversight of quality of care as measured through its surveys and complaint investigations. The auditors' conclusions and recommendations are reported in Chapter 1. The Office of the State Auditor reviewed the effectiveness of QCIP financial incentives in improving nursing facility quality of care. The conclusions and recommendations of audit staff are presented in Chapter 2.

Oversight of Nursing Facility Quality of Care

Chapter 1

Introduction

In recent years quality of care at nursing facilities has become a major focal point nationally. According to the U.S. Department of Health and Human Services, nursing facility quality of care has declined. There have been increases in health care problems related to negligence. Pressure sores, weight loss, and malnutrition are of increasing concern to residents and their families.

To promote quality of care at nursing facilities, the General Assembly established the Quality Care Incentive Payment program (QCIP) in 1994. The purpose of the QCIP program is to provide financial incentives to nursing facilities for delivering high-quality care. The State paid about $4.4 million in state and federal Medicaid funds to nursing facilities for QCIP incentive payments during Fiscal Year 2000. Of this amount, $1.3 million was allocated to nursing facilities based on a single quality of care measure—deficiencies identified through federally mandated certification surveys and complaint investigations conducted by the Health Care Facilities Division (Division) at the Department of Public Health and Environment. This chapter reviews the effectiveness of the Division's activities in overseeing quality of care through certification surveys and complaint investigations. Chapter 2 discusses the effectiveness of the QCIP program in encouraging nursing facilities to deliver high-quality care.

Quality of Care Monitoring Activities

One of the primary ways the Division oversees quality of care at nursing facilities is through investigations, termed "surveys," mandated by the federal Health Care Financing Administration (HCFA). All 224 Colorado nursing facilities that participate in either the federal Medicaid or Medicare programs receive unannounced surveys by the Division at least once every 15 months. Interdisciplinary survey teams, primarily composed of registered nurses, dietitians, therapists, and social workers, assess whether the quality of care provided at the facility complies with federal regulations.

In addition to conducting surveys, the Division investigates complaints and occurrences. Complaints may be alleged by anyone, but occurrences are incidents, such as patient abuse or serious injury, that are self-reported by the nursing facility. All investigations, whether resulting from surveys, complaints, or occurrences, may identify deficient practices that can adversely impact quality of care. Deficient practices are categorized by 196 deficiency "tag" numbers, and coded for scope and severity. Scope and severity codes determine the actions nursing facilities must take to remedy a deficiency and also establish the sanction that will be imposed. Scope and severity codes are displayed in the following chart:

Scope and Severity Codes for Medicare and Medicaid Compliance Deficiencies

Severity of Deficiency	Scope		
	Isolated	Pattern	Widespread
Actual or Potential for Death or Serious Injury	J	K	L
Other Actual Harm	G	H	I
Potential for More Than Minimal Harm	D	E	F
Potential for Minimal Harm (Substantial Compliance)	A	B	C

Source: Federal Health Care Financing Administration.

Facilities with A, B, or C deficiencies are in substantial compliance and no remedy or sanction is assigned. Deficiencies coded D through L become progressively more serious and subject facilities to remedial actions and sanctions.

Federal regulations require the Division to follow up promptly on all deficiencies cited that are coded B or greater. Follow up entails either an on-site or paper review. The nursing facility must submit a plan of correction, and the Division must resurvey the facility within 90 days or the facility will be denied payments for new Medicare and Medicaid patient admissions. If the deficiency has not been corrected, the deficiency is cited again and more stringent sanctions may be imposed. Deficiencies, scope and severity codes, sanctions, and resurvey results are all reported to the public on the Division's Web site.

Quality of Care Issues at Nursing Facilities

As we have discussed, deficiencies cited through certification surveys and complaint investigations are the primary way the Division measures and assesses quality of care at nursing facilities. Additionally, these investigations form the basis for $1.3 million in incentive payments for QCIP, the State's financial incentive program for nursing facilities. We reviewed the Division's oversight of nursing facility quality as monitored through certification surveys and complaint and occurrence investigations. Our audit included review of data from several sources:

- We compared survey deficiencies identified by Division surveyors with deficiencies identified by HCFA surveyors.

- We used the expertise of nurse consultants to observe the effectiveness of Division surveyors in identifying quality of care issues during surveys.

- We compared survey deficiencies in Colorado with regional and national data.

We found that, in general, the Division is conducting surveys and complaint investigations in accordance with the protocols set forth by HCFA. Additionally, the Division makes detailed information on the results of these investigations available to the public through its Web site. We commend the Division for the value of the public information maintained on its Web site.

We also noted quality of care concerns at nursing facilities. The Division needs to improve its surveys to better identify quality issues at nursing facilities, as discussed below.

Deficiencies Cited by HCFA Surveyors

HCFA provides oversight of the Division's survey process by conducting comparative surveys (where HCFA resurveys the nursing facility within 60 days of the Division's survey). We reviewed these surveys as one indicator of the Division's effectiveness in identifying quality of care issues. HCFA conducted four comparative surveys in Colorado between February of 1999 and March of 2000. These surveys were conducted between 12 and 32 days after the Division's surveys, depending on the nursing facility. We found that HCFA surveyors cited eight times the deficiencies that Division surveyors did. In contrast, HCFA cited about two times the deficiencies as surveyors in other Region VIII states (HCFA Region VIII states include Colorado,

Montana, North Dakota, South Dakota, Utah, and Wyoming). For three Colorado facilities with a total of 49 deficiencies, HCFA determined that 28 deficiencies would have been present when Division surveyors were on-site. Further, of 73 deficiencies identified by HCFA surveyors, 15 related directly to quality of care standards, including pressure sores, nutrition, and hazards for residents. These comparative surveys raise questions about the effectiveness of the Division's surveys in uncovering quality of care concerns at Colorado nursing facilities.

On-Site Reviews

We contracted with three registered nurse consultants to conduct on-site evaluations of two surveys conducted by Division surveyors and to review 25 completed survey files. Our consultants, with 30 cumulative years of experience reviewing quality of care issues, made the following observations:

- **Division surveyors did not identify a significant medical treatment issue for investigation at one nursing facility.** Our review determined that there was a quality of care issue related to the nursing facility's treatment of pressure sores. Pressure sores were observed on more than one resident. In one instance, the pressure sores developed during the resident's stay at the facility and progressed to wet gangrene. The resident had to have his foot amputated. Division surveyors did not investigate pressure sores during the survey until our nurse consultants brought these concerns to the survey team's attention. A deficiency was subsequently cited. At another facility, we observed that Division surveyors did not follow HCFA investigative protocols for three pressure sores identified on a resident.

- **Division surveyors did not appropriately assign scope and severity to a housekeeping and maintenance deficiency at one facility.** Division surveyors noted numerous problems with dirt and grime throughout the facility. The surveyors assigned a scope and severity of "E" (a "pattern" of incidents with potential for more than minimal harm). Our nurse consultants would have assigned a scope and severity of "F" ("widespread" problem with potential for more than minimal harm) because the problem was evident in 48 of 75 rooms, 3 of 4 dining rooms, and 5 of 5 units at this facility. An "F" sanction is significantly more serious than an "E" sanction, since more severe penalties may be imposed.

- **Division surveyors overlooked problems with administering pain medication at one facility.** During the survey at one facility, our nurse consultants observed a resident who was exposed and in substantial pain. The resident had a doctor's order for pain medication each hour as needed, but the

resident had not received his pain medication for at least five hours. The Division's surveyor noted that the resident was exposed, but did not observe that the resident was in pain and had not received his pain medication. Although the Division cited a dignity deficiency, no focused review or investigation of pain control occurred during the survey. Additional focused review may have resulted in citing a deficiency.

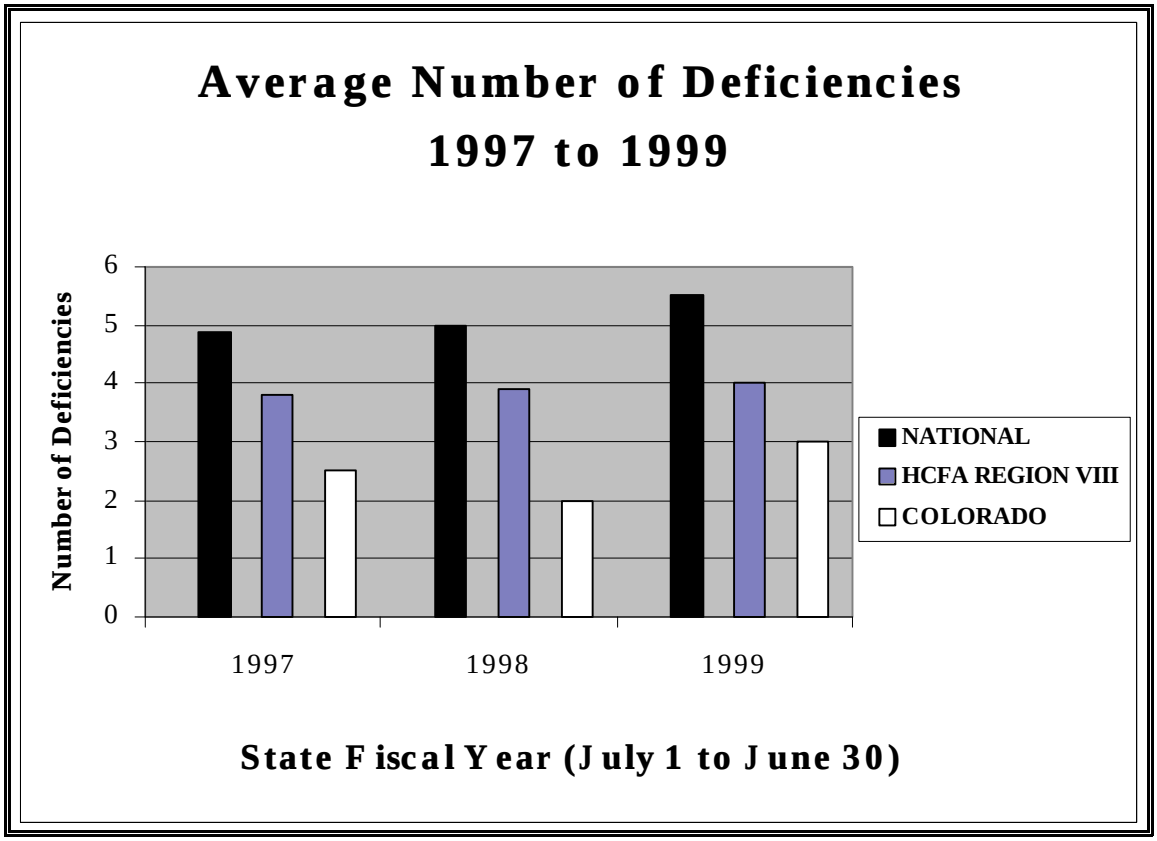
- **Division surveyors did not thoroughly investigate infection control issues at one nursing facility.** During the initial tour of the facility Division surveyors noted catheters hanging in one resident room with the tips exposed and lying on the floor. The exposed catheters should have raised an issue about the facility's commitment to infection control; however, Division surveyors did not investigate this issue further. The Division cited infection control as an "A," indicating substantial compliance. The Division could have substantiated a scope and severity of "D" if surveyors had conducted the investigation as warranted by the circumstances.

- **Division surveyors did not consistently comply with HCFA documentation requirements.** Our survey observations noted that Division surveyors filed incomplete forms, did not record the number of required resident interviews on sampling forms as required by HCFA, and modified the sample size without documenting the rationale. During our review of 25 completed survey files, we noted that 14 of 25 files contained incomplete forms required by HCFA and 5 of 25 files contained at least one missing document. Of 25 files, 11 Resident Review Worksheets were not completed as required by HCFA regulations. Resident reviews are critical because they often uncover problems with quality of care. Complete documents are important for supervisory review, to substantiate deficiencies, and to withstand scrutiny upon appeal.

Our review of HCFA comparative reports revealed that HCFA surveyors identified some of these same issues during their surveys at different nursing facilities. For instance, HCFA also raised issues concerning pressure sores in prior surveys. In each instance, HCFA surveyors cited deficiencies when Division surveyors did not.

Deficiencies Cited in Colorado and Other States Regionally and Nationally

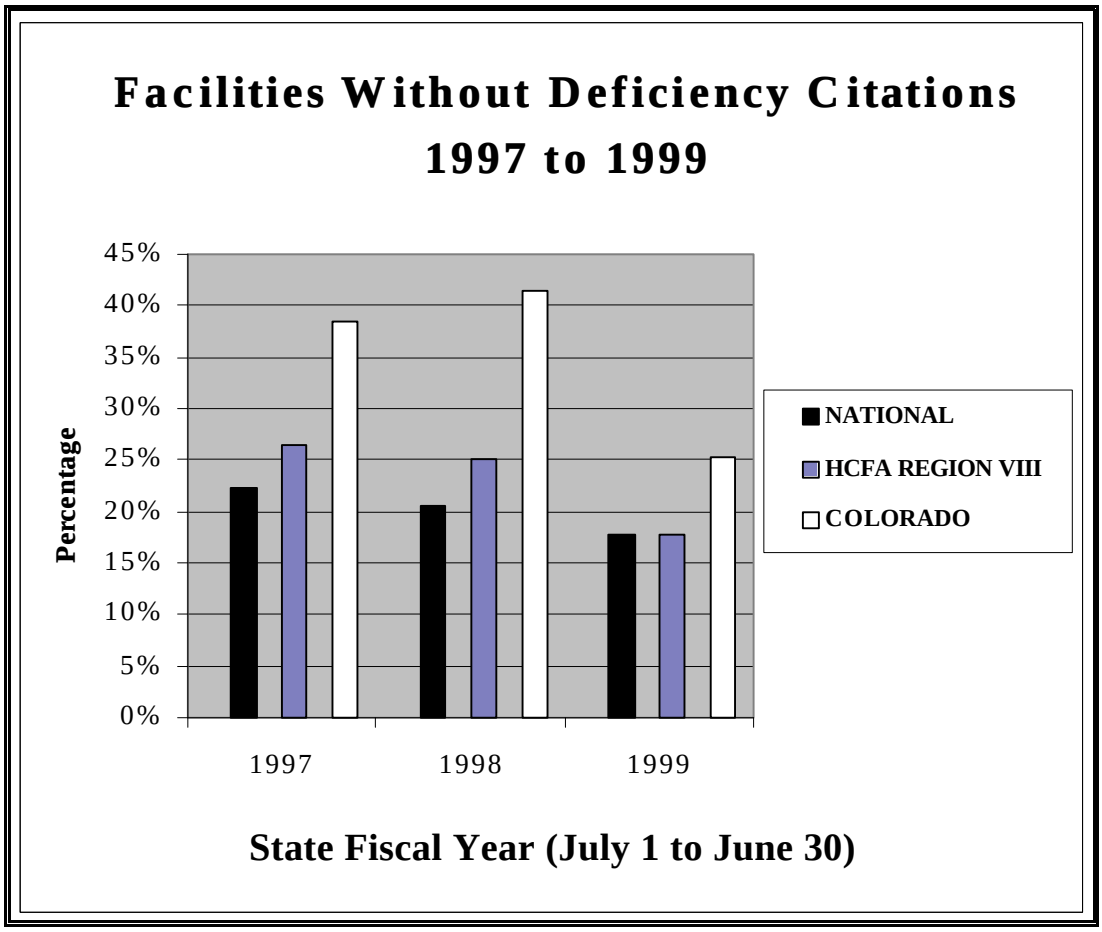
We compared deficiencies cited during surveys in Colorado with federal data available at national and regional levels (HCFA Region VIII states include Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming). We found that during the past three years the Division's surveyors have identified, on average, 51 and 36 percent fewer deficiencies, respectively, than other states nationally and regionally. Deficiencies cited for the past three years are shown in the following graph.



Source: American Health Care Association's *Nursing Facilities' Deficiency Report.*

From these data one could conclude that Colorado's nursing facilities are providing higher quality care than other states nationally or in Region VIII. However, when this information is viewed along with the data already presented in this report, this raises questions about Colorado's oversight of quality of care through surveys.

We also found that, on average, 35 percent of Colorado facilities were not cited with any deficiencies during the past three years. In contrast, an average of 23 and 20 percent of facilities, respectively, in Region VIII and nationally were not cited with any deficiencies. These data are presented in the following graph.



Source: American Health Care Association's *Nursing Facilities' Deficiency Report.*

Further, we found that Colorado cites deficiencies with an average lower severity than other states nationally and regionally. For example, substantially fewer facilities in Colorado receive deficiencies coded with a scope and severity of "F" or higher. A facility cited with a deficiency of "F" or higher will be subject to more serious sanctions, including monetary penalties, than a facility cited with deficiencies coded at D or E. The percentage of deficiencies coded at "F" or higher in Colorado, Region VIII, and nationally is displayed in the following chart.

Comparison of Scope and Severity Ratings Colorado, Region VIII, and U.S. Federal Fiscal Year 1999			
Scope and Severity	Colorado	Region VIII	United States
A through E	93%	83%	82%
F through L	7%	17%	18%
Source: American Health Care Association's *Nursing Facilities' Deficiency Report.*			

The chart shows that, during 1999, about 7 percent of the deficiencies cited in Colorado had a scope and severity of F or greater and 93 percent had a scope and severity of E or less. In contrast, about 18 percent of the deficiencies cited nationally during 1999 had a scope and severity of F or greater and about 82 percent had a scope and severity of E or less.

These graphs and charts show that Colorado is an outlier in terms of both the number and scope and severity of deficiencies cited. Again, these data raise questions about whether the Divisions' surveyors are effectively uncovering quality of care issues at Colorado nursing facilities.

Increased Training and Supervision Are Needed

The importance of citing a deficiency, when supported by adequate evidence, cannot be overstated. Federal rules require that all deficiencies of B or greater result in a plan of correction. The plan of correction must be submitted by the nursing facility within 10 calendar days. Additionally, federal rules require the Division to resurvey any facility with a deficiency of G or greater. The facility must be in substantial compliance within 90 days or the facility will be denied payment for new Medicaid and Medicare patient admissions. The resurvey is focused on reviewing the issues that led to citing the deficiency. If the deficiency is cited again, sanctions may be imposed by the federal government.

The Division resurveys all facilities with a deficiency of B or greater within 90 days. For a sample of 19 nursing facilities with deficiencies cited at B or greater, we found that all 19 facilities submitted required plans of correction within specified time frames. Resurveys also occurred within 90 days as required by federal rules. In each instance, the deficiencies were corrected and no further deficiencies were cited.

Since deficiency citing is key to ensuring nursing facilities correct quality of care issues, it is critical that Division surveyors identify and thoroughly investigate

potential deficiencies and cite and code them appropriately. The Division can improve its deficiency citing as explained below.

First, we identified a need for increased teambuilding for Division surveyors. HCFA requires a multidisciplinary composition for all survey teams nationwide. Survey teams must include professionals from multiple disciplines, such as dietitians, therapists, and social workers, in addition to nurses. The Division's survey teams are composed of the mix of professionals required by the federal government. However, multidisciplinary teams need strong teambuilding skills to operate effectively. Through increased training and teambuilding, the Division can ensure that all survey team members have an awareness of clinical issues and can appropriately identify quality of care concerns.

Second, we noted a need for increased training. The Division reports problems with staff turnover. As the Division hires new staff to replace those who leave, fewer staff have experience conducting surveys. Our review of staff experience confirms this fact. Of 23 nursing facility surveyors who spend most of their time on-site at facilities, over half have three years or less experience, and 26 percent have one year or less experience. Division staff report that these newer staff have not had the same training opportunities as more experienced staff. For example, the Division developed a training program on investigative protocols that it presented to its own surveyors and to other states nationally. It reports that three of its nursing facility surveyors have not yet had this training. The Division is currently revising this training and will provide the training to these surveyors when revisions are complete.

Third, Division staff report that more structured observations by supervisors while teams are on-site is needed. According to the Division, for 227 surveys conducted during Fiscal Year 2000, about 12 had structured observations by supervisors. The Division plans to use HCFA surveys, quality indicators, and informal reviews of completed surveys to identify issues that need to be observed and reviewed while teams are on-site. Additionally, the Division plans to increase the number of on-site survey observations completed by supervisors.

Recommendation No. 1:

We recommend the Health Facilities Division increase focus on quality of care and deficiency citing through certification surveys. This should include:

a. Training to enhance cross-disciplinary understanding, focusing on investigative protocols, scope and severity ratings, deficiency tag assignments, and resident

risks observable through interviews, patient records, facility records, and facility inspections.

b. Structured on-site review by supervisors of survey team activities.

c. Teambuilding techniques to ensure timely communication occurs throughout the survey process.

Health Facilities Division Response:

Agree. The Division is committed to improving its focus on quality of care and deficiency citing and will increase surveyor training, on-site supervision, and teambuilding. The Division has hired a Clinical Nurse Field Manager to provide additional on-site supervision of survey teams and is scheduling a gerontological nursing assessment training for all surveyors and supervisors.

Although we agree with the auditors' recommendation, we disagree with the report text in the following areas. First, we disagree with the assumption that HCFA comparative survey results are comparable to the surveys done by the Division. HCFA comparative surveys are completed at different times and with more resources than those available for state agency use. Other states have raised concerns about HCFA comparative surveys and HCFA indicates it will be implementing a state appeals process in the future. Second, we disagree with the consultants' on-site observations. Our disagreement is based on differences in how we perceive the facts and on differences in professional opinion. For example, our survey team identified pressure sores as a potential problem prior to entering the facility, rather than in response to the consultants' comments. Finally, we disagree with the assumption that a simple comparison of the number of deficiencies in Colorado and other states is valid. This comparison does not recognize that legitimate factors such as Medicaid reimbursement rates, state licensure laws and regulations, consumer information, and the involvement of the state's ombudsman program may cause variances from state to state.

These disagreements, however, do not diminish the Division's agreement with the recommendation.

Additional Quality of Care Measures

Currently the Division monitors quality of care at nursing facilities almost exclusively through federally mandated certification surveys and complaint investigations. We found that the number of deficiencies cited through these investigations is increasing. For example, the number of facilities with deficiencies has increased by 26 percent and the number of deficiencies per facility has increased by 20 percent. The number of enforcement actions has more than doubled. Federal guidelines around enforcement actions have become more stringent. However, these increases are still indications that quality of care may be suffering at nursing facilities.

We found that other states do not rely solely on federally mandated activities to address quality issues at nursing facilities. Some are developing additional measures to monitor and assess quality. Of nine states we contacted, eight had implemented or were developing additional quality measures. These eight states uniformly agreed that deficiencies identified through surveys and complaints were not, without additional measures, adequate to measure and monitor nursing facility quality of care. Quality measures reported by these states included staff turnover, staff expertise, financial stability, and consumer satisfaction survey results.

The Division is currently developing a database that captures risk factors, such as nursing facility ownership, changes in key personnel, complaints, deficiencies, enforcement remedies, and financial data. These data will be used to profile nursing facilities and identify potential quality of care concerns. These data could also be used to develop additional quality measures similar to those in use in other states. The Division should research measures in use by other states and use this information along with information in its profiling database to develop additional measures to assess and monitor nursing facility quality.

Recommendation No. 2:

The Health Facilities Division should improve the information available for measuring and assessing quality of care at nursing facilities by developing additional quality of care measures. To assist with this effort, the Division should research and evaluate quality of care measures in use in other states along with information maintained in its profiling database.

Health Facilities Division Response:

Agree. The Division is continuing to develop a database of quality measures for each nursing facility and has contacted all states and several universities requesting information on additional quality measures.

Oversight of Complaints

The Division is responsible for investigating and resolving all complaints regarding nursing facilities. Complaints come from a number of sources, including the resident's family, the nursing facility's employees, another state agency, or the ombudsman (a government employee or volunteer who serves as an advocate for residents). The Division has developed an automated, state-of-the-art complaint management system termed the Complaint Priority Assessment System (COMPASS). All complaints are entered into this system and prioritized according to HCFA and Division guidelines. Complaint investigations are generally performed on-site and will cite deficiencies and impose sanctions, if warranted. The results of complaint investigations are available to the public on the Division's Web site.

The Division received about 580 complaints during State Fiscal Year 2000. During the past four years, the number of alleged and substantiated complaints has increased by 26 and 84 percent, respectively. The following chart shows the number of complaints filed and substantiated for the past four state fiscal years.

Alleged and Substantiated Complaints
Fiscal Years 1997 Through 2000

State Fiscal Year	1997	1998	1999	2000
Alleged Complaints	469	407	470	589
Substantiated Complaints	102	109	143	188
Percent Substantiated	22	27	30	32

Source: Information provided by the Health Facilities Division.

The chart shows that 22 percent of complaints were substantiated in Fiscal Year 1997. In contrast, 32 percent of complaints were substantiated in Fiscal Year 2000, an increase of 45 percent.

We reviewed a sample of 40 complaints covering the period December 24, 1999, to June 21, 2000. We also reviewed the Division's phone log for the complaint hotline. We found:

- **Complaint investigation results are not reported timely.** Although the Division is in compliance with HCFA and state time frames for initiating complaint investigations, it is not reporting the results of these investigations timely. Of 40 complaint files reviewed, the average time from the date the complaint was received until the report was completed was 61 days. Some reports were completed within a week; others were not completed for over 100 days. Currently the Division has not established deadlines for completing investigation reports. The individuals reporting a complaint need timely notification that their concerns have been investigated and resolved. Additionally, individuals relying on information from the Division's Web site to select or monitor a nursing facility need to have complete and accurate information on the outcome of any complaints.

- **Complaint documents are not maintained in one location.** In addition to using COMPASS to prioritize and track complaints, the Division also maintains a paper file of each complaint investigation. However, we found that paper complaint files were not complete. Of 40 files reviewed, 9 did not contain a copy of the computerized priority assessment assigned by COMPASS. Therefore, supervisors must check both paper files and the automated COMPASS system to obtain all information available about the complaint. The Division is moving toward a paperless system for maintaining complaints. The Division should eliminate paper files as soon as possible and maintain all documents on COMPASS so that complaint information can be retrieved and reviewed efficiently. An automated checklist would assist with accountability.

- **The dispositions of complaints coming in on the Division's hotline are not recorded consistently.** The Division's complaint hotline is the entry point into the Division's complaint system. All calls are logged, but the log does not indicate which calls were classified as complaints. Additionally, the log does not indicate the disposition of incoming calls (whether they were entered into COMPASS or referred to another agency). An accurate complaint log would allow the Division to track the number of calls that become complaints and ensure that all complaints are entered into the system and receive responses.

To address these issues, the Division should develop time frames for completing complaint investigation reports. Time frames should vary depending on the seriousness of the complaint allegations. Additionally, the Division should develop an automated checklist on its COMPASS tracking system. The checklist should indicate

when documents have been completed, and enable complaint tracking and monitoring. The checklist should also include an audit trail to the complaint log so that the Division can determine the disposition of all complaints received on the complaint hotline.

Recommendation No. 3:

The Health Facilities Division should improve its tracking and monitoring of complaints by developing time frames for reporting the results of complaint investigations and a checklist for monitoring complaints on COMPASS. The checklist should include dates when complaint outcomes have been determined, entered onto the Division's Web site, communicated to the nursing facility, and entered onto the complaint tracking system. Additionally, the checklist should track when key communications have been sent and include an audit trail to the complaint hotline phone log.

Health Facilities Division Response:

Agree. When HCFA shortened the complaint time frames to two and ten days in January 2000, the Division made a decision to focus resources on doing on-site investigations at the risk of delaying the reports. Because the ability to prepare complaint investigation reports in a timely manner is dependent on having adequate resources, the Division requested additional FTE for complaints in its August 2000 budget request submission to HCFA. Reasonable time frames for completing the complaint investigation reports will be developed based on the resource level approved for Federal Fiscal Year 2001. The Division will also modify its existing information system to add pertinent processing dates and actions taken, and to create an audit trail of significant changes.

Recommendation No. 4:

The Health Facilities Division should revise the complaint intake log to record and track the disposition of all calls and complaints entering through the complaint hotline.

Health Facilities Division Response:

Agree. In an effort to further move toward a paperless system, all complaints and inquiries will be immediately entered into the complaint tracking system

and the paper complaint logs will be eliminated. The system will provide automatic tracking of the disposition and outcome of such complaints and inquiries.

Data Security Issues

When the Division receives a complaint, it enters the information and tracks the complaint through its COMPASS system. Currently, any Division staff member can access the complaint system without a login or password. The complaint prioritization, determined by the automated system when data are first entered, can be changed by anyone. Additionally, there is no audit trail if staff make manual changes to the complaint prioritization (such as changing the priority of the complaint investigation so that it begins in 10 days instead of in 2 days). Other staff can delete notes recorded in the system.

These security problems could allow unauthorized staff to change and delete critical information, such as complaint prioritization, from the COMPASS system. This impacts the integrity of the complaint tracking system and could jeopardize quality of care if important information regarding the complaint is changed or deleted.

Recommendation No. 5:

The Health Facilities Division should limit access to its COMPASS system to authorized users by implementing logins and individual passwords. Additionally, the Division should ensure that when the system prioritizes complaints initially, this prioritization is fixed in the system and any changes tracked through an audit trail. Finally, the Division should establish controls to make sure that notes about the complaint and its investigation cannot be deleted once staff enter them into the complaint tracking system.

Health Facilities Division Response:

Agree. The Division is planning future modifications to the COMPASS system which will further restrict access, limit the ability to make changes, and maintain a permanent record of entries.

Oversight of Occurrences

Occurrences are incidents at nursing facilities—such as death, serious injury, a missing resident, or physical, sexual, or verbal abuse—which statutes require nursing facilities to self-report to the Division the next day. About 460 occurrences were reported during the 1999 calendar year. When a nursing facility reports an occurrence, the Division first evaluates the facility's initial response to make sure the facility has taken immediate steps to ensure patient safety. The Division also monitors the facility's internal investigation along with the facility's compliance history to determine whether an on-site review is necessary or whether an off-site review is adequate. We identified the following concerns with the Division's handling of occurrences:

- **Occurrences are not reported timely.** Of 41 occurrences reviewed, 14 (34 percent) were not reported within one day as required by federal regulations. These 14 occurrences were filed, on average, 7 days late. When the facility files an occurrence, the Division reports the occurrence on its Web site and notes that the facility was reminded of the timely filing requirement. If late filing becomes a problem, the Division can also require corrective action plans or in-service training. However, no other sanctions are available to the Division other than to revoke the facility's license. Intermediate sanctions, such as fines, would provide the Division with more authority to enforce timely reporting requirements. The Division should evaluate whether intermediate sanctions are needed and propose legislation accordingly.

- **The Division has not established deadlines for completing occurrence investigations.** Our review of 41 occurrence investigations revealed that, on average, 54 days lapsed between the date the occurrence was reported to the Division and the date the investigation began. For substantiated abuse occurrences, an average of 49 days lapsed between when the occurrence was reported and the date the investigation began. (Substantiated abuse occurrences represent about 50 percent of all occurrences reported to the Division. Abuse occurrences may involve patient to patient abuse, abuse by a resident against staff, or abuse by staff against a resident.) Neither HCFA nor the Division has established timelines for investigating occurrences. Timely investigation of occurrences is an issue in many other states as well. The timeliness of these investigations is critical, as key staff may leave their positions, people may fail to recall details, and evidence of the abuse may heal.

- **Abuse occurrences are not reported timely to the Medicaid Fraud Control Unit.** A verbal agreement between the Division and the Fraud Unit (located in the Attorney General's Office) requires the Division to provide abuse occurrence information to the Fraud Unit within seven days of notification by

the nursing facility. Our review of 35 substantiated abuse occurrences revealed that, on average, 24 days lapsed between the date of the occurrence and the date the Division forwarded the occurrence information to the Fraud Unit. According to staff at the Fraud Unit, these delays can reduce the effectiveness of the Unit's investigation, since evidence to substantiate the abuse may no longer be available. The Division and the Fraud Unit are currently revising their Memorandum of Understanding (MOU) to address abuse occurrence reporting. The MOU should formalize the time frames for reporting abuse occurrences by the Division.

- **Follow up on abuse occurrences is needed.** According to information provided by the Division, staff do not always follow up with nursing facilities to make sure abuse occurrences are reported to local law enforcement when required by law. During our audit, the Division conducted a review of a sample of 21 abuse occurrences. It identified six occurrences that were not reported to local law enforcement. Of these six occurrences, two appeared to meet criteria warranting police notification. The Division needs to follow up with both nursing facilities and local law enforcement to make sure that abuse occurrences are reported and investigated.

- **The Division lacks an integrated system for tracking occurrences.** The Division tracks occurrence outcomes through management reports. However, occurrence outcomes are not integrated with complaint and survey outcomes on a single system, such as COMPASS. The Division is currently considering tracking occurrences on its COMPASS system. A single tracking system will assist the Division with monitoring the content and frequency of all problems identified at nursing facilities so that it can intervene promptly.

Recommendation No. 6:

The Health Facilities Division should improve its oversight and management of occurrence investigations by:

a. Evaluating the need for intermediate sanctions to encourage compliance with timely reporting requirements and proposing legislation, if indicated.

b. Establishing reasonable time frames for completing occurrence investigations and ensuring investigations are completed within those time frames.

c. Developing time frames for referring abuse occurrence information to the Medicaid Fraud Control Unit through a Memorandum of Understanding and following up to monitor the outcome.

d. Following up on abuse occurrences to make sure nursing facilities are reporting occurrences to local law enforcement and that local law enforcement is investigating these occurrences.

e. Monitoring the frequency and content of problems identified through occurrences through a single tracking system, such as COMPASS, and taking prompt action when serious problems are evident.

Health Facilities Division Response:

Agree.

a. The Division will conduct a formal analysis of the extent and reasons for noncompliance with the occurrence reporting requirement and whether additional statutory authority is needed to improve compliance.

b. The completion of the majority of investigative reports is dependent on external factors such as analysis by facility staff or third parties (e.g., police, coroner). Reasonable time frames which take into account ongoing or partially completed activities will be developed and tracked.

c. The Division is negotiating a revised agreement with the Medicaid Fraud Control Unit which will include all pertinent time frames and reporting of outcomes. The Division is also exploring electronic data sharing with the Unit to improve access to and timeliness of data.

d. Existing data will be modified to track that facilities are reporting occurrences to law enforcement as appropriate and the Division will follow up on the results of law enforcement investigations. In addition, the Division is working with the Medicaid Fraud Control Unit on a joint letter to facilities providing guidelines on what should be reported. The Division is also providing support to the Unit's initiative to improve the training of law enforcement officers with respect to investigations involving nursing home residents.

e. The Division will proceed with its plans to modify existing data systems to incorporate occurrence information.

Conflict of Interest Statements

The federal government requires all Division surveyors to complete a conflict of interest statement to maintain the integrity of surveys and investigations. The purpose of the conflict of interest statement is to identify any relationships between Division employees and a nursing facility that would impact the objectivity or credibility of a survey or investigation. We reviewed the Division's conflict of interest statements and identified the following problems:

- **Some conflict of interest statements were missing or outdated.** Of a sample of 10 employees, the Division could not find conflict of interest statements for 2 people. Additionally, conflict of interest statements for two employees had not been updated since 1995. If conflict of interest statements are missing or out of date, the Division may not be aware of relationships between surveyors and nursing facilities that could jeopardize the outcome of a survey or investigation.

- **The supervisor who staffs and schedules surveys does not maintain a list of potential staff conflicts of interest.** As a result, the supervisor could inadvertently assign staff to a survey or investigation who may have a business or personal relationship with nursing facility staff. This could compromise the outcome of the investigation at that nursing facility.

- **Conflict of interest statements do not require employees to certify that they have not accepted payments or gifts from nursing facilities or related parties.** Again, this information is important for ensuring that Division staff observe ethical behavior and maintain the objectivity and credibility of the Division's oversight of nursing facilities.

Recommendation No. 7:

The Health Facilities Division should improve its oversight of employee conflicts of interest by requiring all staff to complete and update their conflict of interest statements annually. Division supervisors should review these statements and consider conflicts of interest before assigning staff to surveys or investigations. The Division should modify its conflict of interest statements to require each employee to certify that he or she has not accepted payments or gifts from any nursing facilities or their related parties.

Health Facilities Division Response:

Agree. The Division has asked its employees to complete a current conflict of interest form and has distributed information reminding employees of its conflict of interest policies. The forms will be updated at least annually and as necessary when changes occur. In addition, employee conflict of interest information will be incorporated in the Division's data system where it will be accessible to supervisors.

Staff Qualifications

The Division is required to ensure its surveyors and investigators meet minimum qualifications set forth by the federal government. Our review of 10 personnel files (including 6 registered nurses, 1 registered dietitian, 2 licensed therapists, and 1 licensed practical nurse) identified 9 files which contained either no license or an expired license. Additionally, HCFA requires all surveyors to complete the Surveyor Minimum Qualifications Test (SMQT). Of the 10 files in our sample, 2 files lacked documentation that the surveyor had completed this required test. In all instances the Division was able to locate documentation indicating that licenses and qualifications were current. However, it is important to maintain this information in personnel files for tracking purposes. The Division should review these files at least annually and make sure licenses and qualifications are updated as indicated.

Recommendation No. 8:

The Health Facilities Division should review personnel files annually and require staff to update their qualifications as indicated.

Health Facilities Division Response:

Agree. The Division will review its personnel files to ensure that all files include current information regarding employee qualifications. It will also implement an annual request for updated information and require employees to submit documentation as any changes occur.

Financial Incentives for Quality of Care

Chapter 2

Introduction

In 1994 the General Assembly created the Quality Care Incentive Payment program (QCIP) to improve the quality of care at nursing facilities. The Department of Health Care Policy and Financing (Department) administers the program. A nine-member Advisory Committee (representing the Departments of Health Care Policy and Financing and Public Health and Environment, nursing facility residents, nursing facilities, and the State Long-Term Care Ombudsman) provides recommendations to the Department concerning measuring quality and allocating incentive payments to nursing facilities. The Health Facilities Division (Division) at the Department of Public Health and Environment conducts on-site monitoring of nursing facilities for the QCIP program.

When QCIP was implemented in 1995, incentive payments were based solely on nursing facility surveys conducted by the Division. Beginning in 1996, the Department established a two-part incentive program: one part based on quality of care as measured by deficiencies identified through nursing facility surveys and complaint investigations and the other part based on quality of life as promoted through Resident-Centered Quality Improvement Plans (ResQUIP). Nursing facilities that qualify receive their payments from each incentive program in two installments—once in July and once in December. A brief description of each incentive portion follows:

Survey incentive portion. The survey incentive portion of QCIP is intended to improve quality of care. The survey portion rewards nursing facilities based on the results of certification surveys and complaint investigations conducted by the Health Facilities Division. Nursing facilities receive incentive payments if they have no more than two deficiencies with a scope and severity ranging from D to L (deficiencies coded D through L become progressively more serious and subject facilities to remedial actions and sanctions). The incentive payment is weighted so that facilities that have no deficiencies and more Medicaid patient days receive higher incentive payments than facilities with more deficiencies and fewer Medicaid patient days.

During Fiscal Year 2000 nursing facilities received a total of about $1.3 million in survey incentive payments.

ResQUIP incentive portion. The ResQUIP incentive portion is intended to improve quality of life. It rewards nursing facilities for developing and implementing resident-centered, life-enriching programs that promote enhanced communication, better understanding of resident needs, and freedom of choice. Residents must participate in developing and implementing ResQUIP program plans. Examples of approved ResQUIP plans include building outdoor gazebos, patios, and gardens, purchasing aquariums and aviaries, and adopting pets. The Advisory Committee reviews and approves the ResQUIP plans submitted each year. Approved plans receive incentive payments based on Medicaid patient days. The Advisory Committee also selects up to 12 exemplary plans each year and awards $1,000 to these plans designated as "Stars." During Fiscal Year 2000 nursing facilities received a total of about $3.1 million in ResQUIP incentive payments and $12,000 in payments for ResQUIP "Stars." According to the Department, ResQUIP projects were not intended to be based on costs equal to the incentive payment.

QCIP Funding

During Fiscal Year 2000, the Department spent about $4.4 million in state and federal Medicaid funds on QCIP incentive payments. Total QCIP incentive payments for the past six years, including the portions spent for quality of care (survey incentives) and quality of life (ResQUIP and ResQUIP "Stars" incentives), are displayed in the chart below.

Funding for the QCIP Program
Fiscal Years 1995 Through 2000

	FY 1995 (partial year)	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Cumulative Total
Total QCIP	$1,334,186	$2,905,616	$3,077,195	$3,187,678	$4,093,816	$4,432,847	$19,031,338
Survey Portion	$1,334,186	$1,452,808	$1,230,878	$956,303	$1,224,545	$1,326,254	$7,524,974
ResQUIP Portion [1]	$0	$1,452,808	$1,846,317	$2,231,375	$2,857,271	$3,094,593	$11,482,364
ResQUIP "Stars" [2]	$0	$0	$0	$0	$12,000	$12,000	$24,000
Medicaid Residents	Not Available	10,392	10,579	10,265	10,378	10,263	
Average Per Medicaid Resident	Not Available	$279.60	$290.88	$310.54	$394.47	$431.93	

Source: Office of the State Auditor's analysis of information provided by the Department of Health Care Policy and Financing.
Notes: [1] Fiscal Year 1999 money is used to fund the calendar year 1998 ResQUIP plans.
[2] $12,000 in funding for ResQUIP "Stars" is taken from the total amount available for QCIP prior to allocating funds between the survey and ResQUIP incentive programs.

Accountability for QCIP

According to Section 26-4-410 (2) (c.5) (I), C.R.S., the purpose of QCIP is to encourage nursing facilities to improve their quality of care through incentive payments. Our audit concluded there is no evidence that QCIP has improved quality of care. Deficiencies and complaints at nursing facilities are increasing. QCIP lacks adequate measures to assess quality of care, and criteria for incentive payments are too lenient. Finally, financial accountability for ResQUIP incentive payments is absent. Since program inception, funding has increased by two-thirds. In total, the Department has spent over $19 million in incentive payments without evidence that quality of care has improved. The section of the statute governing QCIP should be changed to allow for an overhaul of the program as recommended by this report.

Quality of Care Measures Are Insufficient

Our audit concluded that neither the survey nor the ResQUIP incentive programs pay incentives based on adequate measures of quality care as required by statutes. Statutes clearly require that QCIP incentive payments be based on measurable assessments of quality of care. Section 26-4-410 (2) (c.5) (II), C.R.S. sets forth factors the Department should consider in establishing payment criteria. Among these factors are (A) whether a nursing facility delivers a high level of quality of care as measured by surveys conducted by the Health Facilities Division and (B) whether a nursing facility meets other patient care standards as established by the Department after considering advice from the Advisory Committee. Section 26-4-410 (2) (c.5) (VI) (A), C.R.S. also requires the Advisory Committee to make recommendations on the appropriate method of measuring a "high level of quality of care" for the purpose of making payments to providers.

We found that QCIP, as currently structured, lacks valid measures to assess the extent to which nursing facilities are delivering or improving their quality of care. As a result, neither the survey nor the ResQUIP incentive portions establish a sufficient basis for distributing incentive payments. In regard to the survey portion, we found:

- **Department staff, Advisory Committee members, and nursing facility administrators do not have confidence that surveys adequately measure quality of care.** Consequently, the Department, upon advice from the Advisory Committee, has consistently reduced the portion of QCIP funds dedicated to survey incentive payments. When the program was first implemented in Fiscal Year 1995, 100 percent of QCIP funds were dedicated to survey incentives. Beginning Fiscal Year 1998, the survey incentive

portion was reduced to 30 percent of total QCIP funds. The Advisory Committee has recently considered recommending that the Department further reduce the survey incentive portion to 1 percent of total QCIP incentives.

- **Surveys are not adequately identifying key health and medical issues related to quality of care.** As discussed in Chapter 1, nurse consultants hired by our contractor identified quality of care issues during surveys that the Division's surveyors overlooked. We recommended that the Health Facilities Division improve surveys and identify additional measures for assessing quality of care at nursing facilities.

In regard to the ResQUIP incentive portion, we found:

- **The ResQUIP incentive portion is not based on quality of care measures**. ResQUIP is intended to improve quality of life. The Department lacks any measures for assessing the impact of the ResQUIP incentives on either quality of life or quality of care at nursing facilities. No criteria exist to determine the extent to which one nursing facility's ResQUIP program is achieving better quality of care outcomes than another and, thus, is more worthy of an incentive payment. Because of the nature of the ResQUIP program, it is doubtful that objective measures for these quality of life programs can be developed in the future.

- **Nursing facilities do not have to meet minimum quality standards to receive ResQUIP incentive payments.** For example, in July of 1999 there were 63 facilities with too many deficiencies to qualify for the survey incentive portion of QCIP. However, 55 of these facilities received payments from the ResQUIP portion. Of these 55 facilities receiving ResQUIP payments, 9 had more than 10 deficiencies with a scope and severity of D through L. Altogether, these 55 facilities received a total of $470,000 in ResQUIP incentive payments without meeting minimum standards of care.

QCIP Criteria Are Too Lenient

Our audit found that a high percentage of nursing facilities are receiving incentive payments. During Fiscal Year 1999, 148 of 195 nursing facilities (76 percent) received at least one survey incentive payment. During the same year, 172 of the 174 nursing facilities that submitted a ResQUIP plan (99 percent) received at least one ResQUIP incentive payment. We determined that one reason so many facilities are receiving incentive payments is that the criteria are too lenient. The criteria for

receiving incentives under this program raise questions about whether the incentive payments play a sufficient role in motivating facilities to provide better care. We identified the following problems:

- **Survey incentive portion.** First, nursing facilities receive survey incentive payments for doing what is required by their provider agreements, that is, minimizing their survey deficiencies. They receive payments as long as they have no more than two deficiencies classified as D or greater. Some of these allowed deficiencies are serious. Our review of a sample of facilities that were awarded survey incentive payments found deficiencies such as 1) residents getting differing doses of medication because conflicting prescription orders were on file; 2) violations of resident privacy (e.g., providing medical treatment to or examining a resident in front of others); and 3) unsanitary conditions in the kitchen. Second, the Department does not count all deficiencies when determining eligibility for survey incentive payments. It counts neither Life Safety Code deficiencies (deficiencies addressing potentially harmful facility safety issues) nor deficiencies identified by federal HCFA comparative surveys. Of our sample of 12 nursing facilities, we identified 3 facilities that would not have received an incentive payment if these deficiencies had been counted.

- **ResQUIP incentive portion.** ResQUIP incentive payments are paid in two installments annually. In practice, the criteria for receiving a ResQUIP incentive payment are minimal. Essentially, a nursing facility must 1) demonstrate that its plan was developed with resident input and 2) submit its ResQUIP plan on time. The Department will allow a nursing facility to receive its first incentive payment just for submitting an approved plan. The Department does not recover the first payment if the facility never implements the plan. Additionally, nursing facilities may develop ResQUIP plans for programs that already exist. Neither the Department nor the Health Facilities Division evaluates whether ResQUIP programs exist before approving plans or awarding payments.

Since criteria are lenient and a high percentage of nursing facilities are awarded incentive payments, the dollar value of incentive payments is relatively insignificant to nursing facilities. For those facilities receiving QCIP incentives, the average total QCIP payment (from both the survey and ResQUIP portions) was about $22,000 during Fiscal Year 1999, or about 0.5 percent of a nursing facility's average revenues. Nursing facility administrators told us that receiving or not receiving the incentive payments would not significantly impact their bottom line. When incentive payments are small, nursing facilities have little incentive to strive for improved quality of care.

Financial Accountability for ResQUIP Is Lacking

We concluded the Department lacks information on how nursing facilities are spending ResQUIP incentive payments. The Department and Advisory Committee have an elaborate review process to attempt to ensure accountability for the ResQUIP program. Oversight activities include reviewing and approving plans and conducting a series of progress reviews (including on-site visits) to make sure plans are implemented. These reviews include reading resident council meeting minutes, interviewing residents, and reading progress reports. No financial analysis is done. Few plans are denied and recoveries rarely occur. Although the Department spends about $70,000 per year to oversee ResQUIP, the Department cannot be sure that nursing facilities are spending ResQUIP incentives for the benefit of residents.

Our audit found that many residents lack knowledge of or access to ResQUIP incentive payments. This is troubling because in the past five years the Department has spent over $11 million on the premise that residents are informed of and benefitting from ResQUIP incentive money. Of 12 nursing facility ResQUIP files reviewed, 9 did not include any discussion of the incentive money available for implementing the plan. Of those nine, one facility receiving over $18,000 in ResQUIP incentive money had a plan for increasing community outings. The plan states that funding for the project "will come from residents, through their personal needs accounts, and through donations to the resident activity fund for residents who do not have sufficient funds to pay for outings." A file we reviewed at another facility included a letter from the resident council inquiring about the funding available and where it was coming from. There was no evidence in the minutes that the facility provided the funding information. Only two plans we reviewed had evidence that the residents were aware of the funding available for implementing their ResQUIP plans. In both cases, the residents developed plans that appeared to use a greater percentage of the incentive money available.

Additionally, we found that the Department does not require nursing facilities to use ResQUIP incentive payments for implementing residents' plans. Further, it does not require nursing facilities to account for how ResQUIP monies were spent. We identified some resident programs, such as building gazebos, outdoor patios, or raised gardens, that likely required a large portion of the ResQUIP incentive payments. We identified other projects, such as playing soothing music over the intercom, greeting new residents, or improving self-esteem, that likely required very little of the ResQUIP incentive payments. If nursing facilities are not using ResQUIP incentives for residents' plans, they are using them for other things, including corporate needs. Since the facilities are not required to provide information on how ResQUIP incentive payments were spent, the Department cannot determine where incentive payments are going or to what extent the payments are actually benefitting residents.

A Substantial Overhaul of QCIP Is Needed

Our review clearly indicates that QCIP, as currently structured, is not applying objective criteria for evaluating quality care. Statutes require QCIP incentives to be distributed based on quality of care measures. As a result, QCIP needs substantial revision. To address our concerns, the Department needs to take the following steps, explained in detail in the remainder of this chapter:

- Restructure the quality of care incentive portion to include a comprehensive array of valid, defensible quality of care measures; stringent eligibility criteria; and more substantial incentive payments to encourage nursing facilities to improve their quality of care.

- Propose legislative amendments to address financial accountability for ResQUIP incentives through statutory funds managed by residents.

According to testimony during legislative hearings for the QCIP program, incentive programs can be effective in improving the quality of care at nursing facilities. Audit evidence indicates that other states reward quality of care through incentive programs. Of nine states we contacted, five had established incentive programs and three were in the process of program implementation.

As currently structured, the quality of care incentive portion of QCIP—the portion dedicated to survey incentive payments—has little value. We have established that 1) surveys alone do not adequately measure quality of care, 2) criteria are too lenient, and 3) incentive payments are too low. To address these issues and develop an incentive program that motivates nursing facilities to improve quality of care, the following changes must occur:

- **Improve surveys and develop an array of quality of care measures.** As we discussed in Chapter 1, the Health Facilities Division needs to make improvements to surveys to better identify quality of care issues. Further, the Division needs to develop measures, in addition to deficiencies identified through surveys and complaints, to assess quality of care. Of the eight states we identified that have implemented or are implementing quality of care incentive programs, none were relying on surveys alone to assess quality of care. These states were also using an array of measures, such as staff turnover, staff expertise, consumer satisfaction, financial stability, and complaint frequency, to assess quality of care.

- **Establish more stringent eligibility criteria.** The Department needs to ensure that only those nursing facilities that can demonstrate substantially higher quality of care receive incentive payments. To achieve this, the Department needs to evaluate the seriousness of deficiencies for nursing facilities awarded incentive payments in the past and determine whether it is appropriate for **any** facility to receive an incentive payment if a deficiency is present. The Department needs to incorporate other deficiencies, such as those resulting from Life Safety Code surveys and HCFA comparative surveys when evaluating quality of care. New measures, when developed, need to have sufficiently high standards to ensure nursing facilities earn incentives by measuring quality of care improvements.

- **Dedicate a larger percentage of QCIP funds to measuring quality of care.** Currently only 30 percent of QCIP funds are dedicated to survey incentive payments. Since the purpose of QCIP is to improve quality of care, the Department needs to evaluate the percentage of QCIP funds that should be dedicated to quality of care incentive payments and increase funding for the quality of care portion to at least 50 percent. Additionally, the Department should review the feasibility of developing non-financial incentives. Florida is in the process of implementing a non-monetary quality of care evaluation system based on an array of quality indicators. Facilities that meet requirements will be eligible for nomination by the Governor for "Gold Seal" status. The facility can use the "Gold Seal" in its advertising documents to increase demand for its services (including private-pay demand), which could increase the facility's profitability.

Recommendation No. 9:

The Department of Health Care Policy and Financing and the Health Facilities Division should overhaul the QCIP program and establish a comprehensive quality of care incentive program that includes valid quality measures sufficient for distributing incentive payments to nursing facilities. This should include:

a. Improving surveys to increase the focus on identifying quality of care issues as discussed in Chapter 1.

b. Developing an array of quality of care measures, in addition to survey deficiencies, to assess quality of care at nursing facilities.

c. Establishing more stringent eligibility criteria so that facilities must earn incentives and so that larger incentive payments are provided to fewer facilities.

d. Evaluating the QCIP funding dedicated to the quality of care incentive portion and ensure that a minimum of 50 percent of QCIP funds are dedicated to the quality of care incentive payments. Additionally, the Department should evaluate other non-financial incentives for improving quality of care.

Department of Health Care Policy and Financing Response:

Agree. The Department will work collaboratively with DPHE in their commitment to improve the survey process as well as developing alternative quality of care measures in addition to survey deficiencies. The Department will propose to the Medical Services Board more stringent eligibility criteria. Implementation of such new eligibility criteria should cause a re-examination of the allocation of funds. A final recommendation or reallocation will be based on input from residents, client's advocates, caregivers, and nursing facility representatives.

Health Facilities Division Response:

Agree. Please see the Division's responses to the recommendations in Chapter 1.

Legislative Amendments for ResQUIP

We have already discussed our concerns that 1) residents lack knowledge of and access to ResQUIP incentive payments, and 2) the Department lacks information on how nursing facilities spend ResQUIP payments. Additionally, our audit identified concerns about the content of ResQUIP plans at nursing facilities, some of which appeared to have little substance. The following are examples of ResQUIP programs approved by the Department that demonstrate a wide variety of quality of life projects developed by residents:

- One ResQUIP program provided a "prom" and "glamour shots" for nursing facility residents who had never experienced these opportunities when younger.

- One ResQUIP program had monthly themes and activities that included residents giving the staff a class on the importance of please and thank you, making crafts filled with candy and distributing to other residents and staff, creating a scrapbook, sponsoring a canned food drive, sending "pat on the back" cards to residents and staff, and hosting family nights with entertainment.

- One ResQUIP program built a gazebo and outdoor patio with barbeque so that residents could sit and eat outdoors.

- One ResQUIP program developed raised vegetable and flower gardens, planted and tended to by residents. Produce from the garden was used for resident meals.

- One ResQUIP program adopted three dogs. Residents feed, care for, and walk the dogs. The dogs visit with every resident at least once per day.

According to our interviews with Department and Health Facilities Division staff, Advisory Committee members, and nursing facility directors, these programs directly benefitted residents because the programs were developed and implemented by the residents themselves. However, we have established that the Department lacks objective measures that determine the benefits residents have received from these ResQUIP programs. Further, Department and Division staff doubt that objective measures can be developed for this program in the near future. According to Department staff, objective measures of quality of life have not been developed anywhere. As a result, this program does not meet a basic requirement of statutes—that incentives be based on measures that provide evidence of improved quality of care.

Despite a lack of objective, quantifiable evidence that ResQUIP benefits residents, Department, Division, and nursing facility staff all report they are very satisfied with the ResQUIP incentive and believe it has had a positive impact on nursing facility residents throughout Colorado. According to these staff, the primary benefit of the ResQUIP program is that all residents at all nursing facilities can receive the benefits of the ResQUIP program–as long as each nursing facility submits an approved plan—even if quality of care at some facilities is suffering. Department and Division staff support all nursing facilities receiving ResQUIP incentive payments because ResQUIP programs allow residents to impact one area of their lives when everything else, including the quality of the care they receive, is beyond their control.

If the primary benefit of ResQUIP is that residents have opportunities to control their environments and make their own decisions about how to improve their quality of life, then the Department needs to make sure that ResQUIP incentive payments reach the

hands of residents and are controlled by them. As we have established, this is currently not the case. Further, the Department needs to seek statutory authority for ResQUIP (including establishing the portion of QCIP funds allocated for ResQUIP payments) because the ResQUIP incentive portion lacks any quality of care measures and, thus, is outside of legislative intent. Finally, it needs to establish financial accountability for ResQUIP payments to make sure funds are spent for the purposes intended.

To address these issues, the Department should seek statutory authority establishing a separate fiduciary ResQUIP fund at each nursing facility that would be controlled by residents. A small percentage of the fund could be set aside to pay nursing facilities for assisting residents with fund management. The State could save administrative costs of $70,000 by monitoring fund expenditures during annual financial audits at nursing facilities. Financial audits could review fund expenditures to be sure funds were spent only for purposes determined by residents and in accordance with statutes.

If about half of the QCIP funds were dedicated to ResQUIP and distributed to every Medicaid nursing facility, funds would equal an average of about $12,000 per nursing facility and $215 per Medicaid resident. Although these incentives may be insignificant to nursing facilities, they are significant to residents. While we are not recommending that ResQUIP incentives go into personal needs accounts, as a comparison, each Medicaid-eligible resident receives $600 per year for their personal needs. An additional $215 per resident increases the funds available to residents by 36 percent. This amount is enough to make a difference to residents, enabling them to purchase items collectively or develop projects that matter to them.

Recommendation No. 10:

The Department of Health Care Policy and Financing should propose legislation establishing statutory authority to use QCIP funds for ResQUIP. The legislation should:

a. Recommend the percentage of QCIP funds to be allocated for ResQUIP programs.
b. Establish a separate statutory ResQUIP fund at each nursing facility to ensure ResQUIP funds reach the hands of nursing facility residents.
c. Establish oversight of statutory ResQUIP funds through annual audits at nursing facilities. Monitoring and oversight of ResQUIP plans by the Department and the Advisory Committee should be discontinued.

Department of Health Care Policy and Financing Response:

Agree. The statute authorized the Department to utilize alternative methods of measuring quality of care other than the survey process. The Quality of Life Project represents such an alternative approach. The Department agrees such alternative methods are not readily measurable. The statute should be changed to reflect that such alternatives are not measurable.

The Department believes the auditor's proposal that Quality of Life Funds be distributed to a legal fund (unique to each facility) subject to resident oversight has merit. In addition to the financial audit requirement, the Department believes some new form of program monitoring may be necessary. Under the auditor's proposal the residents would oversee the money in the fund. These dollars would be used to finance Quality of Life Projects. While the Department believes this proposal has merit we would need to consult with advocates, residents, caregivers, and facility representatives before rendering a final recommendation.

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