INTRODUCTION

The following report is based on a proposal and contract signed March 16, 2016. Work began on April 1, 2016.

Background

The Division of Licensing and Certification is not in compliance with the Federal requirement for conducting annual surveys of nursing facilities. The Division of Licensing and Certification is experiencing a high turnover and vacancy rate. At the beginning of this project seven of thirteen positions were vacant; at the time of this report there are six of thirteen positions that remain open. According to reports from the Division, it is the vacancy rate and turnover that have led to deficiencies in the time related requirements for conducting federal certification surveys. The Division has entered into a contractual agreement with an outside agency to assist with the federal certification surveys.

In addition, the Division is under scrutiny from the Provider Community, with negative reports relating to the survey process itself, high citation rates at high scope and severity, as well as inconsistencies in citations as compared to other States.

There are a number of forces at play, Lobbyists, CMS, the Provider Community and the Department of Health and Welfare. However, regardless of the potential and sometimes apparent differing of interests of all parties, there is one overriding question Richard Armstrong, Director posed, "What do all of the issues mean to the quality of care we are providing to the citizens of Idaho?" With the intention of answering that question, I established a number of goals and solicited questions from David N. Taylor, CPA, CFE, Deputy Director over Support Services / Licensing and Certification.

Project Goals

The overall goals and objectives of the contract included the following (please refer to Tab 1 for contract specifics):

- To identify any inconsistencies in survey data as compared to three other States, Wyoming, Alaska and Montana, that utilize the standard survey process. I needed to go outside CMS Region 10 to Region 8 as other than Alaska, all Region 10 States utilize QIS as opposed to the standard survey.
- To better understand the organizational culture of the Division utilizing individual, group and organizational processes.
- To search for data correlations that will lead to causes and solutions for turnover and any survey inconsistency issues.
- Conduct a causal analysis and a needs assessment.
- Provide recommendations.

In addition to the above goals, there were a number of questions provided to me by David N. Taylor, CPA, CFE, Deputy Director over Support Services / Licensing and Certification:

- Is the Idaho survey process fair to providers?
- What flexibilities do the CMS survey regulations allow a State surveying agency in the survey process?
- Is the Idaho high citation rate, particularly relating to "G" citations a good thing or a bad thing?
- Would the utilization of the QIS Survey process create less citations?
- What States would you encourage Idaho to work with as we strive to improve the timeliness and efficiency of our surveying process?
- How should we proceed?

OVERVIEW OF THE SURVEY PROCESS & ISSUES

CMS requires States to conduct annual surveys of nursing homes (called Tier I), surveys of non-nursing homes (Home Health, Intermediate Care Facilities, Hospice – also called Tier I) complaint surveys (called Tier II), other non-nursing homes (such as non-deemed Hospitals and CAHS – also called Tier II & III) and new certifications for new facilities or existing facilities (called Tier IV). CMS allows a State to determine a new facility or existing facility a Tier III, especially in rural areas where services are needed and for Dialysis facilities due the increasing need. There are penalties for a State that does not conduct surveys in keeping with CMS requirements. The Idaho Division has not met performance measures related to timing of surveys for Tier I or Tier II facilities and complaints in 2014 or 2015. Please see Tab 10 for 2015 State Performance results for Idaho. The Idaho provider community is critical of the length of time it takes the Division to recertify a facility and to certify a new facility.

A survey results in citations based on a surveyor's review of findings generally relating to record reviews, interviews and direct observation as compared to the Federal Interpretive Guidelines and Investigative Protocols provided by CMS. The citations are provided on a form called a 2567 that by requirements should be provided to a facility within ten working days. The facility then has ten days to provide the State with a plan of correction based on specific requirements. Generally, a facility is provided 45 days to implement a plan of correction prior to remedies beginning; remedies are based on the severity of the citation(s). Revisits or desk reviews typically occur within 60 days. The State may conduct a desk review as opposed to an on-site visit if the facility citations are not of high scope and severity. If the facility is in compliance no further visits are required. If the facility remains out of compliance another visit occurs; the State typically must obtain permission from CMS Regionals to conduct a second or a third revisit; revisits typically occur 30 to 45 days from the most recent survey. The facility that does not pass a resurvey within six months loses its CMS Provider agreement. In

addition to the timing requirements, the State of Idaho has often been out of compliance with providing the facility with a 2567 within the 10-day time frame, has often not revisited a facility for over 60 days, and typically has more revisits than desk reviews relating to high scope and severity citations. The Idaho provider community is critical of the number of citations at a high scope and severity by the Division as compared to other States.

There is much written about the inconsistencies of citations among State surveyors across the United States, as there tends to be much subjectivity in the survey process. In an attempt to eliminate subjectivity and inconsistency, CMS implemented a new survey process called Quality Indicator Survey (QIS). In a 2007 Executive Summary, that included an evaluation of QIS, evidence shows the process did not improve consistency or time efficiency of surveyors, and led to an increasing number of citations often at a higher scope and severity. However, QIS appeared to result in greater accuracy due to training of surveyors in the principles of reliable measurement and use of investigative protocols, and improved documentation of deficiencies. Please see Tab 3 for the 2007 Executive Summary. The Idaho provider community points to and is critical of a number of inconsistencies in citations by the Division.

The annual survey is a high stress time for the providers and for the surveyors. It is essentially a snapshot that must provide evidence of whether or not a facility is in compliance with the Federal Minimal Requirements, the CFR's at §483 and any State Requirements. The providers are having their work and the care they provide, reviewed and criticized through the citation process. Surveyors are very dedicated to their role of resident advocates and often in their role become impatient with providers, especially when they feel a resident is injured or potentially injured by a deficient practice. This can often lead to heated discussions and rude behaviors on the part of both parties. In my over 35 years of experience consulting to hundreds of facilities nationwide, I have often found surveyors in their role of advocates to be insistent and prescriptive about what should or should not be implemented for particular residents. In response, providers become disillusioned with the care process, fearful of their responsibilities and accountability for a particular citation, and frustrated with the survey process overall. The Idaho provider community and the Division have complaints about such behaviors during the survey.

Nursing Home Compare is a CMS website that provides consumers with star ratings for nursing facilities. Star ratings are between 1 much below average, and 5 much above average. Star rating calculations begin with the survey or health inspection score and then take into consideration other star ratings as related to Staffing, Quality Measures, Penalties and an Overall rating. The ratings compare facilities to other facilities as well as to State and National ratings. The quality measures are those measures that may be an indicator of the quality of care the facility is providing. Under

quality measures a consumer or any interested party can observe ratings for pain, re-hospitalization, outpatient visits, discharge to community, pressure ulcers, catheter in bladder use, urinary incontinence, falls with injury; antipsychotic, anti-anxiety and hypnotic medication use; improvement or decline of function, weight loss and vaccinations. The staffing measure offers information on licensed nursing, certified nursing assistants, and therapy. The inspection measure provides a three-year history of surveys and information on substantiated complaints.

There have been questions about the validity of the information on Nursing Home Compare from both the provider community and regulators. On the provider side there are questions relating to inconsistencies in the survey and therefore survey data, definitions of the quality measures, and staffing data provided by the facility at time of annual survey that may be inaccurate due to vacations or other absentees, or outdated (CMS is changing how staffing information will be provided for Nursing Home Compare). On the regulator side there are questions about the quality measure data accuracy, as this data is provided by the facility through the completion of a mandated assessment tool called the Minimum Data Set (MDS). The MDS looks back at residents' services and conditions and is generally supported by clinical record data and observations. There is a Federal citation for MDS accuracy, 483.20(g) – F278. All survey investigative protocols, utilized by surveyors at the time of survey, include a review of the MDS to identify potential issues for review. Idaho infrequently provides citations for MDS accuracy; in 2015 Idaho cited F278 less than all three comparative States at 13%, see Table 4, Tab 9. CMS has established an additional survey for MDS accuracy. Due to scheduling difficulties, Idaho is not participating in the MDS accuracy survey.

SCOPE AND METHODOLOGY

Three States were chosen who continue to participate in the Standard Survey. Alaska in CMS Region 10; and Wyoming and Montana in CMS Region 8. Montana in particular is very close in similarity of numbers and types of facilities when compared to Idaho; the other two States have less facilities. I limited my main focus to 2015 data. However, I have provided some figures CMS provided from 2013 and 2014 as well. Methods utilized to address the goals outlined above include interviews and review of CMS and other data as follows:

Statistical Documentation Review

- The Division's hiring criteria and process for hiring
- The Division's Job Descriptions – all positions
- Training Program for new hires and ongoing
- The Division Quality Improvement Program
  - Measurements – what is measured routinely

- Goals / Thresholds
- What is done with data – analysis & actions
- Current projects
- Strategic Plan

- The Division turnover statistics past two including available exit interviews
- The Division employee satisfaction survey results
- The Division employee compensation
  - Pay and Benefits
  - Rewards
- Grievance Procedures
- Other Division policies and procedures
- CMS data including:
  a. Numbers of citations per facilities surveyed in 2013 to 2015 for Alaska Idaho, Montana, and Wyoming.
  b. Number of "G" citations per facilities surveyed in 2013 to 2015 Alaska Idaho, Montana, and Wyoming.
  c. Number of "IJ" citations per facilities surveyed in 2013 to 2015 for Alaska Idaho, Montana, and Wyoming.
  d. The average amount of time it takes to complete a survey in Alaska Idaho, Montana, and Wyoming.
  e. CMS performance measures and how the States of Alaska, Montana, and Wyoming performed as compared to Idaho in 2015
  f. A listing of the top ten most frequently cited deficiencies (by Ftag) for Alaska, Idaho, Montana, and Wyoming for 2015.
  g. Review of multiple facility survey results (2567's) from Alaska, Idaho, Montana, and Wyoming.
  h. Informal Dispute results – Number of IDR's and results for 2015 for Idaho provided by Idaho Health Care Association. Unable to obtain information from Montana and Wyoming as data not tracked.

Note: There is little in the way of statistical information available for revisits, therefore I was unable to perform a benchmark of Idaho statistics. However, one can presume revisits based on the scope and severity of citations. I was unable to obtain turnover statistics and employee satisfaction results from Alaska, Montana and Wyoming. If the data is available, I feel it would be valuable in further assessing Idaho results.

- Interviews with Division employees and community providers
  a. Nine employees of the Division including Tamara Prisock, Deb Ransom, Trainers, Surveyors and Human Resources. Please see Tab 3 for interview questions.

b. Twelve providers three who did well on survey and nine who did poorly this year or in the past had multiple survey revisits; interviews were with owners, administrators, directors of nursing, corporate consultants and medical directors. Interviews were also conducted with Idaho Health Care Association executive director and board staff. Please see Tab 4 for provider community questions.

Note: I also requested interviews with contracted surveyors. Tamara Prisock put in the request and the request was denied.

- Review of Nursing Home Compare data other than survey data for multiple facilities in Idaho, Montana, Wyoming and Alaska.
- Review of facility surveys including thirty-three Idaho facility surveys, four Montana surveys, four Wyoming surveys, and two Alaska surveys.
    a. Surveys were chosen based on revisits, similarity of tag citations, and similarity of scope and severity.

RESULTS & IMPLICATIONS

I. Review of Division Internal Practices

1. Hiring and Training

a. Hiring

The Division currently has six open surveyor positions. The State hiring criteria can be found at Tab 4. The hiring process is a seven step process including, job announcement, completion of the application, the examination, the register, the hiring list, the interview and the job offer. I had the opportunity to interview a newly hired surveyor, and it took approximately 60 days from the time of her application to receive a call for an interview. This applicant had actually applied twice prior to receiving a call or an interview. The Human Resource (HR) Specialist confirmed the timelines indicated by the newly hired surveyor. However, the HR specialist does not feel vacancies are related to the timeline it takes to contact the individual or arrange an interview. During our interview when asked her opinion of the issues surrounding the vacancies, the HR specialist indicated the issues related to hiring are related to Geographics, on-boarding, time for training and the ability to train only one new surveyor at a time; and as HR suggested as a recommendation, for this division to examine how other departments within the bureau are able to hire and retain employees.

The interview part of the facility surveyor interview includes six questions (see Tab 4) and a writing portion consisting of five questions. The writing portion requires the applicant to document narrative answers to the questions within 30 minutes, an

average of six minutes per question. The applicant is expected to use narrative format with correct grammar and punctuation. Based on the answers to the interview questions and the writing portion of the interview, a decision is made to make a job offer. The surveyor trainer indicated to me the written portion is performed on computer and there are some difficulties when the applicant does not have computer or typing skills. The five questions are what one might expect on an interview and are very detailed. As examples,

- "From your work experiences, describe a time when you were provided with information (verbal or written) that did not make sense in terms of your professional training and experience. How did you reconcile those differences into a cohesive version of what actually happened?"
- "You enter a facility and discover a resident has an in-house acquired pressure ulcer. How would you investigate the development of the ulcer? How would your investigation change if the facility documented the pressure ulcer developed due to the resident's non-compliance?"

Hiring statistics for February 19, 2016, provided to me by the Division indicated the number of applicants as 41; only one applicant was interviewed and was hired as a facility surveyor. I was not provided an explanation of what occurred with the other 40 applicants.

Hiring statistics dated May 31st, 2016, provided to me by the Division, indicated the following for 36 possible applicants:

- "8 candidates said during the screening call that they couldn't travel." The travel requirements do appear on the website.
- "11 candidates declined an interview, saying the pay was too low." See employee satisfaction and retention, #3 below.
- "3 candidates expressed interest in interviewing but had no long-term care experience, so they were not interviewed." I could find no requirements from materials provided to me or on the Idaho Government website indicating long term care experience is necessary; although may certainly be desirable.
- "7 candidates were interviewed but not selected – 4 of these had poor writing skills and 3 did not interview well." Please see implications below.
- "7 candidates declined interviews because they accepted other positions". Please see implications below.

I visited the Idaho Department of Health and Welfare website and found an icon for jobs that was easy to navigate. However, if I visited the Division website (Health and Welfare), there were no specific icons that might lead me to the job openings. I found the "Health Facility Surveyor – Registered Nurse (RN) – Health Facility Surveyor" job opening. The information relating to the position did describe the travel requirements;

the "Preview Exam" section, when opened provided information relating to licensure, experience and driver's license. In reviewing the job descriptions of a Health Facility Surveyor provided to me by the Division, the job description does not designate that only RN's may survey, rather the description states other professionals can participate, including LPNs per Nurse Practice Act. Please see Tab 5 for Division Hiring Process, questions, writing competency and job descriptions on web site and provided to me from Division .

On interviews, all Division employees indicated the vacancy rate an issue that led to increased work and stress due to staff shortages. In addition, both the HR Specialist and other individuals I interviewed identified the pay as a major issue in filling the current vacancies. The Division increased pay in 2015 and another pay raise has been approved by the Governor for 2017. Please see employee satisfaction and retention relating to this topic.

b. Training

The orientation and training provided and/or available to the surveyors is extensive and appears to be excellent. It takes six months to fully train and certify a surveyor. There are multiple ongoing training programs offered and required as per the documentation provided to me and based on my interview with the Training Coordinator. All interviewed indicated the training programs were excellent and well-prepared them for their roles as a surveyor. In November 2015, a training program called, "Crucial Conversations Training" was held for all surveyors. On my visit to the Division, it was not possible for me to obtain internal access in order to review the specific program details. At the time of this report, I have not yet completed that task. I am interested in details of the training programs relating to nursing standards that might be provided, as well as aspects of supportive vs. defensive communication on an ongoing basis.

c. Implications

There were 36 RN applicants and none were hired. It seems like a very high decline rate. The basic criteria for any organization with vacancies is to ensure availability of information, and utilize swift action in contacting the applicant and having specific criteria in ensuring the applicant is a viable candidate. The greater the length of time from application to interview, the more likely an applicant will go on to other positions. The general rule of thumb for many organizations is to contact the applicant within 14 days acknowledging receipt of the information and to conduct a brief screen. The time frame for scheduling interviews and actual hiring is anywhere from 45 to 60 days. It appears the Division does not conduct calls or other notification letting the applicant know the application is being reviewed; the applicant screening is performed

after the position applications have closed which in many cases is 45 days or later. This greatly reduces the chances of finding a viable candidate.

Without good interview criteria, it is possible that an interviewer's subjective reaction might screen out potentially good candidates. I am not clear about the specific requirements for passing the written portion of the Division's applicant interview other than grammar, punctuation and speed. The answers to the interview questions are very detailed and in my opinion would take longer than 5 minutes per question to answer. I have asked the Division for the specific criteria to judge writing skills and at the time of this report have not received a reply. It is possible that such specific criteria do not exist. While I agree that written skills would be an important aspect of surveyor responsibilities, I am not clear that eliminating four perspective candidates was based on specific quality criteria, especially given the amount of time allotted to complete the questions. I do not know if the Division has specific rating criteria in answering the interview questions that would lead to a screening out of 3 RN's.

Given the vacancy issue, it seems the Division might consider widening the search for surveyors for candidates other than RN's. I am unclear if there is a quota that does not permit hiring other professionals other than RN's. Many State survey agencies have such quotas as well as additional requirements, such as RN's that are Master Degree prepared.

As computer and typing skills have been identified as a key factor in declining applicants, it may be beneficial to consider establishing a training program, or making it a prerequisite for application.

As there is evidence of surveyor communication issues based on provider satisfaction surveys as well as provider interviews as discussed below, it is important to consider ongoing training and mentoring relating to supportive communication.

2. Quality Improvement (QI)

The information provided to me with regards to quality improvement and current projects can be found under Tab 6. The Division's 2016 plan addresses many issues covered in this report, including, pay for employees and career ladder advancements (see employee satisfaction, engagement and retention below), ensuring Tier 1 and Tier 2 work is accomplished in keeping with the Federal survey timing requirements, continued core infrastructure requirements such as maintenance of ASPEN databases and more, emergency preparedness software, a technology program, and a communication plan to better relationships among the survey teams and the provider community. Currently the Division is well on the way in reaching the goal of the Federal survey requirements. I have requested an update on tasks documented on the various action plans to determine progress towards goal dates. I have been able to confirm task completion on all but career ladder development.

It does not appear the Division has identified performance measures, other than those provided by CMS, in order to better understand results and outcomes, of surveys, employee performance in conducting the survey, timing and communications, and benchmarking to other States. There is data collected from providers on survey satisfactions, however I did not see a specific performance measure or how data is currently analyzed to develop effective action plans. There is data collected on turnover and failed applications. I did not see an analysis or actions implemented as part of the failed applications. There is a formal employee grievance process, however informal complaints are not logged or analyzed. According to surveyor interviews I conducted, there are informal QI debriefings after surveys, however no real analysis of data or action plans. None of the surveyors interviewed were aware of any data results including employee satisfaction surveys. They all were very interested in the data when I reviewed it with them; none of them were particularly surprised by the data results relating to survey deficiencies or employee satisfaction. On interview the Bureau Chief was not aware of the specific employee satisfaction data for the long term care Division and indicated a disinterest in statistics that benchmark against other State survey agencies. The Division Administrator indicated there were no specific metrics; however, it was clear she understands the importance of measurement, analysis and action plans; and has identified the need for implementation. I have provided Idaho CMS performance results in Tab 10 and will discuss further under II (5) CMS Performance Measures.

Implications

The Baldrige Performance Excellence Health Care Criteria, published by the National Health Institute of Standards and Technology, is an award that is provided to Health Care Institutions by the President of the United States on an annual basis. Baldrige states, "A major consideration in performance improvement and change management involves the selection and use of performance measures or indicators." Without measures the Division lacks knowledge about systems and processes, limits its ability to identify systems and processes that are effective, and creates a barrier to improvement of those systems and processes that require attention. It requires many voices to affect improvement. Many of the Division employees I interviewed were not aware of results of survey data or employee engagement surveys. An effective quality improvement program is not easy to implement, and requires planning, coordination and cooperation from all levels of staff, particularly the leaders.

3. Employee Satisfaction, Engagement and Retention

The responses for the 2013 Employee Engagement Survey and the full 2015 report can be found at Tab 7. The 2015 survey had excellent participation at 91% (32 of 35 raters). The following are the top favorable results:

- Work contributes to the overall success of the organization – 2013
- Work is important to the respondents personally – 2013 and 2015
- Becoming immersed in the job – 2013 and 2015
- Supervisors allow utilization of vacation and time off – 2013 and 2015
- There are people in workgroups that care personally about the respondent – 2013
- Confident that co-workers will do what they say – 2015
- Job expectations and responsibilities are clear - 2015

The following results identify the top lowest ratings:

- The position vacancies and the amount of work – for both 2013 and 2015
- Advancement opportunities – for both 2013 and 2015
- Professional development which may also be related to the vacancies and comments about lack of time to attend training programs – for both 2013 and 2015
- The organization cares – 2013 and 2015
- Recommending the organization as a great place to work – 2013
- Working effectively across departments and functions – 2015
- Confidence in the organization changing as a result of the survey – 2015

The 2015 report shows 38% of the respondents are fully engaged, 38% are key contributors, 22% present opportunities for engagement, and 3% are fully disengaged. While the ratings were not the highest or the lowest, I took note of the ratings under "Supervisor", as there were a number of ratings that indicate issues with lack of encouragement for new ideas and suggestions, fear of retribution, motivation, regular feedback on performance, and mentoring.

The Division implemented an action plan related to the results that included a plan to address vacancies, career advancement, professional development and the overall work culture; in addition, other improvements were made related to environmental factors (new chairs and desks, and new break room furniture). Please see Tab 7.

According to the 2015 Turnover report provided to me, between July 1, 2014 and June 30, 2015, 12 employees separated from the Division. Ten of these employees voluntarily separated; six from the Long Term Care Division equaling 60% of the turnover. The top three reasons for separation were, 1) Retirement, 2) Pay, 3) Supervisor / Management.

While the benefit package is good, the pay is of major concern. When I asked the newly hired surveyor if she thought she would remain with the Division, she answered that she loved the work but did not know if she could afford to remain regarding the pay. Other Division employees also mentioned pay as an issue during interviews.

The Division employee recognition programs that include the following:

- Employee snack cart every Wednesday for employees to purchase snacks (fundraiser)
- In January, a "Souper" bowl party – soup contest and fundraiser
- In March, a basket contest fundraiser and a St Patrick's Day pot luck
- In May, a public employee recognition week where food and activities are provided daily Monday through Friday
- In June, a silent auction fundraiser
- In June, and August periodic farmers' markets – fundraiser
- In July, a garage sale fundraiser
- In September, a summer BBQ where supervisors and managers cook for employees
- In October, Halloween decorating contests and pot luck
- In December there are annual employee recognition awards and a secret Santa. An employee can be awarded by a Director in one of four categories, Customer Service (for improving the Department's overall customer service culture), Award of Excellence (a significant contribution to improving the Department's operations, efficiencies or work processes),
- There are also "Cause for Applause" awards that in employee can complete at any time for recognize a fellow staff member. I noted that education is provided about this program as part of employee orientation.

Note: I do not know what the fundraisers produce or how the money is used if at all to further employee engagement.

Implications

Organization Culture is a system of shared assumptions, values, and beliefs which governs how people behave in organizations. Typically, there are seven characteristics that have a high or low value to the organization and govern how the members of the organization make judgments on the value their organization places on these characteristics. These characteristics are:

- Risk Orientation – Placing value on innovation and encouraging employees to take risks.
- Precision Orientation – Places value on attention to detail to which employees are expected to be accurate in their work.
- Achievement Orientation - Placing value on results, but not on how the results are achieved.
- Fairness Orientation – Places value on how decisions affect the people in their organization.
- Collaboration Orientation – Places value on teamwork and positive relationships among coworkers.

- Competitive Orientation – Values aggressiveness as a group, especially when dealing with those individuals in the marketplace.
- Rule Orientation – Values rules, predictability and often bureaucratic in nature. Resistive to change.

There is really no absolute good or bad when defining an organizational culture. It is the results of tools such as satisfaction and engagement surveys as well as turnover that point to the strength of an organizational culture. Using this information, organizational leaders can determine changes that are needed to strengthen the culture. Overall I feel the engagement surveys and the turnover reports point to potential weaknesses with the organizational culture of the Division, especially relating to the current vacancies and the current workload, pay, cooperative work environment and behaviors, and fear of retribution. The current culture may not produce employee retention and sustainable engagement, even after the vacancies are filled. The aim of engagement is to establish a goal of enabling and encouraging the workforce to contribute effectively and to do the work to the best of their ability. According to the Baldrige Criteria, "Research indicates that engagement is characterized by performing meaningful work; having clear organizational direction and performance accountability; and having a safe, trusting, effective and cooperative work environment." While there is evidence through my interviews with Division staff, of meaningful work and organizational direction; I question performance accountability and a cooperative work environment as well as behaviors based on the engagement surveys, my interviews with Division staff and with the provider community. Increasing conversations about change and engaging in group conversations to identify ideas and implement solutions, then implementing those ideas and solutions will be important to sustainable engagement. The development of processes to resolve conflicts will assist in creating a cooperative environment. Holding surveyors accountable for their work as well as their attitude and communication while at work, will also improve cooperative behaviors among co-workers and the provider community. Engagement methods may take a while to produce effective results. The current Administrator, Tamara Prisock, has been instrumental in implementing some initial methods.

Typically, employee satisfaction/engagement surveys are performed annually as opposed to every two years which appears to be the Division's schedule. Given the consistently poor results, it may be wise to conduct the surveys more frequently in order to determine the effectiveness of the actions implemented.

4. Interviews with Division staff

Please refer to Tab 3 for a copy of the questions I utilized in conducting interviews. Please also see the information relating to interviews and provided within the above specific topics.

In addition to what I have already mentioned above, overall the interviews I conducted were positive and in general produced the following results:

- All interviewed were very passionate and dedicated to their work.
- All felt the training prepared them well for their job. Especially related to pressure ulcer prevention.
- The majority of the surveyors worked previously in the provider community (facilities owned by corporations) and were very disillusioned with their former work when their suggestions were not acknowledged. They wanted to be part of a larger system to change the face of care.
- All felt supported by their supervisors, however acknowledged communication difficulties among team members. All were pleased with either Deb Ransom's or Tamara Prisock's leadership.
- Surveyors overall felt the increasing numbers of citations were at least in part reflective of a surveyor's ability.
- All were skeptical of deficiency free surveys.
- All appeared to have a very strict attitude towards following Appendix P and PP instructions.
- All responded negatively about writing reports for the 2567 and indicated it takes an extreme amount of time and that their writing is very closely scrutinized and corrected. There is a strong opinion the writing of deficiencies must be in a manner that reflects on all employees of the Division.
- Some responded positively about the quality of care residents receive in Idaho nursing facilities; roughly half answered with "I do not know."
- None of the interviewees were aware of Idaho survey statistics or Employee Engagement results. There was an overall mistrust of the numbers; indicating that some States do not survey properly.
- All responded that staffing and training needed to be increased related to the question of what improvements could be made in nursing home care. Many felt Corporate owned facilities in particular needed to examine their staffing and their training.
- At least one surveyor supervisor pulls a report on prior citations for completion of employee (surveyor) annual performance reviews.
- All had additional job duties not necessarily listed on their job description.
- Many are close to retirement.
- Many of my questions relating to potential performance or communication issues related to the surveys were not answered directly. I sometimes felt the staff member did not want to share too much information. One surveyor refused to answer a question for "fear of getting into trouble" as she was not sure she could share the information.
- Some felt they were badly treated by the community providers.

Implications

I enjoyed my discussions with the Division staff. I found them to be professional and willing to engage. Their dedication to the mission of the Division, the survey process and documentation was obvious.

The surveyors' generally reflected dedication to strictly following Appendix P and PP, skepticism about deficiency free surveys, a mistrust in survey data statistics, the reasons for becoming a surveyor in order to be an agent for change and what appears to be an overzealous amount of attention to writing deficiencies. While all these characteristics may appear as a positive force for quality care and change, in concert and if carried to extreme, these could also lead to increasing numbers of citations at a high scope and severity which may or may not lead to quality care. I will reserve further discussion until CMS review of results and provider interviews below. Please also see the implications relating to employee satisfaction, engagement and retention above.

It is important to develop both a retention plan and a succession plan for the future.

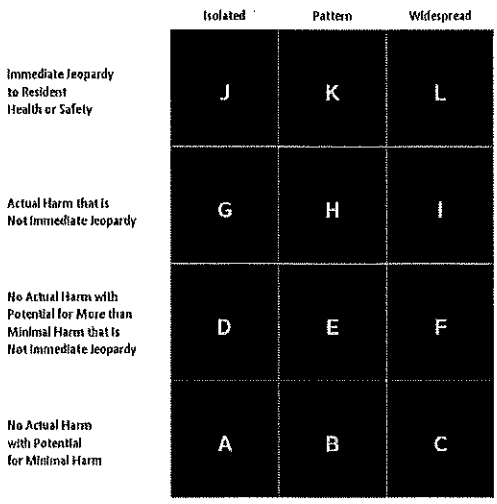
II. CMS Data – Comparison of Idaho to Alaska, Montana and Wyoming

Please find Graph 1 and Tables 1 through 8, as well as a listing of Ftags by descriptive name at Tab 8.

1. Citations

a. Average Number of Citations by State

Alaska, Idaho, Montana and Wyoming utilize the Standard Survey Process. When comparing the average number of deficiencies cited, there is no substantial difference other than comparison to Montana and the Nation. Please see Graph 1 at Tab 8 that also provides information as of June 2016.



b. Scope and Severity

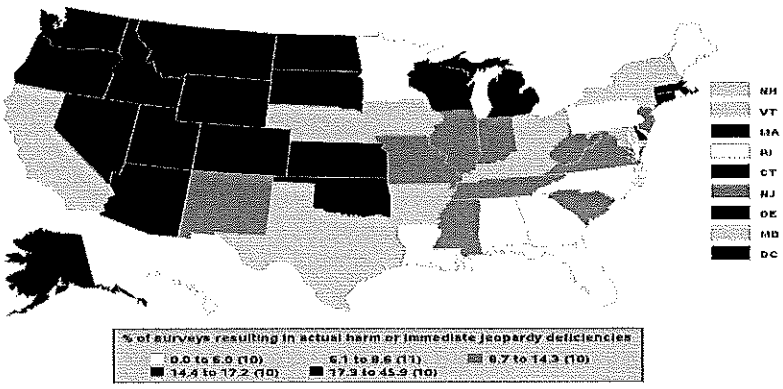
When issuing a citation, the surveyor must determine the accurate scope and severity for the topic being cited. The scope and severity scale and a decision tree from CMS are utilized in making this determination. There are 4 levels of severity with Levels 3 and 4 indicating a resident was injured or a potentially life threatening injury occurred, and three scopes, indicating if a citation is isolated,

a pattern or widespread. When a citation is issued on a 2567, a letter is chosen to determine both scope and severity. The scope and severity of a citation determines remedies, timing of plans of corrections and assists in determining a facility's star rating. Please see the scope and severity grid above as well as the decision process map utilized to determine accurate scope and severity placed at Tab 8.

In 2015, CMS published the "Nursing Home Data Compendium" that provided nursing home data from Casper reports dated 2010 to 2014. Casper reports include data provided via transmission from Survey Agencies that includes inspections relating to standard and complaint surveys and Providers that relates to staffing and MDS data for Quality Measures. This report provided information on the % of citations by State for 2013 and 2014, Please see the maps below.

In 2013 Idaho and Alaska were in the 17.3 to 45.9 range for G and above citations, including Immediate Jeopardy; In 2014 Idaho, Alaska and Wyoming were in the 17.3 to 45.9 range for G and above citations, including immediate jeopardy. Idaho was at the higher end of the range.

2013



2014

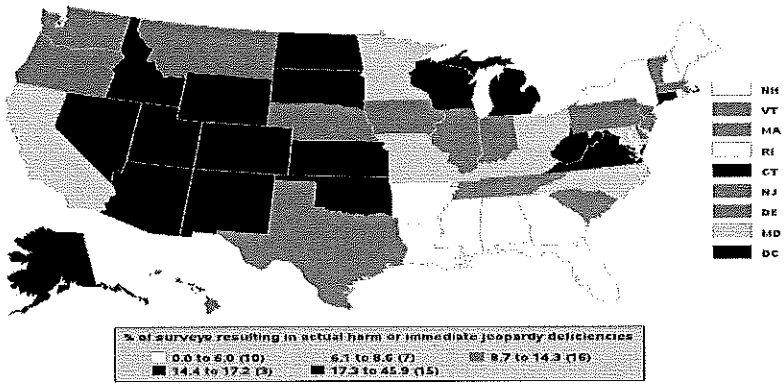


Table 1, found in Tab 8, provides information relating to G or higher citations. Idaho leads in % of G or higher citations for 2015 at a rate of 63.6%, almost double the rates for Alaska, Wyoming, and Montana.

To obtain 2015 data, I required Casper information that I obtained through the Idaho Health Care Association as well as data from CMS – Western Division Survey and Certification Workload Report. Please see Tab 9.

The CMS data compendium also provided information specific to Immediate Jeopardies. In 2013, Alaska, Idaho, and Wyoming were at a rate of 3.9 to 22.2%, while Montana was at a rate of 2.9 to 3.8%. In 2014, Idaho was at a rate of 0.7 to 1.6% while the Alaska, Wyoming and Montana were at a rate of 3.9 to 22.2%. G citations in

Idaho for 2013 remained constant; Immediate Jeopardies decreased significantly. The 2015 Casper data provided through the Idaho Health Care Association and found at Table 2 at Tab 9, provides 2015 information; Idaho provided citations at an Immediate Jeopardy less than Alaska and Wyoming, and slightly greater than Montana. As mentioned previously, the Casper and CMS Data used for 2015 results can be found at Tab 9. The maps can be found below.

The CMS data compendium also provided information specific to zero deficiency citations. In 2013, Idaho and Wyoming were at a rate of 2.5 to 6.0%, while Montana was at 6.1 to 10% and Alaska at 0 to 2.4%. In 2014, Idaho joined Alaska at 0 to 2.4% while Wyoming and Montana were at 6.1 to 10%. The 2015 data at Table 3 in Tab 8 shows Idaho at 2.5% less then Wyoming and Montana; Alaska had 0%.

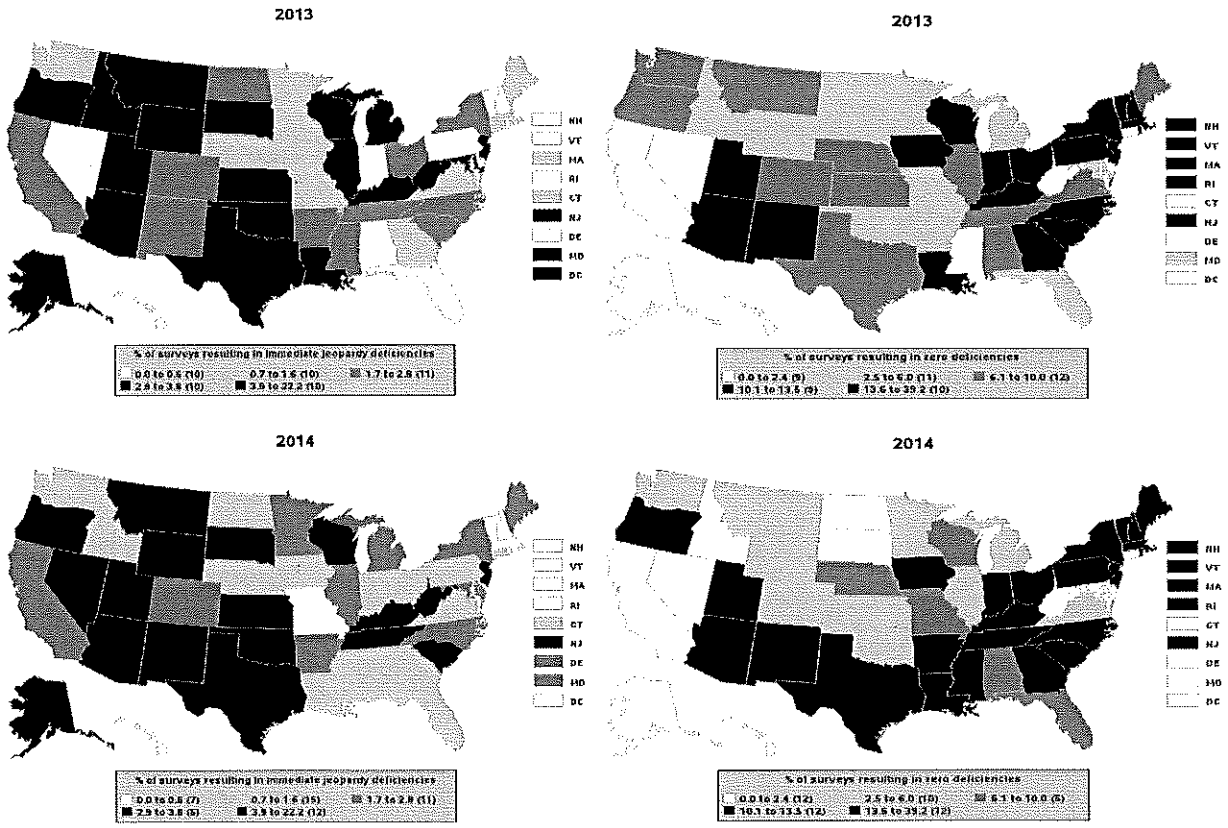


Table 4 in Tab 8 provides information relating to citations for MDS Accuracy previously mentioned in my overview of the survey process.

Implications

The survey data shows Idaho surveyors are more likely to cite a citation at a higher scope and severity percentage rate. It was beyond the scope of this project to compare

Idaho to the rest of the nation, however in 2013 the CMS Nursing Home Data Compendium ranks Idaho third in the nation for G citations behind Massachusetts and Connecticut and in 2014 Idaho was tied in fourth place with Connecticut, behind Massachusetts, North Dakota, and New Mexico. Idaho does cite less Immediate Jeopardies as compared to the other States. The questions are difficult to answer and include:

- Are the Idaho facilities deficient in practices related to systems and processes as well as providing quality care as compared to the other States that conduct standard surveys? Please see Nursing Home Compare information below.
- Are the other States providing better care and have improved quality systems and processes as opposed to Idaho? Please see Nursing Home Compare information below.
- Are the other States deficient in their survey processes as well as determination of scope and severity? There is no substantial difference between the number of tags cited at a survey between the other three States. The other three States have a higher rate of Immediate Jeopardies. The other States are meeting CMS performance measures. I do not feel the data points to deficient surveys.
- Does Idaho apply a stricter interpretation of the rules without utilizing all the all of evidence available? Please see information relating to the Informal Dispute Process below.

Based on my interviews with surveyors and providers, review of available Casper and CMS data, review of the results of 2015 Informal Dispute data (discussed below), and review of multiple 2567's, I do believe Idaho utilizes a stricter interpretation and/or the surveyors may not utilize all the evidence available – please see provider community interviews below. Having said that, it would be difficult to tell a surveyor, "stop citing so many G citations." Idaho is meeting CMS documentation requirements. According to a December 30, 2015 letter to Governor Otter, from Richard Armstrong, Director, CMS independently surveyed 12 facilities the Division surveyed and found 103 deficiencies with five cited at a G or greater, and the Division's results for the same 12 were 85 deficiencies with two cited at a G or greater. I was not provided underlying data for review and analysis, therefore I do not know if these CMS surveys were conducted in 2015. One would need to read the citations and the examples to further understand CMS findings vs. Idaho survey findings. This area, relating to increasing numbers of citations at a high scope and severity, requires further review.

2. Ftag Deficiencies and Documentation

There are mainly two types of Ftags that are cited, those related to process, that includes paperwork and observations, and those relating to outcome, that includes issues relating to pressure sore development, weight loss, falls, and other possible

issues that develop with residents. Please see Tabs 8 & 9 for 2015 CMS and Casper Data relating to the top ten citations in Alaska, Idaho, Wyoming and Montana at Table 5. I have also provided a titled listing of all Ftags on Table 5 in Tab 8.

There are some correlations to point out with regards to F309 Quality of Care, cited at number two in both Idaho and Wyoming; and F323 Prevention of Accidents, cited at number two for Montana and number three for Alaska, Idaho and Wyoming. Idaho has F314 Prevention and Treatment of Pressure Ulcers in the top five most cited deficiencies, compared to Wyoming at number nine; F314 is not in the top ten cited deficiencies in Alaska and Montana. F281 Services Must Meet Professional Standards of Quality is at position one for Montana and position eight for Alaska and Wyoming; it is not in the top ten for Idaho. F309, F323 and F314 are typically related to poor outcomes and are often cited at a high scope and severity. F309 has many issues that can be cited under this tag, pain, non-pressure related wound issues, dialysis, hospice, dementia care, quality of life, and other quality of care issues that cannot be cited under other specific tags. For the most part, in all States the citation was related to pain management or not following a physician's order for diabetic care. I was surprised to find Alaska and Montana did not have F309 in the top ten as usually this tag is highly cited. F323 is related to accident prevention covers a range of issues that might be considered both process and outcome oriented; such as falls, failure to assess or provide supervision of smoking, resident elopements, equipment failures, hot water temperatures and more. F314 is specific to pressure ulcer prevention and treatment.

In my review of survey citations for specific tags as well as for revisit documentation for all three States, I found the following:

- While there were a few exceptions, overall, I found the examples listed under the citations to be relevant in all States. One exception was a citation in Idaho (at an E level) that cited weeds in a planter box under homelike environment as multiple residents were seen going past the box and the surveyor felt the residents could potentially suffer psychological harm. The citation did not document the residents were interviewed to identify their opinion.
- Overall, revisit citations are related to the same deficiency.
- Revisits in Idaho often cite deficiencies involving different tags than those cited on the original or last survey. While in the citation it was obvious why a resident was chosen on revisit, another issue was found and a different tag was cited. For example, a resident was chosen for weight loss on a revisit that was the same resident that was chosen previously and now had a pressure sore; a new citation was given for F314 related to pressure ulcer prevention and treatment. In another example a citation was provided at F328 Special Needs, for failure to follow a physician's orders for Oxygen Use; on revisit the same resident was

chosen and the orders again were not being followed. At times some of the revisit citations did not correlate with the original citation. For example, one facility I reviewed had an original citation at F329 Unnecessary Drugs related to documentation that did not clearly state the indications for use of the Antipsychotic Medication; on revisit, the surveyor watched and cited a medication pass; I am unclear why the surveyor chose to assess Unnecessary Medication Use related to documentation by watching a medication pass.

- In the 2567 survey documentation I reviewed for Alaska, Wyoming and Montana, I found the survey citation documentation to be direct and to the point. I want to mention here that Alaska in not in compliance with CMS performance for documentation of citations; Wyoming and Montana are in compliance. In Idaho, the citation documentation, particularly at a G is lengthy, citing many observations and with repeated information. For example, in one citation at F327, the citation itself repeated four observations where water was not within reach for a resident whose Activity of Daily Living status required extensive assistance and could not help herself. While there were other issues related to this citation, it appeared over-zealous to repeat a point four times in a citation.
- There were consistency issues with regards to scope and severity when citing similar deficiencies within each State and when compared to each State.
- In Idaho, what is communicated at exit may not be what ends up being cited. For example, one facility reported to me that at their exit they were told they would receive 18 citations and two G citations. When the report came they had four citations and no G citations. Please see provider interviews for further information.
- All the States cite the same examples under multiple tags.
- Based on provider interviews and my review of 2567's, Idaho surveyors tend to question the validity of documentation by a MD for treatment or order if that treatment or order is outside normal practice, such as the frequency of dressing changes; and they tend to question the validity of discontinuing treatments and orders when a resident has chosen something other than what is normal practice, such as weighing a resident who is terminal with a diagnosis of Cancer. It appears existing documentation is often not acceptable to the surveyor.
- It appears the timing of interventions are an issue for Idaho surveyors. I found multiple citations related to interventions not being implemented in an acceptable time frame, such as a weight loss documented and an assessment did not occur until five days later. Obviously, assessments and interventions should occur as quickly as possible. However, everything cannot happen immediately. I am unaware of any time frames listed in the requirements for assessment and implementation of interventions other than the MDS timing requirements and that a care plan is implemented within 7 days of an assessment.

- While it is an action plan item as part of the Division's 2015 strategy, in my own recent experience, some facilities have not received their 2567 within 10 working days.
- Please see provider interview results and Informal Dispute for further information.

Implications

CMS has outlined the procedures surveyors are to follow, timelines and documentation performance measures. While there is little flexibility with the timelines and specific documentation requirements, there is flexibility in the provision of survey citations; there is also a wide range of techniques and processes that could be utilized for documentation of survey citations in keeping with the CMS specific documentation requirements. As I have previously mentioned there is much written about the inconsistencies of citations among State surveyors, as there tends to be much subjectivity in the survey process. In an attempt to eliminate subjectivity and inconsistency, CMS implemented a new survey process called Quality Indicator Survey (QIS); however, the QIS survey has not yet produced consistency in citations. Consistency issues are related to citations rates, scope and severity, and specific issues cited as deficiency issues under particular tags. There are no concrete conclusions to be formed with the Ftag listings, other than what I have already mentioned above. I did not review all 2567's in the three States. I chose my sample related to revisits and citations at a high scope and severity as well as similar Ftag citations. While I could identify some interesting facts as mentioned above and those facts might lead one to believe Idaho has a stricter standard for citations (as I have previously mentioned), further study of what was available to the surveyor at the time of the survey would be needed to draw more concrete conclusions. I had requested attendance at an Idaho survey, however CMS would not permit me access.

Given the fact facilities are given little information at exit to develop an effective plan of correction; and given what information may be given at exit could change; it is imperative the facility receives their 2567 in accordance with CMS time requirement, 10 working days.

3. Timing of Surveys

After a certification survey that results in citations, revisit occurs within 60 days. If the facility requires a revisit due to lack of compliance, the visit typically occurs between 30 and 45 days. Other than the issues with CMS timing performance measures, I could find no substantial differences in the timing if surveys or revisits as compared to Alaska, Montana, and Wyoming. In reviewing survey data specific to revisits conducted in Idaho in 2015, all the facilities were resurveyed in accordance with CMS standards.

Regarding the rate of revisits, I was unable to obtain information from the States other than Idaho as States do not typically collect this data. However, in reviewing data provided to me by the Division as part of their Performance Measurement Report follow-up surveys (revisits) have increased steadily from 2012 equaling 185, to 2015 equaling 308. Please see Tab 10. Nine Idaho facilities required greater than one revisit in 2015 prior to achieving substantial compliance.

Implications

I am unable to substantiate specific timing issues or revisit issues; except there is evidence in Idaho that revisits have increased. An increasing number of revisits will definitely add to the Idaho Division Workload. It may be that Idaho Surveyors use a stricter standard in revisits that could include focusing on issues outside of what was originally cited or Idaho facilities are not thorough in implementing plans of corrections.

Many facilities develop plans of corrections based on the survey citation examples and allege compliance without realizing a surveyor assesses substantial compliance based on the entire Ftag and all deficiencies that can be cited under that tag. By not focusing on the entire tag as opposed to survey examples only, many facilities are found out of compliance on revisit for other issues cited under the same tag. CMS wants surveyors to focus on the entire tag when revisiting and assessing compliance as opposed to cited examples. Please see above and my review of Ftag Deficiencies.

4. Nursing Home Compare – Star Rating Results

In order to answer the question from Director Armstrong, "What do all of the issues mean to the quality of care we are providing to the citizens of Idaho", I utilized the Division Interviews (see above), the provider interviews (see below) and Nursing Home Compare. I have included information at Tab 8 that provides current data on Re-hospitalizations, Emergency Room Visits, Discharge to the Community; please see Table 6 under Tab 8; and staffing, please see Table 7 under Tab 8. I also reviewed the Quality Measures for Pressure Ulcers, Pain, and Accidents, which are top citations in all the four States. In addition, I included Antipsychotic Medication Use as that is a top citation for Idaho. Please see Table 8 under Tab 8.

In Table 6, Idaho out performs the Nation in all measures. All States do better than Idaho with Emergency Room Visits. Idaho out performs all States with Discharge to Community with the exception of Alaska.

In Table 7, Idaho out performs all National averages in staffing. However, all other comparative States have higher staffing level in RN staffing. Alaska out performs all, likely due to increased staffing and their reimbursement system.

Idaho is equal to or out performs the Nation in all measures for Pressure Ulcers, Accidents and Antipsychotic Medication Use. In the measure for Long Stay Pain, Idaho is above National Averages. Idaho out performs the comparative States in all measures for Pressure Ulcers, Long Stay Pain, and Falls. In the measure for Short Stay Pain Idaho is slightly higher than Wyoming; in Short Stay Antipsychotic Use Idaho is slightly higher than Alaska; in Long Stay Antipsychotic Use Idaho is above all States. Alaska is above all National Averages with the exception of Long Stay Pressure Ulcers, and Short and Long Stay Antipsychotic Use. Wyoming is above all National Averages except Long and Short Stay Pressure Ulcers and Long Stay Antipsychotic Use. Montana is above all National Averages except Long Stay Pressure Ulcers, and Long and Short Stay Antipsychotic Use.

All the interviews indicate the citizens of Idaho are receiving quality care.

Implications

The Nursing Home Compare website is what hundreds of consumers utilize on a daily basis to choose nursing homes. CMS uses the identical information to make policy decisions and to conduct surveys. It assists in determining quality. Based on the above information, I would say the citizens of Idaho are receiving quality care.

A question might be asked about the correlation between an inspection report and a quality measure. On Nursing Home Compare, Idaho has 31% (23 of 78) facilities with an overall star rating of 2 or less. This is compared to Alaska with 23% (4 of 17), Wyoming with 28% (13 of 38), and Montana at 31% (25 of 80). Of the 23 facilities in Idaho at an overall rating of 2 or less, 12 facilities are equal to a rating of 4 (above average) or 5 (much above average) stars. There does not appear to be any correlation and in fact there are questions that could be asked about the validity of both the survey and the MDS data transmitted that produces the quality measures. Another question might be asked about the Division's potentially stricture application of the requirements and the quality measure results.

In examining staffing, I did note that Idaho staffing for RN's is below that of Alaska, Wyoming and Montana. Research has shown that an increasing number of RN hours provides better assessments and therefore leads to better quality outcomes.

5. CMS Performance Measures

Please see Tab 10 for the CMS performance measures from Alaska, Idaho, Wyoming and Montana. For Alaska, in the Nursing Home Performance Measures, there are "not mets" in nursing home survey documentation and conduct; Alaska has a number of

additional measures not met relating to non-nursing home facilities. I have previously discussed Idaho Measures which are all "met" except in nursing home survey frequencies. Wyoming has "met" all Performance Measures and with some non-nursing home measures "not met". Montana has "not-met" documentation Performance Measures on Tier II surveys.

Implications

It appears each State has issues meeting CMS Performance Measures. In February 2009, the GAO provided a report to "Congressional Requesters" entitled, "CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities." The report outlines the issues States are having concerning compliance with CMS survey timing performance measures. I believe a collaboration with Wyoming and Montana to discuss comparative data and issues may assist Idaho in innovative plans to sustain compliance with CMS timelines.

6. Informal Dispute Process

2015 Idaho IDR information was provided to me by the Idaho Health Care Association. Ten facilities participated in IDR for a variety of tags at various levels and five facilities had positive results. The IDR process was changed in March of 2016 and no results are available at this time. However, in my experience appointments for IDR's are months from the exit.

Implications

While most States are not collecting IDR data, in the past both Oregon and Washington have. I don't recall the year data stopped being collected in these States, but I do remember the statistics were 32 to 37% success rate. Therefore, the 2015 statistics provided to me appear fairly good.

It is important the IDR process occur prior to revisit if possible. This alleviates some work updating the 2567 and allows the facility to concentrate on the priorities.

III. Interviews with the Provider Community

Please see Tab 4 for questions utilized to conduct provider community interviews.

The providers discussed the following:

- Communication has gotten better, the surveyors appear more professional, however in recent three months, surveyors are going back to their old ways.
- The prescriptive behavior of the surveyors even in the face of physician's orders or documentation or resident requests. Providers told me stories of being made to call a physician to change an order or to write a specific policy.
- If there is a failed practice, then a citation should occur.

- The often rude and inappropriate remarks to staff. There were actual reported altercations between management staff and some surveyors.
- An overall mistrust the provider is doing the right thing.
- Shifting priorities during a survey; focusing on one thing intensely and then dropping that topic and going on to another.
- Overall fear of retribution if they spoke openly, requested an IDR or even talked to me.
- What they felt was a desire to cite, even the smallest of issues. Often there is a threat to cite "or else...." The facilities appear to think the surveyors come into a building with a preconceived notion about the care and services being provided.
- The length of time it takes to get a 2567 and then a revisit.
- The length of time it takes to schedule an IDR.
- Not accepting all the documentary evidence. It appears that if a surveyor thinks it should be documented on the Medication Administration Sheet a citation will occur even if there is evidence of documentation elsewhere.
- Blocking staff on tours and other activities. Staff should be allowed to tour and provide information as well as ask questions.
- Unreasonable citations.
- Assuming all deficient practices lead to negative outcomes.
- Cognitive Biased: Premature closure, first determining the citation that is going to occur and then collecting evidence, often ignoring other evidence, to support that decision; Closed minded, not accepting additional data to review; and then anchoring bias; as opposed to collecting all the evidence, analyzing and then making a determination.
- Challenging professional experts such as psychiatrists, nurse practitioners, wound experts and physicians.
- G citations given in clusters in order to make it difficult to dispute.
- Using the excuse, "we are doing what CMS wants."
- Questions are often worded in a way to entrap a staff member.
- Personalized citations – Citing something they don't like as opposed to what is an acceptable standard.
- Not being willing to engage in conversations about potential citations.
- IDR is not a good process when it is the Division making the determinations.
- Surveyors themselves not honoring standards such as HIPPA requirements for Corporate Integrity or residents' right to privacy or to make choices.

The majority of these above statements were survey issues that have occurred in 2016. The Division is attempting to make gains in this area through classes and meetings for surveyors and now conducting a provider satisfaction survey after the survey. The Division has provided me with the satisfaction surveys and the majority of the ratings are good to excellent; the comments are positive as well. However, of the

twenty provided to me, there were unfavorable ratings on six (32%) of them. I contacted the facilities to verify and one facility stated they had a horrible experience but did not provide full information for fear of retaliation.

Implications

It would be difficult for the Division to take action if facility surveyor behavior is not reported. I am not clear how the post survey satisfaction surveys are utilized for change in surveyor behavior. There are still issues that need to be addressed. I believe the buck stops with the Senior Leadership of the Division. There is a saying that "you lose trust in buckets and you gain trust in drops." There has been much trust lost and with fear there is some difficulty in opening the conversation. I am aware there are issues with communication on the provider side as well. However, the focus of this report is to make recommendations to the Division. I obviously have recommendations for the providers as well and will make them part of this report. There are actions that require implementation.

CLOSING REMARKS

The individuals that suffer in a divisive community are the residents and their families. In 2017, facilities with a less than 3-Star overall rating on Nursing Home Compare will find it difficult to obtain contracts from outside providers for services for their residents. Currently, 31% of Idaho facilities have less than a 3-Star overall rating, some in very rural communities that will need increasing services. Acuity levels are increasing and will continue to increase as our population ages. Idaho leads in G citations and revisits that contribute to poor star ratings as well as overwork for the Division, which has led to a back-log of survey work since 2014.

Provider's with poor education programs, lack of staff and a deeper understanding systems and processes to sustain quality of care contribute to poor star ratings. However, it is not the provider community that caused the increasing turnover or the current Division vacancies. It is the Division's responsibility to take bold and innovative action related to vacancies, turnover, surveyor behavior and the apparent survey inconsistencies. It is the provider community's responsibility to take bold and innovative action to improve survey results through conscious and continued attention to systems and processes as well as their own senior leaders' communications with surveyors during survey. I know the current Administrator is working hard towards resolving issues, but there remains much work to be done.

Respectfully Submitted,

Demetria P. Haffenreffer, RN, MBA
President / CEO

RECOMMENDATIONS

1. **Related to vacancies.** Your vacancy rate is not improving. The majority of the candidates do not pass the written exam. The process does not establish an early relationship with the applicant. Establish a hiring process that includes the following:

   a. Contact the individual within 14 days to perform screen and to let the individual know of the Division's interest in hiring.
   b. Change the written portion of the exam to provide more time (45 minutes to one hour) and to establish specific criteria for pass / fail other than grammar and punctuation.
   c. Update the screening information on the website to include more information about travel and computer skills.
   d. Is hiring based on one person's decision? I feel you need to establish a review committee that examines all the documented interview results including the written portion. Establish specific rating criteria.

2. **Related to vacancies.** Your website and your position descriptions do not depict what is actually happening. Your pay is too low. Possible employees were turned away due to lack of long term care experience.

   a. Bold travel on your website – explain what you mean by extensive travel
   b. Consider, if possible, hiring other candidates / professionals other than RN's as the position description depicts OR update the job description to reflect actual Division Practice of hiring only RN's.
   c. Update the Job Description to include computer skills.
   d. Review your pay scale. What would your current employees be satisfied with – hold group meetings to discuss pay.
   e. While I see you have expanded reach beyond the Treasure Valley – how many have applied and how many from outside the Valley have been hired? Consider conducting an analysis.
   f. Either update you job qualifications on the website to say applicants must have long term experience or consider establishing a training program and hire a good and willing professional to learn.
   g. Consider conducting a study of other teams within the Division that do not have such a high vacancy rate or turnover in order to implement actions and model their actions.

3. **Related to Turnover and Sustainability.**

   a. Develop a succession plan even with the current vacancies as you have additional employees retiring soon.
   b. Review your current employee professional evaluation process.
   c. Consider conducting employee satisfaction/engagement surveys at least annually.
   d. Make time for employees to attend training.
   e. I know you are currently meeting with staff routinely; however, I wonder how directed these meetings are related to employee engagement. Consider having more directed activities and discussions with the goal of increasing conversations about change and engaging in group conversations to identify ideas and implement solutions. The important aspect of these conversations is then to implement those ideas and solutions suggested by the staff and then to use their knowledge is reevaluation of the implemented solutions.
   f. Develop processes to resolve team conflicts – this will require teams to feel comfortable with sharing. It is a long process. Consider certifying a member from some department in the Bureau to become certified in conflict resolution.
   g. Ensure "Crucial Conversations" or another communication program is offered more than once annually. Make it part of the training package for new employees.
   h. Consider a book club where surveyors would choose a book from a list and discuss related issues – choose books pertinent to team management, development and communication.
   i. Give the surveyors a platform to vent about their concerns with a facility's care and services during and after a survey in an attempt to minimize a stressful situation that could lead to communication issues at a surveyor level.
   j. Continue with the plan to establish a career ladder with pay increases and / or increasing benefits to match.
   k. Begin tracking, trending and analyzing informal complaints in order to identify areas for improvement.
   l. I noted many fundraisers as part of the Division's employee recognition programs. I would suggest these dollars be used to add more programs and awards to employees if not already utilized for that purpose.

4. **Related to continued compliance with CMS survey timeframes.**

   a. See vacancy, quality improvement and survey recommendations.
   b. Revisit your action plan to get 2567's out per CMS timeframes – perform an analysis and update your action plan.

5. **Related to Data.** As many at the Division appear to mistrust data established from the completion of the MDS, I would focus surveyor during the survey to look carefully at MDS codes for accuracy; or consider taking part in the MDS survey.

6. **Related to Quality Improvement Data.** Your quality improvement program is substandard.

    a. Identify what are the important aspects of services you provide. I would suggest survey and IDR data and some employee engagement measures.
    b. Establish internal performance measures.
    c. Measure and analyze.
    d. Meet routinely and establish improvement teams
    e. Develop ongoing action plans to improve systems and processes in addition to your annual strategy.
    f. Communicate data findings to all employees – get as many voices as possible reviewing and discussing results; and making recommendations for improvements.

7. **Related to surveyor inappropriate actions / communication at a facility level.** Issues remain that require analysis and action.

    a. Give the surveyors a platform to vent about their concerns with a facility's care and services during and after a survey in an attempt to minimize a stressful situation that could lead to communication issues at a surveyor level.
    b. Swift action must be taken with surveyor inappropriate behaviors once you have the knowledge of the event. Establish a culpability scale, similar to James Reason's work, in order to provide a consistent method of actions that will be taken with such behavior. Provide staff training on the culpability scale so staff may understand what actions are taken for specific behaviors.
    c. Discontinue failure to take action related to a surveyor inappropriate behavior based on your current vacancy rate.
    d. Consider open provider / surveyor forums – open to more than just Board Members of IDHCA. Forums could be webinar news hours where providers can call in and engage in the forum.

8. **Related to the number of citations at a high scope and severity. Have continued reviews of the statistics related to citations in Idaho as compared to other states.**

   a. Examine how you currently schedule surveys. Meet with the surveyors to get new and innovative ideas about scheduling.
   b. While there is little flexibility with the timelines and specific documentation requirements, there is flexibility in the provision of survey citations; there is also a wide range of techniques and processes that could be utilized for documentation of survey citations in keeping with the CMS specific documentation requirements. Examine your own criteria for documentation with the goal of streamlining while keeping within the CMS documentation requirements.
   c. If high scope citations occur, consider a careful review with a team to discuss if injury occurred as the surveyor visualizes it.
   d. Consider examining survey practices with regards to revisits.
   e. Consider collaborating (routine discussions and perhaps meetings) with Wyoming and Montana survey agencies concerning surveys, pay and other employment packages.

9. **Related to the IDR Process.** Scheduling is too far from survey exit date and plan of correction date. This could be related to your process in requiring a 5 person panel and scheduling difficulties.

   a. Reexamine your scheduling process. Discuss with teams to establish ideas.
   b. Consider examining the Washington State IDR process.
   c. Begin IDR data collection. Examine tags overturned for deficient survey practices – trend and analyze the data. Establish action plans.

10. **My preliminary provider recommendations.**

   a. Put a team of people to examine revisit failures for system and process issues – other providers other than the nursing home staff.
   b. Establish strong education at the facility level for review of Ftags and the components of compliance for each tag.
   c. Acknowledge the work the Division is doing.
   d. Engage in forums should the Division establish these.
   e. Review staffing at facility levels to determine the need to consider increasing RN staffing as available.