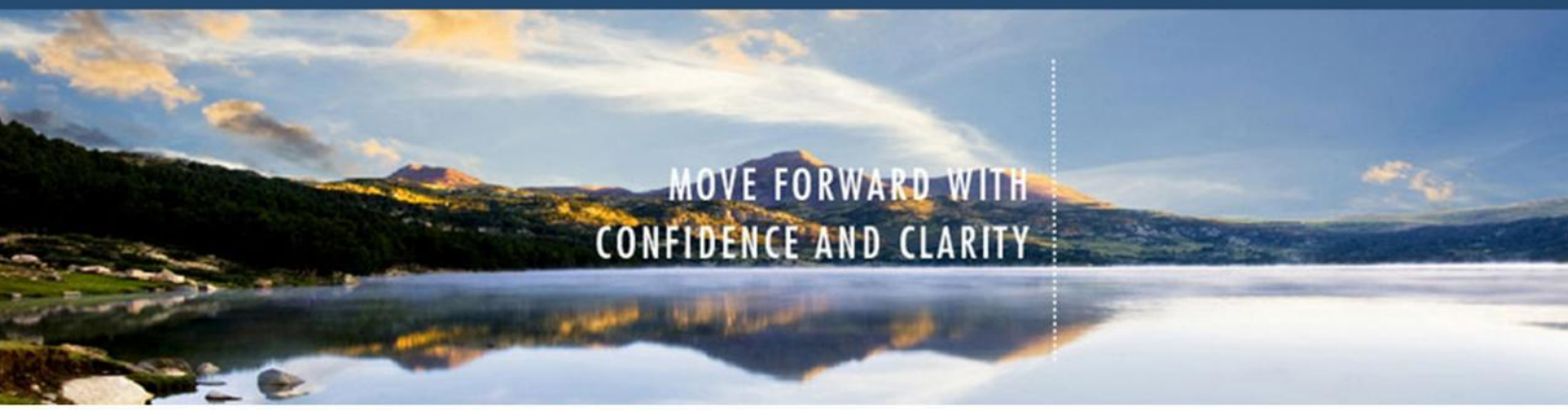
California Department of Public Health
Licensing & Certification Program

Initial Assessment & Gap Analysis Report

August 2014



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EXECUTIVE SUMMARY

The California Department of Public Health (CDPH) is organized into five centers dedicated to different aspects of public health. One of those centers, the Center for Health Care Quality, operates the Licensing and Certification (L&C) Program, which is responsible for licensing and regulating health care facilities throughout the state

The L&C Program is an essential part of CDPH's mandate to serve and protect the public interest. The Program's ability to perform its many tasks with competence and efficiency directly affects the lives of millions of people in hospitals, nursing homes, and other health care facilities each year.

In the spring of 2012, the California Senate expressed concern regarding CDPH's health care facility oversight in several areas. Specifically, L&C was asked to address:

- Hospital accountability for medical error reporting;
- The impact of L&C staffing reductions in the early 2000s;
- A 2007 California Bureau of State Audits report and CMS Office of the Inspector General reports (2011 and 2012) related to the enforcement of state and federal nursing home requirements;
- Delays in the development of several regulations packages;
- The degree to which surveyors use discretion when determining the severity of violations rather than employing standardized criteria; and
- Opportunities to merge the federal and state survey standards into a single survey tool.

In August 2013, the L&C Program engaged Hubbert Systems Consulting to perform a comprehensive organizational assessment to determine the key challenges, issues and barriers inhibiting the fulfillment of state licensing and federal survey and certification requirements.

The purpose of this assessment was to evaluate areas where L&C is experiencing challenges and barriers that contribute to less than optimal performance.

The organizational assessment is an objective external review of the L&C Program, and this report is the result of that assessment. The three major elements of this comprehensive assessment include an initial assessment and gap analysis (included here) and a remediation plan to be issued at the end of the project.

ABOUT THE LICENSING AND CERTIFICATION PROGRAM

Health care facilities in California are licensed, regulated, inspected, and/or certified by a number of public and private agencies at the state and federal levels, including the CDPH L&C Program and the United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS). CMS contracts with L&C to ensure that facilities accepting Medicare and Medi-Cal payments meet federal requirements. L&C is also responsible for ensuring that health care facilities comply with state laws and regulations by conducting on-site inspections (surveys) and investigating complaints and facility-reported events.

In addition, L&C oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators. Other L&C responsibilities include auditing and enforcing nurse staffing levels in long term care facilities; working with California hospitals to prevent health care-associated infections; and assisting facilities in preparing for, responding to, and recovering from disaster events.

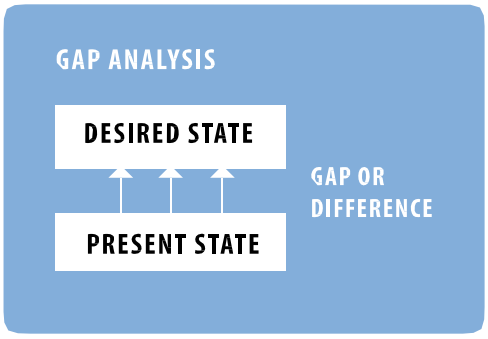
METHODS OF ANALYSIS

The focus of the initial assessment was to identify key issues, challenges, and barriers for the most important processes and results in the L&C Program. During this first phase, the consulting team:

- Conducted more than 200 interviews;

- Spent hundreds of hours observing L&C employees within the context of their day-to-day work;
- Conducted an extensive review of L&C documents; and
- Analyzed employee surveys.

Next, a gap analysis was performed to characterize the gap between current performance and desired performance in key aspects of the L&C Program.



The consulting team worked with L&C staff to analyze gaps and probe for root cause issues. The gap analysis began with a thorough analysis of all L&C federally and state-mandated workloads, and was followed by an analysis of organizational systems and processes that support the completion of that workload. The methods of analysis for this phase included focused document review, interviews with subject matter experts, and in-depth staff surveys.

SUMMARY OF KEY FINDINGS

Our findings indicate that L&C Program employees overall possess strong technical expertise, extensive content knowledge, and a desire to serve. The depth and breadth of staff subject matter knowledge and expertise are key strengths of the Program. The L&C Program is comprised of talented and dedicated professionals who share a goal of providing safe, quality health care for all Californians.

Although the program has a knowledgeable and dedicated workforce, our findings show that L&C is underperforming in many areas of the organization. The L&C Program leaders are aware of these problems and have responded to various requests from stakeholders and the legislature about improvement that is needed. However, the Program needs to take a more proactive rather than reactive approach in planning for improvement efforts.

The summary of our findings, below, is organized into two major sections: a review of L&C's performance results, and the underlying organizational systems and processes that account for L&C's performance.

Federal Survey and Certification Workload

The L&C Program has had difficulty meeting the CMS survey and certification responsibilities for several years. The Program had not met 12 of 18 State Performance Review measures for federal fiscal years 2008-2012. Among the significant concerns cited were the inability to complete CMS workload mandates; the untimely completion and low substantiation of complaint/incident investigations; the untimely submission of survey reports; and the delayed completion of various other survey activities. In addition to timeliness mandates, CMS identified opportunities for improvement in the content and quality of survey findings. Notably, recent improvement has been made with 12 of 18 performance standards met for federal fiscal year 2013.

State Licensing Survey Workload

The L&C Program is mandated to conduct various state re-licensing surveys to ensure that a provider is in compliance with all state laws and regulations. These surveys determine if a facility has the appropriate staff, equipment, policies and procedures to deliver services to patients. The L&C Program is not performing well on state-mandated facility re-licensing surveys. For example, 71% of the skilled nursing facilities (SNFs) appear to be overdue for a

licensing survey, and nearly one-third of these facilities have not had a licensing survey conducted since 2005.

Facility Investigations

L&C staff are tasked with responding to complaints, entity-reported incidents (ERI), adverse events, and medical breaches. These investigations require on-site inspections to evaluate compliance with both state and federal requirements related to the issue reported. Timely closure of complaint investigations has been an ongoing challenge for the L&C Program.

Professional Certification Branch (PCB) Complaint Investigations

A backlog of complaints has been problematic for PCB for several years. Similar to facility complaints, there are numerous complaint investigations received since January 2012 for which investigations have not yet been completed.

Los Angeles County Contract

L&C contracts with the Los Angeles County Department of Public Health to license and certify health care facilities located in L.A. County. As home to nearly one-third of the facilities in the state, L.A. County represents a significant management workload. The current approach to this workload does not allow for adequate oversight and contract management. The L&C Program needs a comprehensive and well-coordinated contract administration and monitoring plan. The Program also needs a defined structure to support collaboration and communication in providing contract oversight.

Civil Monetary Penalties

Violations of federal and/or state regulations or statutes may be subject to monetary penalties. There have been frequent complaints by providers and stakeholders regarding the L&C Program's lack of timeliness in issuing citations in such cases. A recent L&C report indicated the average time interval for issuing state citations is one year.

Workforce - Staffing

Validity and reliability of information collected from the staff timekeeping system, as well as issues with the methods for analyzing and reporting that information, present a serious challenge to determining adequate staffing levels for the Program.

Vacancies in key positions present a significant barrier to achieving federal and state Program mandates. In particular, L&C faces significant challenges in its efforts to recruit, hire and retain Health Facility Evaluator Nurses (HFENs).

The hiring process is slow and a key barrier to completing mandated workloads within required time frames. The hiring and on-boarding processes are time-consuming and ineffective, and serve as significant barriers to recruiting appropriate candidates. In addition, there are often excessive wait times for processing testing results and related promotion paperwork, and salary differentials are a barrier to recruiting HFEN supervisors.

Employee Satisfaction And Retention

Most L&C staff feel a connection to L&C's mission and, in fact, communicate a deep passion and commitment to their role in improving health care in California. This is especially significant in light of the many barriers and challenges they face, including reports by field staff of a culture where there is little acknowledgment of professional success, and where recognition from headquarters management only occurs when there is an error. Many employees report feelings of burnout and low morale. Although L&C leaders have made several efforts to assess employee satisfaction, there did not appear to be an action plan that addresses opportunities revealed in the survey findings.

L&C does not appear to have a comprehensive retention strategy or succession plan. This may be of significant importance because 65% of L&C employees responding to the 2013 CDPH Employee Survey were over the age of 50, and 36% of survey respondents reported plans to

retire within the next 5 years. Moreover, 18% of survey respondents reported they are actively seeking work outside of L&C.

Turnover rates in key Field Operations positions present a significant challenge for the L&C Program. There is nearly 20% annual turnover in HFEN positions. District office HFE supervisor and manager positions suffer from a similar rate of attrition.

Workforce - Staff Development, Support, And Work Environment

L&C requires a comprehensive, Program-wide approach for assessing the needs of its staff and then providing appropriate training. L&C's New Surveyor Academy provides a good foundation for new HFENs, and the CMS-mandated training for health facilities evaluator nurses is comprehensive. However, a structured mentoring program to support classroom training is needed. Even with a designated training supervisor, it is not uncommon for this individual to be assigned other responsibilities that limit their ability to focus on training.

Other than HFENs, staff receive little or no initial orientation or ongoing training. For example, in response to a March 2014 survey conducted by Hubbert Systems Consulting, 37% of the district office analysts and 41% of support staff reported they did not receive initial orientation. Training on Program policy and procedure updates is also needed, with many staff reporting that ongoing training is not satisfactory and often occurs many months after a new process has been implemented.

L&C's field supervisors and managers are typically hardworking and very dedicated individuals. Many frontline staff cite their supervisor or manager as the "one thing that currently works well" in L&C. During the more than 200 interviews and many hours of observation, better development, training, and support of the Program's leaders and managers were frequently identified opportunities for improvement. A significant number of managers and supervisors

have received no orientation to their role, nor any ongoing training and development in leadership and management skills.

Work Systems And Processes

There is a significant lack of standardization in L&C systems and processes. Processes are overwhelmingly paper-based and labor-intensive with multiple redundancies.

The use of modern IT hardware and software to conduct work is not the current practice for HFENs in the L&C Program. HFENs represent nearly one-half of the L&C workforce and conduct the core work of on-site federal and state surveys and complaint/ERI investigations. While all HFENs are provided a laptop/tablet computer, it is rare they use them while conducting an on-site survey or investigation. Documentation related to the survey activities and findings, as well as the employee's record of time spent, are hand-written and later entered into the IT application when returning to the office.

L&C surveyors do not have access to the tools and technology that would help them do their jobs more efficiently and accurately. For example, surveyors do not have cell phones or any other device for Internet access (e.g., to access the State Operations Manual via the Internet).

Many of the existing regulations, in nearly all of the licensure categories, need to be updated. L&C also has numerous overlapping and redundant policies that need to be reconciled.

The organization is in need of a comprehensive communication strategy and plan to facilitate the flow of information both internally and externally. There is no evidence of a well-documented and standardized practice or structure for coordination and collaboration. A formalized process for planning and problem solving could improve standardization and coordination of business practices.

Some district office management staff report that managers and staff at headquarters do not actively engage them or leverage their knowledge and experience in decision making or in support of performance improvement efforts. Many interviewees described communication as being all "one-way," i.e., headquarters pushing information to the field.

Measurement, Analysis and Knowledge Management

The Program can benefit from greater use of comparative data in its performance reporting and from regularly sharing more Program-wide performance data with external stakeholders (e.g., on the L&C Internet site). Instead of leading the conversation about performance and process improvements that address known performance shortcomings, analytic resources are directed to respond to numerous questions from the press, advocacy groups, CMS, the legislature, and other control agencies.

The Program needs to be more consistent in its approach to data collection, analysis, and reporting. There needs to be well-maintained documentation on L&C performance measurement practices and data quality issues, which will improve the usability of reports used by both managers and external stakeholders to evaluate Program performance. A specified entity within the L&C organizational structure should be designated as responsible for performance measurement, management, and improvement.

The Program would benefit from a consistent and structured manner for sharing information on priorities and best practices within headquarters and among district offices. There also would be great value in identifying successful business process improvement initiatives within the organization and in facilitating the adoption of promising process enhancements.

HISTORICAL PERSPECTIVE

L&C's performance and related underlying organizational problems described in this report are not new. Many times during the course of this assessment, it became clear that the issues being

identified were known. Internal staff and external stakeholders agree that the Program's performance and the organizational communication, work systems and work processes require improvement.

In June 2012, CMS identified the need for taking "effective leadership, management and oversight of CDPH's regulatory organizational structure, systems and functions." Many examples have been included throughout this report that are evidence of what appear to be significant opportunities for improvement in leadership and management capabilities of the L&C Program. For example:

- There is a need for a process to create a clearly defined vision and strategic plan to guide organizational improvement.
- The Program must develop a process for establishing and communicating updates to and progress toward the Program's mission, vision and goals. Because of this capability gap, organizational goals are not proactively identified, communicated, nor linked to organizational or individual performance.
- Performance measures for mission-critical, mandated Program responsibilities should be well-defined and expanded beyond the L&C annual fee report and CMS benchmarks.
- The organizational structure must support organizational goals and allow for adequate oversight. For example, training and HR functions are dispersed throughout L&C and the Department, resulting in a diffused delegation of responsibility for these essential capabilities.
- Contract oversight for L.A. County, which accounts for approximately one-third of the Program's workload, must be enhanced. For example, the Los Angeles County Auditor's report found that neither the number of positions currently performing investigations, nor the number of positions needed to ensure timely completion of investigations, could be accurately determined.

- There are significant opportunities for improvement in communication, coordination, and collaboration across the Program This is reinforced by results of the 2013 CDPH Employee Survey, which included the following findings about L&C staff:
    - 44% agreed with the statement "CDPH clearly communicates decisions it makes"
    - 41% agreed "CDPH is committed to an environment of transparency (sharing information)"
    - 33% agreed with the statement that "CDPH effectively collaborates with external stakeholders"
- Based on the results of employee surveys, the organizational culture at this time does not foster improvements in performance and outcomes.

CONCLUSION

This initial assessment and gap analysis provide L&C with the foundational analysis necessary to identify performance indicators and benchmarks to measure its compliance with state and federal regulations and key performance metrics. The report is intended to guide L&C's leaders as they engage in the positive and transformational changes the organization needs.

BACKGROUND and OVERALL APPROACH

The California Department of Public Health (CDPH) is organized into five centers dedicated to different aspects of public health. One of those centers, the Center for Health Care Quality (CHCQ), operates the Licensing and Certification (L&C) Program. L&C is the largest Program within CDPH, consisting of about 1,200 managers and staff located in 14 district offices and Los Angeles County. L&C is responsible for the enforcement of regulatory standards related to the quality of care provided in California's approximately 8,000 health care facilities. L&C licenses approximately 30 different types of health care facilities and conducts roughly 27,000 complaint/incident investigations annually. The L&C Program has a total estimated budget of $184.158 million in Fiscal Year (FY) 2013-14, which is an increase of $1.4 million (0.7%) from FY 2012-13.

According to its 2012-2014 Strategic Plan, CDPH's vision is "Healthy individuals and families in healthful communities." Its mission statement reads: "The California Department of Public Health is dedicated to optimizing the health and well-being of the people of California." The CDPH strategic plan, provided on the CDPH website, lists goals and objectives for the Department.

The L&C Program's mission statement, stated on the CDPH website, reads: "Licensing & Certification is responsible for ensuring health care facilities comply with state laws and regulations. L&C also oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators."

The L&C Program is an essential part of CDPH's mandate to serve and protect the public interest. The Program's ability to perform its many tasks with competence and efficiency

directly affects the lives of millions of people each year. With that in mind, the L&C Program is currently implementing various change initiatives aimed at improving performance.

ORGANIZATIONAL STRUCTURE AND FUNCTIONS

The L&C organizational chart can be accessed on the CDPH website. Following is a brief description of key L&C Program structure, roles, and functions.

Field Operations

Field Operations, consisting of seven branches each representing a region of the state, is responsible for ensuring that health care facilities comply with state and federal laws and regulations. Field Operations staff, some of which are contracted LA County personnel, conduct on-site inspections (surveys) and investigate complaints and facility reported events. Survey teams consist primarily of registered nurses and life safety code inspectors. On some surveys, teams are joined by other health professionals such as pharmacists, nutritionists, physical and occupational therapists, infection control experts, and physician consultants.

In addition to the seven geographically defined branches, Field Operations, includes the following sections and units:

- The Life Safety Code (LSC) Unit conducts surveys for fire prevention, fire protection systems and equipment, building construction standards, and environmental issues for health care facilities.
- The State Facilities Unit (SFU) provides enforcement actions for health care facilities operated by other departments within the state, as well as state prisons.
- The Staff Education & Quality Improvement Section (SEQIS) provides statewide staff training and development for new and existing staff with respect to existing and changing licensing and certification functions brought about by changes in federal and state legislation, regulations, and contract requirements.

- The Central Applications Unit (CAU) was established in order to centralize the processing of facility applications (initial and change of ownership) for state licensure and federal certification. CAU's mission is to ensure standardization of the facility licensure application process and to ensure the review of these applications is done in a timely and consistent manner.
- The Consultants Unit consists of four sections: Medical, Healthcare, Pharmacy and Nutrition. There are 14 physicians, 20 pharmacists, 10 dietitians, 4 nurses, 3 occupational therapists, and 3 medical records specialists who are located at headquarters and in the district offices. These consultants provide expert clinical advice and consultation in their areas of expertise for all L&C survey and certification activities.

Professional Certification Branch

The Professional Certification Branch (PCB) is responsible for the certification of nurse assistants, home health aides, hemodialysis technicians and the licensure of nursing home administrators. The PCB is also responsible for the investigation of allegations involving health care professionals and the enforcement of disciplinary actions.

Policy and Enforcement Branch

The mission of the Policy and Enforcement Branch is two-pronged: 1) promote statewide standardization and consistent application of regulatory requirements governing health care facilities licensed by the L&C Program, and 2) maintain effective oversight of requests for Medicaid-certified health care facilities. The branch accomplishes its mission by conducting analyses of proposed legislation, adopting state licensing regulations, developing policies and procedures and health care facility notices, and providing timely processing and tracking of Medicaid certification requests and associated enforcement actions.

Staffing Audits and Research Branch

The Staffing Audits and Research Branch (STAR) conducts research on the quality of health care provided by California's health professionals and health care facilities. The STAR Branch is also responsible for auditing and enforcing nurse staffing levels in long term care facilities.

Resource and Operations Management Branch

The Resource and Operations Management Branch includes the Business Services, Fee Development and Grant Management, Fiscal, Contracts, and Personnel Liaison Units.

Healthcare-Associated Infections Program

The Healthcare-Associated Infections (HAI) Program's mission is to improve the quality of care in California hospitals through the prevention of health care-associated infections. This is achieved through the public reporting of infection rates and prevention measures and working with partners and stakeholders to enhance infection prevention activities within California hospitals.

Emergency Preparedness and Disaster Response Branch

The Emergency Preparedness and Disaster Response Branch protects the health and safety of individuals in health care facilities during times of disaster, and assists facilities in mitigating the effects of, preparing for, responding to, and recovering from disaster events.

PROJECT OVERVIEW

Health care facilities in California are licensed, regulated, inspected, and/or certified by a number of public and private agencies at the state and federal levels, including the CDPH L&C Program and the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS). CMS contracts with CDPH L&C to ensure that facilities accepting Medicare and Medi-Cal payments meet federal requirements. L&C is also responsible for ensuring that health care facilities comply with state laws and regulations. In addition, L&C

oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

In the spring of 2012, the California Senate expressed concern regarding CDPH's health care facility oversight in several areas. Specifically, CDPH L&C was asked to address:

- Hospital accountability for medical error reporting;
- The impact of L&C staffing reductions in the early 2000s;
- A 2007 California Bureau of State Audits report and Office of the Inspector General reports (2011 and 2012) related to the enforcement of state and federal nursing home requirements;
- Delays in the development of several regulations packages;
- The degree to which surveyors use discretion when determining the severity of violations rather than employing standardized criteria; and
- Opportunities to merge the federal and state survey standards into a single survey tool.

In April 2012, citing performance concerns on State Survey Agency national performance standards (SPSS), CMS placed the CDPH L&C Program on a corrective action plan. In addition to specific benchmark performance criteria, the Program was required to complete a comprehensive assessment of survey and certification operations to identify concerns, issues and barriers related to difficulty in meeting performance expectations.

Since 2012, L&C has focused intensively on building organizational capacity and enhancing accountability and sustainability in order to fulfill responsibilities in the enforcement of state and federal law. For example, L&C has undertaken a concentrated effort to develop short- and long term goals and action plans focused on meeting the CMS Benchmark Performance and SPSS criteria. The Program has experienced significant improvement, with multiple successes and lessons learned as a result of this focused effort. There is more work to be done, however.

The L&C Program engaged Hubbert Systems Consulting (HSC) to complete a comprehensive organizational assessment as a part of its ongoing effort to optimize internal business practices and ensure timely fulfillment of state licensing and federal survey and certification workload requirements. Figure 1 outlines the three major elements of this comprehensive organizational assessment.

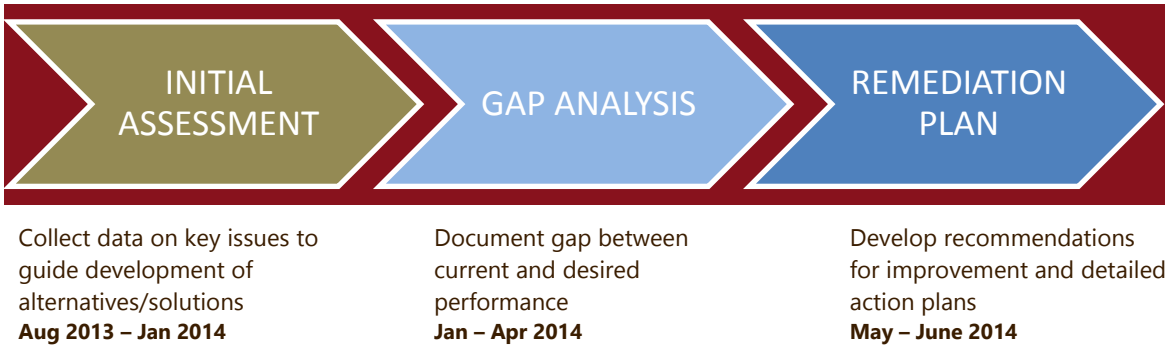


Figure 1 **Elements of the Organizational Assessment**

Overall Approach and Scope

The L&C Program is entrusted with extensive regulatory and enforcement duties in the public interest, and these public duties define the context within which the Program operates. With that in mind, this organizational assessment was designed to help L&C attain its goals by providing the following:

- Identification of concerns, issues, and barriers related to the timely annual fulfillment of L&C's state licensing and federal certification workload assignments;
- Actionable recommendations for corrective measures including but not limited to process and/or quality improvement initiatives; and
- A comprehensive work plan that allows for implementation in stages.

This comprehensive assessment will also provide CDPH L&C with the foundation for identifying performance indicators and benchmarks to measure its compliance with state and federal

regulations as well as other internal key performance indicators. A final report including recommendations will be prepared for L&C Program leaders in order to support positive and transformational organizational change. It is important to note that this organizational assessment is one of several ongoing and concurrent initiatives focused on driving positive performance outcomes. This assessment is separate from these other initiatives and is not intended to replace or duplicate them, but rather to complement them.

The scope of this organizational assessment encompasses all services of the L&C Program. These include all services and functions provided at headquarters, delivered in field locations, and covered in the Los Angeles County contract.

Hubbert Systems applied best practices in organizational performance analysis and project management to efficiently deliver a candid and impactful evaluation that describes a future view of the L&C Program capabilities, a current view of actual practices, and recommendations to close the Program's capability gap. This approach provides an independent look at current business practices, and offers fresh views and ideas for meaningful change.

Governance

To support ongoing validation of the project objectives, assessment approach, and preliminary findings, Hubbert Systems consultants met regularly with Program executives and senior managers. Weekly check-in meetings provided an opportunity to review the status of actions and decisions related to assessment activities. During these meetings, leaders also reviewed project accomplishments, work in progress, upcoming activities, project risks, and outstanding assignments. Regular phone and email communication with L&C leaders also provided the opportunity for interim ad hoc document review and decision-making.

INITIAL ASSESSMENT

Initial Assessment Approach

Our approach to the initial assessment included collecting data and analyzing factors that impact the CDPH L&C Program's performance to identify areas of strength as well as opportunities for improvement. This included assessing interdependent factors, both external and internal, that exist simultaneously and affect the Program's performance. These interdependent variables range from external pressures to the organizational culture and leadership to the skills and behavior of employees. Our assessment approach is a repeatable process that applies social-behavioral best practices developed and proven effective in the public and private sectors. This model provides the foundation to effectively analyze and interpret data, develop recommendations, communicate them effectively, and manage change within an organization.

BALDRIGE CRITERIA FOR PERFORMANCE EXCELLENCE

The surveillance conducted for the initial assessment examined the perceptions and needs of stakeholders, executives, managers and staff through the perspective of the Malcolm Baldrige National Performance Excellence Program criteria. The Baldrige model includes seven separate but interrelated categories that can be evaluated to assess organizational performance. These include:

1. Leadership
2. Strategic Planning
3. Customer Focus
4. Measurement, Analysis, and Knowledge Management
5. Workforce Focus
6. Operations Focus
7. Results

The CDPH L&C Program was evaluated on the seven Baldrige Criteria for Performance Excellence categories. This evaluation was based on two dimensions: process and results. Process refers to the methods used to address the criteria in categories 1-6; the four factors used to evaluate process are approach, deployment, learning, and integration. Results are evaluated for levels, trends, comparisons and integration. A critical consideration in this framework is the importance of various processes and results to the overall goals and objectives of the organization. Thus, the focus of the Initial Assessment was to identify key issues, challenges, and barriers for the most important processes and results in the L&C Program.

METHODOLOGY

Hubbert Systems has developed a methodology for structuring consulting engagements and guiding project teams throughout the process. This methodology provides a structure for the planning, organization and execution of the analysis while also remaining flexible and adaptable to client needs. The methodological elements of the Initial Assessment include:

- A breakdown of the L&C Program into its component parts;
- Interviews of a representative sample of employees, including careful attention to leadership;
- Observations of headquarters and field operations;
- Examination of available documents and relevant data; and
- Review of survey results.

The decision to employ both qualitative research methods (interviews, observation and document review) and quantitative research methods (surveys) is by design. L&C is a large, complex and dynamic organization. Uncovering and understanding the systems, strategies and performance of such an organization calls for a multi-dimensional methodology.

Qualitative research has the advantage of allowing for an in-depth examination of phenomena that survey research alone cannot capture. Importantly, qualitative techniques can yield complex textual descriptions of how individuals experience a given event or issue. Together, qualitative and quantitative approaches can reveal a complex portrait of an organization's culture, successes and limitations.

DATA COLLECTION

Interviews

Interviews were conducted to gather qualitative data regarding the L&C Program's practices. Over a four-month period, the project team interviewed more than 200 L&C managers, staff and stakeholders. A copy of the interview questions and a list of interview participants can be found in Appendix A.

Individuals were invited to participate in one-on-one or group interview sessions. The interviewees were apprised of the assessment purpose and activities. The interview sessions were conducted using an unstructured interview technique. This method of data collection provides a description of multiple realities from an insider's view, which is a means of obtaining information that is more structured than an informal conversation but that is more casual and open-ended than a questionnaire survey. Using this technique provided an understanding of what seemed significant to the individuals in identifying the key issues, challenges, and barriers facing the L&C Program.

This approach relied heavily on listening to the interviewee's responses within a conversational environment and promoted a deeper understanding of underlying beliefs, values, and assumptions. The interview questions addressed the individual's understanding of the key issues, challenges, and barriers facing the L&C Program and contributing to its difficulty in timely fulfillment of state licensing and federal survey and certification workload requirements.

The interview questions helped to ensure that the same areas of inquiry were conducted and similar information was explored with each person.

Observation

The second method of data collection used was the observation of employees within the context of their work. These interactions took place during informal in-person conversations and during structured meetings. Qualitative observation involves watching and recording what people say and do. Since it is impossible to record everything, this is inevitably selective. The observations were systematically recorded in field notes written during and immediately after the observations occurred.

In contrast to interviews alone, observation allows one to see things staff may be unaware of or unwilling to discuss. Observation can lead to deeper understanding than interviews alone because it provides knowledge of the context in which events occur. Observation has the advantage of helping to overcome the discrepancy between what people say and what they actually do. The categories of the Baldrige framework served as a reference for the observational aspect of this study. A description of observation activities is provided in Appendix B.

Document Inventory

Reviewing existing documents helps to understand the operation of the Program and often demonstrates alignment, or the lack of, between formal statements of Program purpose and the actual Program implementation. Record review also provides information for developing other data collection tools, to formulate questions for interviews, and was used extensively in conducting the Gap Analysis.

Hubbert Systems identified a variety of documents to support assessment project planning, to assist with the assessment activities, and to provide evidence of the Program's capacities. This

involved extensive review of L&C documents, most of which are listed in Appendix C. Documents included reports, tracking logs, memos, policies, and agendas.

Surveys

Surveys were the fourth method of data collection used. Three of these surveys were conducted by CDPH prior to and/or during the assessment period and the fourth, the Baldrige Performance Excellence Assessment (provided in Appendix D), was conducted during the October 2013 Field Operations District Manager and District Administrators quarterly face-to-face meeting. These surveys are as follows:

- CDPH Annual Employee Survey (All CHCQ Staff - 2012)
- CDPH Annual Employee Survey (All CHCQ Staff - 2013)
- CHCQ Job Satisfaction & Work Environment Survey (All CHCQ Staff - 2013)
- Baldrige Performance Excellence Assessment (District Administrators & District Managers - October, 2013)

Triangulation

Triangulation of data is a technique wherein more than one data source and/or more than one method of data collection are used. One looks for patterns of convergence to either further develop or confirm an overall interpretation. This technique assumes that any weakness in one method is compensated by strengths in another. Thus, by using more than one data collection method, triangulation attempts to address the issue of internal validity.

Different qualitative research methods present parallel sets of data, each providing a different view of the phenomena. In this organizational assessment, different areas of the Program were accessed, several different types of staff were interviewed, and four distinct methods of data collection were used. This variety on several levels was intended to enhance the quality and credibility of the data and provide a rich and nuanced picture of the state of L&C's operations as described by leadership and staff throughout the organization.

Data Analysis

In a qualitative approach to data collection for an organizational assessment, patterns, themes, and categories are expected to emerge from the data. In this respect, data collection and analysis are not definitively separate, but rather allow for continually going back and forth between the raw data and the process of conceptualizing the findings.

The notes of each interview were transcribed and the data was analyzed systematically. In addition, the data recorded during observation and record review were combined with the interview data. A content analysis process was used which involved creating a list of coded categories and then integrating relevant segments of the transcribed data into one or more categories. The statements made by all interviewees on a particular topic, as well as raw data from written observation notes, were compared with one another. The objective was to sort and code the data to make sense of the events, interactions, and context observed. This process started during the data collection phase as the data already gathered were analyzed and then used to shape the ongoing data collection. As described previously, the Baldrige model served as a framework for the data collection and analysis.

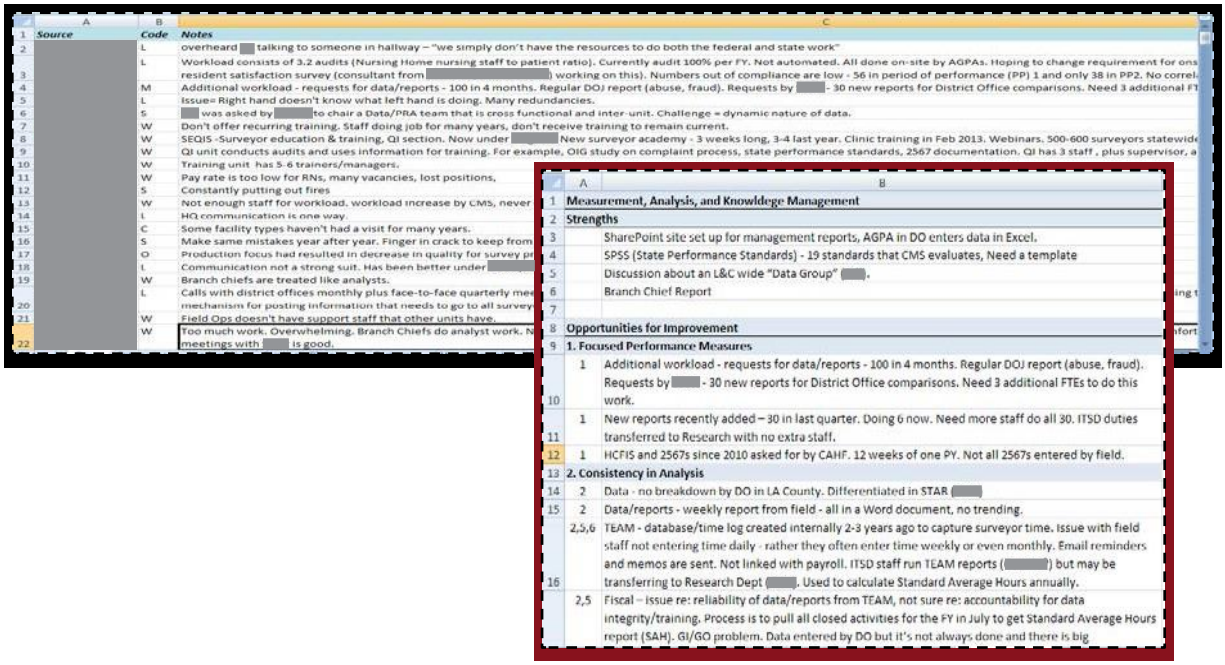
More formal analysis began with identification of the themes and sub-themes emerging from the raw data. Categories were identified, and tentatively named, into which the data were grouped in an effort to create descriptive, multi-dimensional preliminary framework for analysis. Words and phrases that appeared to be similar were grouped into the same category.

After breaking the raw data into manageable parts, a method was designed for identifying these data according to context and the voice of the speaker. Next, the categories were re-examined to determine how they might be linked. Again, the Baldrige criteria were referenced and served as a framework for ongoing data analysis. The categories were compared and combined in an effort to assemble a picture in order to gain a new

understanding of the key issues, challenges, and barriers facing the L&C Program as well as key strengths and successes.

Although the stages of analysis are described here in a linear fashion, in practice they occurred simultaneously and repeatedly. Additional data collection occurred as gaps were uncovered in the data collected previously. Informal analysis began with data collection, and guided subsequent data collection. This interim analysis provided an opportunity to go back and refine questions and to pursue emerging avenues of inquiry in further depth.

Below, in Figure 2, is an example of the data collection and analyses tools used with more than 500 data points entered and analyzed.



	A	B	C
1	Source	Code	Notes
2		L	overheard [redacted] talking to someone in hallway – "we simply don't have the resources to do both the federal and state work"
3		L	Workload consists of 3.2 audits (Nursing Home nursing staff to patient ratio). Currently audit 100% per FY. Not automated. All done on-site by AGPAs. Hoping to change requirement for ons resident satisfaction survey (consultant from [redacted]) working on this). Numbers out of compliance are low - 56 in period of performance (PP) 1 and only 38 in PP2. No correl.
4		M	Additional workload - requests for data/reports - 100 in 4 months. Regular DOJ report (abuse, fraud). Requests by [redacted] - 30 new reports for District Office comparisons. Need 3 additional FT
5		L	Issue= Right hand doesn't know what left hand is doing. Many redundancies.
6		S	[redacted] was asked by [redacted] to chair a Data/PRA team that is cross functional and inter-unit. Challenge = dynamic nature of data.
7		W	Don't offer recurring training. Staff doing job for many years, don't receive training to remain current.
8		W	SEQIS -Surveyor education & training, QI section. Now under [redacted] New surveyor academy - 3 weeks long, 3-4 last year. Clinic training in Feb 2013. Webinars. 500-600 surveyors statewide
9		W	QI unit conducts audits and uses information for training. For example, OIG study on complaint process, state performance standards, 2567 documentation. QI has 3 staff , plus supervisor, a
10		W	Training unit has 5-6 trainers/managers.
11		W	Pay rate is too low for RNs, many vacancies, lost positions,
12		S	Constantly putting out fires
13		W	Not enough staff for workload. workload increase by CMS, never
14		L	HQ communication is one way.
15		C	Some facility types haven't had a visit for many years.
16		S	Make same mistakes year after year. Finger in crack to keep from
17		O	Production focus had resulted in decrease in quality for survey pr
18		L	Communication not a strong suit. Has been better under [redacted]
19		W	Branch chiefs are treated like analysts.
20		L	Calls with district offices monthly plus face-to-face quarterly mee mechanism for posting information that needs to go to all survey
21		W	Field Ops doesn't have support staff that other units have.
22		W	Too much work. Overwhelming. Branch Chiefs do analyst work. N meetings with [redacted] is good.

	A	B
1	Measurement, Analysis, and Knowledge Management	
2	Strengths	
3		SharePoint site set up for management reports, AGPA in DO enters data in Excel.
4		SPSS (State Performance Standards) - 19 standards that CMS evaluates, Need a template
5		Discussion about an L&C wide "Data Group" [redacted].
6		Branch Chief Report
7		
8	Opportunities for Improvement	
9	1. Focused Performance Measures	
10	1	Additional workload - requests for data/reports - 100 in 4 months. Regular DOJ report (abuse, fraud). Requests by [redacted] - 30 new reports for District Office comparisons. Need 3 additional FTEs to do this work.
11	1	New reports recently added – 30 in last quarter. Doing 6 now. Need more staff do all 30. ITSD duties transferred to Research with no extra staff.
12	1	HCFIS and 2567s since 2010 asked for by CAHF. 12 weeks of one PY. Not all 2567s entered by field.
13	2. Consistency in Analysis	
14	2	Data - no breakdown by DO in LA County. Differentiated in STAR [redacted]
15	2	Data/reports - weekly report from field - all in a Word document, no trending.
16	2,5,6	TEAM - database/time log created internally 2-3 years ago to capture surveyor time. Issue with field staff not entering time daily - rather they often enter time weekly or even monthly. Email reminders and memos are sent. Not linked with payroll. ITSD staff run TEAM reports ([redacted]) but may be transferring to Research Dept ([redacted]). Used to calculate Standard Average Hours annually.
	2,5	Fiscal – issue re: reliability of data/reports from TEAM, not sure re: accountability for data integrity/training. Process is to pull all closed activities for the FY in July to get Standard Average Hours report (SAH). GI/GO problem. Data entered by DO but it's not always done and there is big

Figure 2 Example of Data Collection and Analysis

While the staff responses were based on their individual perceptions, it was possible to identify common, repeatable themes. When presenting the findings, responses have been classified as typical when they were supported by most of the interviewees, especially in cases when there did not appear to be any disagreement among the interviewees.

L&C staff were also involved in verifying and clarifying the data analysis. Post-interview sessions were conducted with some staff to inquire whether viewpoints were faithfully interpreted, to rule out gross errors of fact, and to determine whether the analysis makes sense to interviewees with different perspectives. This reaction and feedback provides a check of the credibility of the analysis.

Initial Assessment Findings

As previously described, the framework used for the initial assessment is based on the Malcolm Baldrige National Performance Excellence Program. The seven separate but interrelated Baldrige categories were evaluated to assess organizational performance. These include: Leadership; Strategic Planning; Customer Focus; Measurement, Analysis, and Knowledge Management; Workforce Focus; Operations Focus; and Results.

Assessments of this kind tend to focus on those aspects of an organization that potentially need improvement and could benefit from positive, constructive change. As outlined above, the CDPH L&C Program oversees an array of important regulatory functions, and provides essential services to millions of Californians. As the Program continues to grow and improve, its leaders have recognized the need to modernize and update many essential business processes and supporting technologies in order to better fulfill its mission to secure safe, effective, and quality health care for all Californians.

Internal initiatives are currently underway to simplify and streamline business processes. Accordingly, the findings and improvement opportunities included herein are not meant to detract from the positive aspects of the Program's performance, and should be considered as evidence of the Program's desire to continuously develop, grow, and improve.

This initial assessment summarized the L&C Program's key strengths and opportunities for improvement in each of the first six Baldrige categories (findings in the Results category are embedded in the other categories). For each category, a series of statements is presented. The statements are reflective of our experience, analysis, and observations of the Program and its operations. The statements derive directly from dominant themes that surfaced repeatedly during our research, appeared commonly across multiple business areas, and are supported by comments collected during the more than 200 interviews conducted.

1. Leadership

How senior leaders guide and sustain the organization by establishing the vision, communicating with staff, and ensuring high performance

Strengths

- There is widespread clarity about and commitment to the L&C Program's mission.
- Efforts to promote communication and collaboration between District Office and headquarters management staff have been implemented.
- Written employee performance expectations are being used in some areas.

Opportunities for Improvement

- A vision for L&C has not been fully defined or effectively communicated within the Program.
- The L&C Program would benefit from restructuring to improve efficiency, effectiveness, communication, and accountability.
- Communication and coordination across the L&C Program require improvement.
- Decision-making and collaboration across the L&C Program require improvement.
- The L&C Program lacks a fully-deployed, comprehensive leadership development program.
- Succession and talent management programs within the L&C Program are underdeveloped.
- Processes and practices for communicating standards of conduct and performance are underutilized.

2. Strategic Planning

How the organization develops, implements and modifies strategic objectives and action plans

Strengths

- There is a focus on strategic planning at the Department level. There is consensus opinion among the Program's senior leadership that strategic planning and performance management represent a significant opportunity for improvement going forward.
- Individual managers have taken the initiative to begin a strategic planning process within their sections or units. The CDPH Quality Performance Council has recently been formed and includes representation from L&C.

Opportunities for Improvement

- The L&C Program has no strategic planning process in place. L&C has indicated it is committed to developing a strategic plan but is awaiting the hiring of its new Deputy Director.
- The Program has not yet developed or deployed an effective process for ongoing strategic plan implementation and ongoing strategic management.

3. Customer Focus

How the Program engages its customers, including key stakeholders and partners for long- term success

Strengths

- Stakeholder meetings are conducted on a regular basis.
- Sessions involving representatives from health care facilities are conducted by some district office managers.

- Program executives deliver presentations to external stakeholders at conferences and regional events.

Opportunities for Improvement

- There is significant variability in survey findings among district offices, suggesting inconsistent application of laws and regulations.
- Timeliness in completing mandated workload is a significant challenge for the L&C Program.
- Stakeholders in several groups report that communication channels are not always effective.

4. Measurement, Analysis, and Knowledge Management

How the organization selects, gathers, analyzes, manages and improves its data, information and knowledge assets and how the organization manages its information technology

Strengths

- The CMS State Performance Standards provide clear objectives and related measures for federal survey activities.
- The implementation of a set of tracking logs to monitor federal survey activities via a SharePoint site has resulted in significant improvement in timeliness.
- Quality Assurance audits being completed by the SEQIS team are focused on measuring and improving the quality of survey findings documentation.

Opportunities for Improvement

- The Program has not developed or deployed a focused, standardized, data-driven approach to improving performance.

- The use of comparative data or trending details to support operational and strategic decision-making is limited.
- The Program is inconsistent in its approach to data collection, analysis, and reporting.
- The Program's performance measurement structure limits its ability to respond to unexpected organizational or external changes.
- The Program is limited in its use of performance review findings to develop priorities for continuous improvement and innovation.

5. Workforce Focus

How the organization assesses workforce capability and capacity, and the need to build a workforce environment conducive to high performance

Strengths

- L&C Program employees generally possess strong technical expertise, extensive content knowledge, and a desire to serve. Overwhelmingly, the depth and breadth of staff subject-matter knowledge and expertise were cited as a key strength of the Program.
- The Program provides training for new health facility nurse evaluators (HFENs) in an academy over the course of three months.
- A training supervisor position was created and most district offices have filled the position.
- Good teamwork was frequently cited as a strength among the staff at the majority of district offices.
- Recent improvements in training programs have been made in response to the CMS Benchmark Measure monitoring efforts.
- CHHS and CDPH offer leadership development programs to improve the skills of Program supervisors, managers and executives.

Opportunities for Improvement

- Recruitment, hiring, and promotion processes are reported by line managers to be slow.
- New-hire and ongoing training is not provided for many L&C employees.
- Access to health facility evaluator nurse (HFEN) training is limited by state and federal constraints.
- Employee discipline and performance management is often described to be ineffective, resulting in limited individual accountability and a subsequent decrease in morale.
- Program-specific workforce capacity and capability planning is under-developed.

6. Operations Focus

How the organization designs, manages, and improves its work systems and processes to achieve organizational success and sustainability

Strengths

- CMS provides clearly defined and well-documented guidelines for completing federal survey processes in the State Operations Manual (SOM).
- L&C processes for handling breaches and adverse events are clearly defined and well understood.
- L&C made progress in 2012-2013 with several important regulations packages that provide updated or new guidance to surveyors on the consistent application of state licensing standards.

Opportunities for Improvement

- There is widespread need for standardization in L&C work systems and work processes.
- Processes are overwhelmingly paper-based and labor-intensive with multiple redundancies, representing significant waste.
- Policies and procedures are not current or readily available to staff.

- Many regulations are outdated and no longer in alignment with current practice.
- The capacity to respond to change and encourage innovation is limited.

GAP ANALYSIS

As described in the prior section, Hubbert Systems identified key issues, challenges, and barriers facing the L&C Program using the Baldrige Criteria for Performance Excellence as a framework. Next, Hubbert Systems performed a Gap Analysis to characterize the gap between current performance and desired performance in key aspects of the Program.

Performance gaps are explained by reviewing best practices, analyzing differences in performance among district offices, and by applying industry tools such as the principles of Lean. A key result of the gap analysis is agreement on performance metrics and priorities. During this phase, the consulting team worked with CDPH staff to analyze gaps and probe for root cause issues. The Gap Analysis will be input into the third phase of this comprehensive assessment, the Remediation Plan.

Gap Analysis Approach

The Gap Analysis begins with a thorough analysis of all L&C federally and state-mandated workloads, followed by an analysis of organizational systems and processes that support the completion of workload activities.

In both the Workload section and Organizational Systems and Processes section of the Gap Analysis, opportunities for improvement are described in detail. Later, a description of the desired future state, or “Future View,” and the “Current View,” are provided based on our findings in both the Initial Assessment and the Gap Analysis phase. Then an analysis of the gap between the Future View and Current View using a defined capability maturity framework is provided. The three main components of the Gap Analysis are described below.

Future View

The future view describes the future view of optimal performance and practices based on customer needs, related organizational goals and objectives, and known best practices.

Examples identified during our data collection as well as examples of promising practices that are performed by some staff or business areas in the Program are also included.

Current View

This section describes the actual L&C performance and practices based on results from our surveillance. This current view of the Program explains the major challenges that are being faced and the related resources and stakeholder requirements.

Analysis of Gap

This section of the report describes an evaluation of the gap between current and future L&C Program operational maturity and performance. It compares the current performance to the future requirements for the Program using the following capability maturity framework:

- No Evidence of Defined Approach or Implementation
- Isolated Examples But No Program-Wide Approach
- Early Program-Wide Approach
- Aligned & Integrated Program-Wide Approach

Methodology - Focused Data Collection

The qualitative data collected and analyzed during the Initial Assessment phase provided depth, detail, and a robust description of the L&C Program operations, people, interactions and observed behaviors. As described in the previous section, the purpose of gathering responses to open-ended questions was to help our team understand and capture the perspective of L&C Program staff and stakeholders and allow them to respond in a way that represents accurately and thoroughly their point of view about the Program. This approach is more robust and offers richer detail than a quantitative survey alone.

Where indicated, the consulting team followed this qualitative approach with focused data-collection activities that were often quantitative in nature. A description of these two complementary approaches—qualitative and quantitative—is provided in Table 1 below.

	Qualitative Approach	Quantitative Approach
Objective	To gain an understanding of underlying issues To provide insights into the nature of problems facing the Program To generate ideas for later, focused quantitative data collection To uncover prevalent trends	To quantify data and generalize results To measure incidence of various views and perspectives on issues and problems facing the Program
Sample	Usually a smaller number of respondents	Usually a larger number of representative respondents
Data Collection	Unstructured or semi-structured techniques, e.g., individual interviews, groups, discussions, observation	Structured interviews, survey questionnaires, recorded and transcribed focus groups
Data Analysis	Non-Statistical	Statistical
Outcome	Investigative, initial and thorough understanding of issues	Used to recommend a course of action

Table 1 Comparison of Qualitative and Quantitative Methodologies

Focused Document Review

Document review of the Gap Analysis phase included in-depth review of the documents listed in Appendix C, in addition to the following:

- State workload analyses - AE and ERI Requirements, SNF State Licensing Report

- Deficiency Review Requested Study Reports and related Leadership/Quarterly Reports, Deficiency Review Logs Oct.-Dec. 2013
- Internal Communication Survey
- Policy & Procedure Manual
- Financial Reports - LA County and L&C
- CA Surveyor Employment and Training (SET) Reports FFY 2012 & 2013
- Citation Tracking Log

Focused Interviews with Subject Matter Experts

Structured interviews conducted during the Gap Analysis phase are listed below:

- Policy Branch Managers
- MERP - Pharmacy Consultants
- Headquarters-based Consultants
- ITSD (Information Technology Support Division) - L&C Support Section
- Field Operations Branch Chiefs
- Personnel Liaison Managers
- Professional Certification Branch Managers
- Department Office of Quality Performance and Accreditation
- HAI Program Manager
- Research Branch Manager and Staff

Focused Surveys

In order to identify potential capability gaps, the Hubbert team developed and distributed several electronic surveys to collect quantitative data based on the assessment framework. The surveys conducted examined the perceptions and needs of managers and staff through the perspective of the capacity assessment framework. These tools collected data about the current and expected capability maturity for the Program's identified opportunities for

improvement. Results from these surveys were used to evaluate perceived capacities and potential capacity gaps throughout the L&C Program. Surveys conducted are described below in Table 2.

Respondents	Topic(s)
HFENs	**Orientation, Training, IT**
HFE Supervisors	**Orientation, Training, IT, Leadership & Management Skills**
District Office Managers & Administrators	
District Office Support Staff Supervisors	
District Office Analysts	**Orientation, Training, IT**
District Office Support Staff	**Orientation, Training, IT, Work Environment**
Headquarters Manager & Supervisors	**Orientation, Training, Leadership & Management Skills**

Table 2 List of Surveys

The project team worked with L&C leaders as well as analytical and support staff representatives to circulate the surveys. Selected staff and managers were requested to complete the surveys using SurveyMonkey software. L&C staff involved in overseeing, supporting or performing the targeted activities were selected based on a variety of factors.

Each survey included a number of questions or statements that required a structured response such as selecting for a multiple-choice list or Likert scale (i.e., a respondent's level of agreement with a statement). The surveys also included a small number of open-ended questions. By the time the surveys closed, 362 participants had completed the surveys – an overall 46% response rate. A copy of the surveys and the full results can be found in Appendix E.

Framework for Presenting Findings

This Gap Analysis section of the report identifies gaps between actual and optimal practices in the L&C Program among those Opportunities for Improvement that were the subject of this comprehensive assessment. Although there are few strong Program-wide operations, there also are some practices in which some examples of promising capabilities exist. While all aspects of the L&C Program require improvement to be functioning optimally, some good foundations were identified upon which to build out additional capabilities.

The Gap Analysis findings are organized into two major sections. First, a Workload Assessment is described which includes the following:

1. Federal Survey and Certification Workload
2. State Licensing Survey Workload
3. Facility Investigations (Complaints, Entity-Reported Incidents, Adverse Events, Medical Breaches)
4. Professional Certification Branch Complaint Investigations
5. Los Angeles County Contract
6. Civil Monetary Penalties

The second major section of this report addresses the underlying Organizational Systems and Processes that contribute to L&C's performance outcomes described in the Workload Assessment section. The topics covered in this section include:

7. Strategic Planning
8. Performance Management
9. Performance Improvement Capabilities
10. Organizational Design and Structure
11. Regulations
12. Policies and Procedures

13. Communication and Collaboration
14. Information Technology Systems
15. Timekeeping and Fiscal Estimate Processes
16. Hiring and Promotion Processes
17. Training and Staff Development
18. Employee Satisfaction and Retention
19. Leadership Development and Management Skills
20. Organizational Culture

What follows is a description of Future View, Current View and Analysis of the Gap for each of these twenty topics.

FINDINGS: Workload Analysis - Surveys & Inspections

1. Federal Survey & Certification Workload

Health care facilities in California are licensed, regulated, inspected, and/or certified by a number of public and private agencies at the state and federal levels, including the CDPH L&C Program and the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS). L&C is responsible for ensuring health care facilities comply with state laws and regulations. In addition, L&C cooperates with CMS to ensure that facilities accepting Medicare and Medi-Cal payments meet federal requirements. The Program's 2014-2015 Annual Fee Report indicates that in state fiscal year (SFY) 2012-2013, 68% of surveys conducted were Medicare/Medi-Cal certification surveys, 11% were state licensing surveys, and 21% were for follow-up and revisits.

The L&C Program provides oversight and enforcement for more than 30 different facility types, most of which are licensed by the state and about half of which are certified to provide services for Medicare/Medicaid. Facility types are divided into two major categories: long term care and non-long term care. Long term care facilities include skilled nursing facilities (SNFs); five distinct types of intermediate care facilities (ICFs); congregate living health facilities; and pediatric health care and respite care facilities. Long term care facilities represent nearly 70% of the survey visits and complaint/incident investigations. The L&C Program reports that 70% of its surveyor time is devoted to long term care facility activities.

Federal re-certification surveys ensure that providers are in compliance with all federal laws and regulations. L&C can enter a certified health care facility at any time to conduct an onsite survey. If a violation of federal requirements is identified, L&C will cite the deficiencies for the identified violation(s) and the provider must submit a plan of correction. CMS requires the L&C Program to assess scope and severity levels as either isolated, pattern, or widespread, and the

four severity levels range from no actual harm to immediate jeopardy. The federal scope and severity levels, and their corresponding letter-codes, are shown in Table 3.

NURSING HOME SURVEY DEFICIENCY SCOPE AND SEVERITY GRID

		SCOPE OF THE DEFICIENCY		
		ISOLATED (One or a very limited number of residents affected and/or one or a very limited number of staff involved, and/or the situation occurred only occasionally or in a very limited number of locations.)	**PATTERN** (More than a limited number of residents affected, and/or more than a limited number of staff involved, and/or the situation occurred in several locations and/or the same resident(s) have been affected by repeated occurrences of the same practice.)	**WIDESPREAD** (Situation was pervasive throughout the facility or represented a systemic failure that affected or had the potential to affect a large portion or all the facility's residents.)
SEVERITY OF THE DEFICIENCY	**LEVEL 4****** (Immediate jeopardy to resident health or safety)	J	K	L
	LEVEL 3*** (Actual harm that is not immediate jeopardy)	G	H	I
	LEVEL 2** (No actual harm with potential for more than minimal harm that is not immediate jeopardy)	D	E	F
	LEVEL 1* (No actual harm with potential for no more than minimal harm)	**SUBSTANTIAL COMPLIANCE** A	**SUBSTANTIAL COMPLIANCE** B	**SUBSTANTIAL COMPLIANCE** C

SHADED AREAS=SUBSTANDARD QUALITY OF CARE for any deficiency in s. 483.13 Resident Behavior and Facility Practices (F221-F226), s. 483.15 Quality of Life (F240-F258), and s. 483.25 Quality of Care (F309-F334).

Table 3 Nursing Home Survey Deficiency Scope and Severity Grid

The CMS Mission and Priority Document provides direction for L&C federal survey activities required under CMS grant funding. The document delineates four priority tiers that reflect statutory mandates and CMS policies. Planning for lower-tiered items presumes that the state will accomplish higher-tiered workloads. For example, states must assure that Tiers 1 and 2 will be completed as a prerequisite to planning for subsequent tiers. It is not necessary to complete Tier 1 or Tier 2 work before beginning Tier 3 if the multi-tier work included in the state's submission has been approved by CMS, and the higher tier work will be completed by the end of the fiscal year. States must not make the scheduling and conduct of such surveys, nor their other initial certification survey workload, a higher priority than their Tier 1 and 2 workload,.

CMS helps assure the adequacy of survey and certification processes by issuing guidance, monitoring data that state survey agencies enter into CMS's database, and annually assessing

performance against specific standards, referred to as the State Performance Standards System (SPSS). Three dimensions — frequency, quality, and enforcement — serve as the organizing framework by which CMS organizes and measures the value associated with the survey process overall. In addition, these three dimensions structure efforts to standardize and automate the data that are used in the CMS state performance evaluation process.

In addition to the certification survey activities described above, CMS requires the L&C Program to conduct Life Safety Code (LSC) surveys. The LSC is a set of fire protection requirements that L&C surveyors assess for compliance in health care facilities. In most cases, L&C schedules the LSC survey to coincide with the health survey.

FUTURE VIEW

With regard to the federal workload, the overall goal for the L&C Program is to support the CMS mission of promoting the timely and economic delivery of appropriate quality of care via compliance with federal Medicare/Medicaid quality requirements. The L&C Program will meet all CMS survey and certification responsibilities through:

- Adequate staffing;
- Comprehensive training for all staff;
- Standardized, effective, and efficient work systems and processes; and
- Effective leadership, management and oversight.

Enforcement of basic quality of care standards by health care providers will help ensure Californians receive safe, timely, effective, quality health care services.

CURRENT VIEW

The L&C Program has struggled to meet the CMS survey and certification responsibilities for several years. The Program had not met 12 of 18 State Performance Review measures for

federal fiscal years 2008-2012. CMS tiered workload mandates and current performance details are provided in Appendix F - RO-IX (Regional Office 9) FY 2013 End-of-Year State Performance Review Draft Results.

In a letter dated June 20, 2012, CMS notified the L&C Program of serious concerns regarding the Program's ability to meet many of its survey and certification responsibilities and cited the need for taking "effective leadership, management and oversight of CDPH's regulatory organizational structure, systems and functions." Among the significant concerns cited were the inability to complete CMS workload mandates; the untimely completion and low substantiation of complaint/incident investigations; and the untimely submission of survey reports.

In addition to timeliness mandates, CMS identified opportunities for improvement in the content and quality of survey findings. Referring to a 2012 report by the Office of the Inspector General, CMS expressed concerns about the Program's performance in identifying deficiency ratings, ensuring the adequacy of correction plans, and verifying the correction of deficiencies in California nursing homes. Furthermore, an overall decline in citing "higher scope and severity" deficiencies in nursing homes was identified as a concern. As shown in Figure 3, between 2008 and 2012 the average number of deficiencies per survey for skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) has declined from 11.7 in 2008 to 8.8 in 2012, a decrease of nearly 25%.

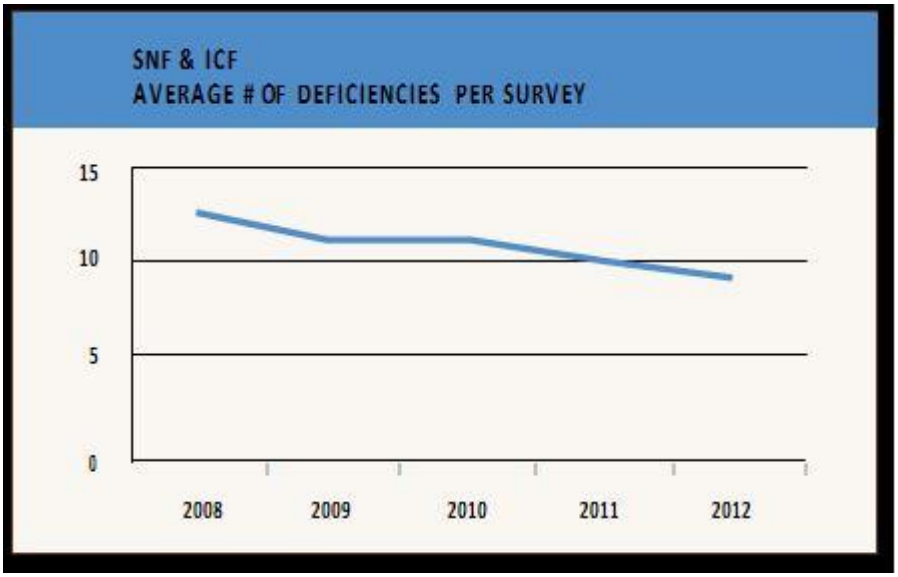


Figure 3 Average Number of Deficiencies per Survey

An independent study conducted by Abt Associates using September 2012 data showed a high level of variation in SNF survey ratings across L&C geographic areas. For example, the mean number of deficiencies per survey ranged from a low of 6.38 to a high of 16.08. As shown in Table 4, an analysis of SNF and ICF survey findings by district office for 2008 through 2012 reveals an average number of deficiencies per survey ranging from a low of 6.2 to a high of 17.5. Similarly, a review of deficiencies at the G-L level of severity by district office reveal a range of 0% - 21% as shown in Table 5.

AVERAGE # OF DEFICIENCIES PER SURVEY (SNFS & ICFS)	
DISTRICT OFFICE	**2008-2012**
Fresno	**6.2**
Ventura	**7.4**
San Diego North	**8.2**
San Francisco	**8.4**
East Bay	**8.7**
Santa Rosa/Redwood Coast	**9.0**
Chico	**9.4**
LA East	**9.5**
Bakersfield	**9.5**
LA San Gabriel	**9.5**
Riverside	**9.7**
San Diego South	**9.8**
Sacramento	**9.8**
State Facilities Unit	**10.8**
LA West	**11.7**
LA North	**12.7**
San Jose	**12.9**
San Bernardino	**13.2**
Orange County	**17.5**

Table 4 **Survey Findings by District Office**

% G-L DEFICIENCIES – 2012 (SNFS & ICFS)	
DISTRICT OFFICE	**% G-L**
State Facilities Unit	**0**
LA East	**1**
San Jose	**2**
Riverside	**2**
Ventura	**2**
LA San Gabriel	**2**
San Diego South	**2**
Santa Rosa/Redwood Coast	**3**
Sacramento	**3**
San Diego North	**4**
Fresno	**4**
San Francisco	**5**
East Bay	**6**
LA North	**8**
LA West	**10**
Chico	**10**
Bakersfield	**11**
Orange County	**11**
San Bernardino	**21**

Table 5 **Percent of G-L Deficiencies by District Office**

In 2012 L&C implemented a comprehensive, system-wide tracking log along with supporting tracking and reporting processes for Tier 1 and Tier 2 workload requirements. While improvement has been made, the L&C Program continues to face challenges in meeting all federal workload requirements. Specifically, the FY 2013 End-of-Year State Performance Review report indicates the L&C Program has met performance expectations for 12 of the 19 measures. The seven SPSS measures not met for FY 2013 are:

- Frequency of Non-Nursing Home Surveys - Tier 3
- Frequency of Data Entry of Complaint Surveys for Non-Deemed Hospitals and Nursing Homes
- Documentation of Deficiencies Threshold 2 - Non-Nursing Home
- Accuracy of Identification of Deficiencies During Nursing Home Comparative Surveys
- Prioritizing Complaints and Incidents

- Timeliness of Complaint/Incident Investigations - Non-Immediate Jeopardy High-Nursing Homes
- Quality of Complaint/Incident Investigation

In addition to monitoring tiered workloads as described above, the L&C Program also tracks, monitors, and reports performance related to CMS workload in the Benchmark Performance Summary Reports. This report includes four benchmark categories: Management Structure and Personnel Stabilization; Training; Tiered Workload; and Complaints. CMS required L&C to report on these benchmarks beginning in 2012. A copy of the federal fiscal year 2013 and the first quarter 2014 Benchmark Performance Summary Reports can be found in Appendix G.

Identifying the key factors contributing to the L&C Program's inability to meet federal workload requirements is a key purpose of this comprehensive assessment. These factors, along with areas where recent improvements have been made, are outlined below.

Federal Survey & Certification Workload

STAFFING

Strengths

- In December 2011 steps were taken by the state in support of CDPH including: eliminating furloughs; lifting a hiring freeze and initiating aggressive recruitment and hiring efforts; permitting staff to attend out-of-state CMS trainings; and authorizing the hiring of a permanent training manager.
- L&C staff are knowledgeable, hardworking, and dedicated to the mission of the organization. Many individuals expressed a passion for their work and stated that they love their jobs in spite of the many challenges and barriers they face on a daily basis. Many managers and supervisors work very long hours and demonstrate a strong commitment to their work. They convey a deep passion for ensuring safe, quality, effective health care for Californians.

Opportunities for Improvement

- L&C has significant challenges related to accessing accurate data to ensure adequate Program staffing. This includes the statewide facility count, activity count, timekeeping systems and processes, and the calculation of standard average hours. Validity and reliability in data collection, analysis and reporting, standardized procedures, process monitoring and oversight, performance measures, and written policies and procedures contribute to the challenges of adequately staffing the Program. L&C Leaders have identified this as a key barrier and are currently gathering the necessary detail and conducting an analysis to determine how to proceed with improving the timekeeping system. Refer to the Timekeeping and Estimate Process section.
- Vacancy rates and turnover in surveyor and managerial positions have improved, however L&C continues to face challenges in this area. Refer to the analyses on Hiring & Promotions and Employee Satisfaction and Retention.

TRAINING

Strengths

- Training for new HFENs is provided in three week-long sessions over three months. This purpose of this training is to orient new HFENs to the role of a surveyor and prepare them for the CMS-required Basic Long Term Care training course.
- California is participating in the CMS pilot initiative to expand training resources through the Magnet Area (MAT) program. There is currently one fully trained MAT instructor and seven more individuals in the process of completing this training.

Opportunities for Improvement

- The L&C Program continues to struggle with providing optimal training to ensure HFENs have the necessary knowledge and skill sets. While CMS Benchmark requirements related to training for HFENs have been met, opportunities for improvement in this area remain. A detailed assessment of training for HFENs is provided in the Training section.

- L&C staff other than HFENs receive little or no initial training. This includes analytical, support, and management staff at both headquarters and the district offices. Nearly 100% of the more than 140 interviewees at both headquarters and in the district offices reported lack of training as a key barrier for the Program. Refer to the assessment of training later in this report.

WORK PROCESSES AND IT SYSTEMS

Strengths

- The L&C Program is using the federal survey process statewide and CMS provides clearly defined and well-documented guidelines for completing federal survey processes in the State Operations Manual (SOM).

Opportunities for Improvement

- There is significant lack of standardization in L&C systems and processes. Processes are overwhelmingly paper-based and labor-intensive with multiple redundancies resulting in significant waste. In many cases, this results in entering the same information in two or three different logs. In an employee survey conducted in October 2013, less than one-half (47%) of the 343 L&C respondents agreed with the statement "I am satisfied with the productivity and efficiency in my program." Additional examples are provided in several sections of this report, including in the assessment of Facility Complaint Investigations and Citation processes. In addition, specific challenges with IT systems and applications are described in detail in the IT section of this report.
- Policies and procedures are neither current nor readily available to staff. Refer to the Policy & Procedure section of this report.

LEADERSHIP, MANAGEMENT & OVERSIGHT

Strengths

- The implementation of a set of tracking logs to monitor federal survey activities via a SharePoint site has resulted in significant improvement in timeliness. Additionally, the

L&C Field Operations management team implemented a focused performance improvement plan aimed at Tier 1 and Tier 2 workload and related SPSS measures.

- Quality Assurance (QA) audits being completed by the SEQIS team are focused on measuring and improving the quality of survey findings documentation.
- The L&C Field Operations management team has implemented a focused approach to addressing the facility complaint backlog. This is addressed in detail in the complaint investigation section of this report.

Opportunities for Improvement

- Significant opportunities for improvement in strategic planning, performance measurement, and performance management are addressed in detail in those sections of this report.
- Significant opportunities for improvement in communication, coordination, and collaboration are addressed in detail in that section of this report.

GAP ANALYSIS **Federal Survey & Certification Workload Assessment**				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Staffing		X		
Training		X		
Work Systems & Processes		X		
Leadership, Management & Oversight			X	

Table 6 Gap Analysis – Federal Survey & Certification Workload Assessment

2. State Survey and Audit Workload

In addition to the federal survey and certification mandates described in the previous section, the L&C Program is mandated to conduct various state licensing activities. Re-licensing surveys are a major aspect of this work and ensure that a provider is in compliance with all state laws

and regulations. These surveys determine if a facility has the appropriate staff, equipment, policies and procedures to deliver services to patients. L&C can enter a facility at any time to conduct a state survey. If a violation of state statutory or regulatory licensing requirements is identified, L&C can take the following types of actions:

- Write a state deficiency for the identified violation(s) for which the provider must submit a plan of correction.
- Issue an administrative penalty, including a civil monetary penalty, for a violation or deficiency that constitutes an immediate jeopardy to the health and safety of a patient. An "immediate jeopardy" is when the provider's failure to comply with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to a patient.
- Based on findings by the state, L&C representatives contact CMS to report possible federal violations.

There are at least 19 different facility types requiring re-licensing surveys every two or, in some cases, three years. Completing all re-licensing surveys within the mandated time frames represents more than 2,000 survey visits per year. A summary of licensing and certification survey requirements and a list of each type of facility by district office are provided in the Appendix.

In addition to the state-mandated licensing survey workload, L&C is required to conduct additional oversight and enforcement activities. For example, the Skilled Nursing Facility Quality and Accountability Supplemental Payment (QASP) System was created by state law to provide supplemental Medi-Cal payments to skilled nursing facilities (SNFs) that improve the quality of care rendered to its residents. The QASP system uses performance measures to assess overall facility quality of care and improvements on an annual basis. Before quality measures can be scored, facilities must be in compliance with Health & Safety Code (HSC) §1276.5 (a) providing a minimum of 3.2 actual nursing hours per patient day (NHPPD). The Staffing Audits Section,

created within L&C, conducts more than 1,100 statewide audits annually in skilled nursing facilities to monitor and enforce compliance. Non-compliance with a staffing audit will result in exclusion from the QASP scoring and additional funding. An administrative penalty may also result depending on the severity of the non-compliance.

L&C also conducts Medication Error Reduction Plan (MERP) surveys. The Health and Safety Code requires, as a condition of licensure, that all general acute care hospitals, surgical clinics, and special hospitals adopt a formal plan to eliminate or substantially reduce medication-related errors. MERP surveys are triennial, with each facility being surveyed once every three years. Each survey is conducted onsite by one or more pharmaceutical consultant(s) to monitor implementation of the facility's Medication Error Reduction Plan and compliance with applicable state regulations. The first survey cycle started on January 1, 2009, and concluded on December 31, 2011. As of December 31, 2013, two years into the survey cycle, 192 surveys had been completed.

Finally, the Central Applications Unit (CAU) was established to centralize the processing of facility applications (initial and change of ownership) for state licensure and federal certification. The mission of the Centralized Applications Unit is to ensure standardization of the facilities licensure application process and to ensure the review of these applications is performed in a consistent manner.

FUTURE VIEW

As with federal survey mandates, the overall goal for the L&C Program is to ensure safe, timely, effective health care through the enforcement of basic quality of care standards. This will be accomplished through sound approaches to:

- Adequate staffing;
- Comprehensive training for all staff;
- Standardized, effective, and efficient work systems and processes; and

- Effective leadership, management and oversight.

Improvements in these areas will allow L&C to meet all licensing survey responsibilities and ensure that basic quality of care standards are met by health care providers.

CURRENT VIEW

Both the 3.2 Nursing Audits and MERP are performing well. For example, nearly all of the required MERP surveys were completed in the first triennial period of 2009-2011, with 93% of the hospital providers receiving at least one deficiency. Prior to the start of the second triennial period, Program enhancements were implemented with stakeholder input. As of December 31, 2013, 192 surveys had been completed for the second period.

Similarly, QASP has also been a success in that all staffing audits and scoring were completed for the baseline performance year (2011-12) and subsequent performance year (2012-13). The first payment is scheduled to be sent at the end of April 2014 to all facilities that met the minimum quality scoring criteria. In addition, 56 administrative penalties were assessed and released for staffing non-compliance during the baseline performance year. Of the 23 facilities that appealed the penalty, the findings were upheld on all but one case. During the second performance year there was a decrease in penalty-related staffing audits with just 35 potential penalties. Twenty-three of these penalties have already been released and are in the appeal or pay process. The Staffing Audits Section is on schedule to complete all of its required audits, and subsequent quality reviews, for the third year in September 2014.

The L&C Program is not, however, performing well on state-mandated facility re-licensing surveys. An analysis of licensing surveys completed for just one facility type, skilled nursing facilities (SNFs), during a two-year look-back period to the beginning of 2012 revealed that 71% of the SNFs are overdue for a licensing survey. In fact, nearly one-third of these facilities have not had a licensing survey conducted since 2005. The statute requires that L&C conduct re-

licensing for SNFs every two years or within one year if the facility had been issued a state citation. In the Annual Fee Report, the Program reports the actual number of re-licensing visits completed in FY 2012-2013. Table 7 compares the actual number of surveys completed to the number required for three of the highest volume facility types that require re-licensing surveys per state statute. These data reveal that only 21% of SNFs, 49% of GACHs, and less than 1% of ICFs had re-licensing surveys completed. In addition, for eight of the 19 facility types listed, re-licensing surveys were not conducted.

Facility Type	# of Facilities	Frequency Required	# to be completed each year	# completed in SFY 2012-2013
Skilled Nursing Facilities (SNFSs)	1,265	2 years	632	135
General Acute Care Hospitals (GACH)	431	3 years	140	69
Intermediate Care Facilities (ICF) all types	1,212	2 years	606	5

Table 7 **Number of Surveys Required vs. Actual Number Surveyed for SNFs, CACHs, and ICFs**

This issue was addressed in a 2012 Bureau of State Audits report that recommended L&C should explore opportunities to coordinate the licensing and certification surveys, which could facilitate more timely surveys while minimizing additional workload. Although L&C has established a policy to coordinate federal certification and licensing survey activities as much as possible to maximize efficient use of staff resources. It is not evident, however, that this policy has been implemented statewide. Several district office managers reported that they do not require or schedule staff to combine federal and state survey activities during scheduled on-site inspections.

The focus of this state workload assessment is on the re-licensing survey mandated activities. Identifying the key factors contributing to the L&C Program's inability to meet state workload requirements is a second key purpose of this comprehensive assessment. These factors, along with areas where recent improvements have been made, are outlined below.

State Survey and Audit Workload

STAFFING

Strengths

- In December 2011, the state took steps in support of CDPH, including: eliminating furloughs; lifting a hiring freeze and initiating aggressive recruitment and hiring efforts; and authorizing the hiring of a permanent training manager. There are currently 10 staff in the training section, and 2 staff recently have been hired to start in August 2014 (once these 2 staff start, this unit will be filled). The Quality Improvement Section currently includes 6 staff and one vacancy.
- The New Surveyor Academy provides instruction on State workload, including training on complaint investigations, issuing state citations, and the dual enforcement process to hold SNFs accountable for violations of state and federal regulations.

Opportunities for Improvement

- The same obstacles to ensuring adequate staffing for the federal survey and certification workload also apply to the state licensing survey workload. Refer to the Timekeeping and Estimate Process section.
- As with the federal workload, vacancy rates in surveyor and managerial positions present a challenge for the L&C Program. Refer to the sections on Hiring & Promotions and Employee Satisfaction and Retention.

TRAINING

Strengths

- At times, the Training Unit has presented selected state-only training on primary care clinics, GACHs and Adverse Events.

Opportunities for Improvement

- Training for L&C Program HFENs is primarily focused on CMS-mandated training and state complaint and citation processes. There are limited resources available for training

on state licensing survey processes and requirements. A detailed assessment of training for HFENs is provided in the Training section of this report.

- As stated in the previous section, L&C staff, other than HFENs, receive little or no training. This includes analytical, support, and management staff at both headquarters and the district offices. Nearly 100% of the more than 140 interviewees at both headquarters and in the district offices reported lack of training as a key barrier for the Program. Additional information is in the training assessment section of this report.

WORK SYSTEMS AND PROCESSES

Strengths

- No notable strengths identified.

Opportunities for Improvement

- Most state regulations (Title 22) are outdated and, in many cases, do not reflect current practice. Refer to the Regulations section of this report.
- L&C Program policies & procedures for licensing survey activities are outdated and difficult to access. Refer to Policy & Procedure section of this report.
- Each district office develops and deploys its own approach to prioritizing state licensing surveys. Determinations are made based on criteria determined at each district office rather than using a consistent statewide approach.
- There is considerable redundancy and duplication of effort in completing the federally required survey and certification workload and state licensing survey mandates.

LEADERSHIP, MANAGEMENT & OVERSIGHT

Strengths

- No notable strengths identified.

Opportunities for Improvement

- Tracking and reporting activities for monitoring compliance with state survey requirements are decentralized. Each district office monitors compliance with these mandates and reports status weekly to a headquarters-based branch chief.
- The process for identifying yearly workload and making assignments is inadequate for ensuring all licensing surveys are completed within mandated timeframes. Disparate approaches to assigning this workload to the district offices were reported. For example, one approach described simply identifying the total number of surveys to be completed in a given year for a specific facility type by dividing the total number of facilities by the frequency requirement. For example, if there are 1,200 skilled nursing facilities in the state and the mandate is to conduct a licensing survey every two years, then a target of 600 surveys per year is set and assignments are made for each district office. At the same time, however, it was reported that each district office is assigned to complete one licensing survey per month for SNFs only. For both approaches, the determination of which facilities to survey is made at the district office level with no centralized reporting or management oversight. Other than SNFs, assignments are not made to ensure completion of licensing surveys for the remaining 18 facility types, including, for example, the 431 general acute care hospitals or the more than 1,100 community clinics.
- Significant opportunities for improvement in strategic planning, performance measurement, and performance management are addressed in detail later in this report.

GAP ANALYSIS State Survey Workload Management				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Staffing	X			
Training	X			
Work Systems & Processes	X			
Leadership, Management & Oversight	X			

Table 8 Gap Analysis – State Survey Workload Management

FINDINGS: Workload Analysis - Investigations

3. Facilities

L&C staff respond to complaints, entity-reported incidents (ERIs), adverse events (AE), and medical breaches in all facility types licensed and certified by the Program. These investigations often require on-site inspections to evaluate compliance with both state and federal requirements related to the issue reported. The federal complaint process, an abbreviated survey approach, is followed for all onsite investigations conducted in long term care facilities. If during the course of a long term care complaint investigation L&C uncovers additional problems, a full on-site survey may be initiated. For non-long term care facilities, L&C investigates using the state complaint process, and when directed by CMS, will investigate using the federal process for appropriate certified facilities.

Complaints

The Health and Safety Code (HSC) requires the L&C Program to investigate a complaint regarding a nursing facility within 10 working days of receipt, unless it determines that the

complaint is willfully intended to harass the facility or lacks a reasonable basis. When a complaint allegation is sufficiently severe, as when there is threat of imminent danger of death or serious bodily harm, referred to as immediate jeopardy, statutes require L&C to initiate a complaint investigation within 24 hours. There are no state statutes addressing the complaint initiation time requirements for facility types other than nursing homes. In addition to these state-mandated requirements, federal requirements for complaint investigation are described in Table 9.

5075.9 – Maximum Time Frames Related to the Federal Onsite Investigation of Complaints/Incidents
(Rev. 18, Issued: 03-17-2006; Effective/Implementation Dates: 03-17-2006)

Intake Prioritization				
Provider Type	**Immediate Jeopardy (IJ)**	**Non-IJ High**	**Non-IJ Medium**	**Non-IJ Low**
Nursing homes	SA must initiate an onsite survey within 2 working days of receipt.	SA must initiate an onsite survey within 10 working days of prioritization	No timeframe specified, but an onsite survey should be scheduled	SA should investigate during the next onsite survey
Non-deemed Providers/suppliers, other than nursing homes	SA must initiate an onsite survey within 2 working days of receipt	N/A	SA must initiate an onsite survey within 45 calendar days of prioritization	SA should investigate during the next onsite survey
Deemed providers/suppliers	SA must initiate an onsite survey within 2 working days of receipt of RO authorization	N/A	SA must initiate an onsite survey within 45 calendar days of receipt of RO authorization	SA should investigate during the next onsite survey
CLIA, non-exempt, non-accredited	SA investigates within 2 working days of receipt	N/A	N/A	N/A
CLIA, exempt	SA notifies RO within 10 calendar days	N/A	N/A	N/A
CLIA, accredited	SA submits information to RO within 2 calendar days	N/A	N/A	N/A
EMTALA	SA must complete investigation within 5 days of receipt of RO authorization	N/A	N/A	N/A
Death related to restraint/seclusion used for behavior management-Hospitals	SA must complete an onsite investigation within 5 working days of telephone authorization from the RO	N/A	N/A	N/A
Fires resulting in serious injury or death	SA must initiate an onsite survey within 2 working days of receipt	N/A	N/A	N/A

Table 9 **Federal Requirements for Complaint Investigations**

Entity-Reported Incidents

Entity-reported incidents (ERIs) are events that facilities are required to report, including interruptions of services essential to the health and safety of residents; alleged or suspected abuse; all fires, disasters, and other risks to resident life or health resulting from accidents or incidents at the facility; and administrator or director of nursing personnel changes. The requirements for investigating ERIs are described above.

There are no state statutes or federal mandates for completing a long term care complaint investigation within a specified time frame. However, a bill has been introduced in the 2012-2014 Legislative session (AB 1816) that may impact the time it takes to complete investigations of long term care complaints or ERIs.

Adverse Events

The reporting of adverse events, a special type of ERI, applies to hospitals. Adverse events are defined as any one of 28 events described in HSC §1279. Examples include surgery on the wrong patient or wrong body part and various other events that cause death or disability of a patient, personnel, or visitor. Hospitals are required to report such events to L&C no later than five days after the event is detected. For any report of an adverse event that indicates there is an ongoing threat of imminent danger of death or serious bodily harm, the L&C Program is statutorily mandated to conduct an onsite investigation within 48 hours of the receipt of that report and must complete that investigation within 45 days.

EMTALA

EMTALA (Emergency Medical Treatment and Labor Act) is a federal law that requires hospitals to provide an examination and necessary stabilizing treatment, without consideration of the patient's ability to pay, when a patient presents to the emergency room for attention to an

emergency medical condition. Pursuant to federal regulation, L&C Program staff are required to complete EMTALA investigations within 5 days of the authorization from CMS.

Medical Breaches

Medical breaches involve the unlawful or unauthorized access to, use, or disclosure of patients' medical information. While HSC §1280.15 requires clinics, health facilities, home health agencies and hospices to report a breach incident no later than five days after it is detected, there is no requirement for the L&C Program to initiate and/or close an investigation within a certain period of time.

Complaint Validation Surveys

Complaint validation surveys are an additional workload activity required by CMS to evaluate whether an accredited provider is meeting Medicare health and safety requirements. The L&C Program conducts validation surveys of deemed provider types in accordance with established procedures to ensure a fair basis for evaluating the effectiveness of approved accreditation organizations.

FUTURE VIEW

The overall goal for complaint and incident investigation is to promote and protect the health, safety and welfare of residents, patients, and clients receiving health care services. This includes providing protective oversight through uniform enforcement of state and federal regulations among L&C district offices, and promotion of efficient use of staff and processes. This will be accomplished through the identification and spread of best practices throughout L&C district offices and among the surveyor workforce and other approaches described in the management of federal and state workload including:

- Adequate staffing to timely initiate and complete investigations;
- Comprehensive training for all staff;
- Standardized, effective, and efficient work systems and processes; and

- Effective leadership, management and oversight.

CURRENT VIEW

Our first objective in evaluating the L&C Program's current performance on the investigation of complaints and ERIs was to determine the volume of each type of investigation. Table 10 provides a comparison of the reported volume of facility complaints for state fiscal year 2012-2013 as reported in the L&C Annual Fee Report from the CDPH website.

Complaints SFY 2012 - 2013 Annual Fee Report			
	Complaints Received	**Complaints Requiring Investigation**	**Immediate Jeopardy Complaints**
Long Term Care	6,404	5,426	229
Non-Long Term Care	4,077	3,825	46
Total	10,481	9,751	311

Table 10 **Reported Facility Complaints for FY 2012-13**

Similarly, Table 11 provides the volume of entity-reported incidents for state fiscal years 2012-2013 as reported in the L&C Annual Fee Report from the CDPH website.

ERIs SFY 2012 - 2013 Annual Fee Report			
	ERIs Received	**ERIs Requiring Investigation**	**Immediate Jeopardy ERIs**
Long Term Care	20,154	13,721	222
Non-Long Term Care	8,271	7,038	46
Total	28,425	20,759	268

Table 11 **Reported Entity – Reported Incidents for FY 2012-13**

It is relevant to note that not all complaint and ERI intakes warrant an investigation. The reasons an investigation may not be required include cases of duplicate entry, facilities that are not within L&C's jurisdiction, and intakes that are withdrawn before an investigation begins.

Table 12 provides the volume of adverse events for state fiscal year 2012-2013 as reported in the L&C Annual Fee Report.

Adverse Events SFY 2012 - 2013 Annual Fee Report		
	AEs Received	Immediate Jeopardy AEs
Hospitals Only	1,686	17

Table 12 **Reported Adverse Events for FY 2013-13**

Notably, the Hubbert Systems team faced significant challenges obtaining consistent complaint and ERI data, which is in part due to lack of strong application controls in the CMS ASPEN database (e.g., documented procedures for staff who input data into ASPEN and for staff who create reports using ASPEN data). The Program's opportunities for improvements to data collection, analysis, and reporting are discussed further in the Performance Management section of this report.

The L&C Program faces significant challenges in the timely closure of investigations even as there appear to be positive trends with respect to opening investigations. For example, analysis of the L&C Program's performance on initiating facility complaint investigations reveals that the Program reports 97.3% to 98.4% compliance with complaint investigation initiation within 10 days for non-immediate jeopardy and two days for immediate jeopardy cases. This is similar to findings in a recent report requested by the Hubbert Systems team and prepared by the Research Section which shows that 96% of immediate jeopardy ERIs were initiated within two days. It is unclear, however, what precisely is involved in "initiating" a complaint. In several

district offices, they described this as doing a “drive by” so that they could indicate the investigation had been opened and therefore meet the 1- or 10-day requirement.

Timeframes for completing a complaint investigation are another matter. L&C Program leaders report that there is no internal policy on timeframes for closing complaints. There is a federal performance standard of 60 days for the time between exiting the facility and uploading the findings into the federal system. The Program reports 80.9% compliance with the CMS requirement. This metric, however, does not capture the entire period of time from receipt of complaint to closure. Rather, it measures the time from finishing the write-up to uploading the case in the CMS database.

Timely closure of complaint investigations has been an ongoing problem for the L&C Program for many years. A 2007 Bureau of State Audits report found that L&C failed to close more than one-half of its complaint cases within its stated 45 working day policy goal that existed at the time of the audit. Similarly, the March 28, 2014, response to the Assembly Committee on Aging and Long Term Care and Committee on Health reported between 45% and 60% of cases were closed in fewer than 90 days for fiscal years 2007-2008 through 2012-2013. This report also indicated there were a significant number of cases for which closure was longer than one year. For example, there were between 612 and 1,168 cases that remained open for more than one year for fiscal years 2007-2008 through 2011-2012. Notably, the L&C Program was operating under mandatory furloughs and a hiring freeze between February 2009 and December 2011.

At the request of the Hubbert Systems consulting team, data pulled from the ASPEN system for State Fiscal Years 2007-2008 through the first half of 2013-2014 show trends for completion of Long Term Care complaint investigations within 45 days. As shown in Figure 4, 54% of complaint investigations and 49% of ERI investigations were closed within 45 days in the first half of SFY 2013-2014. Also, there has been no evidence of improvement since 2007.

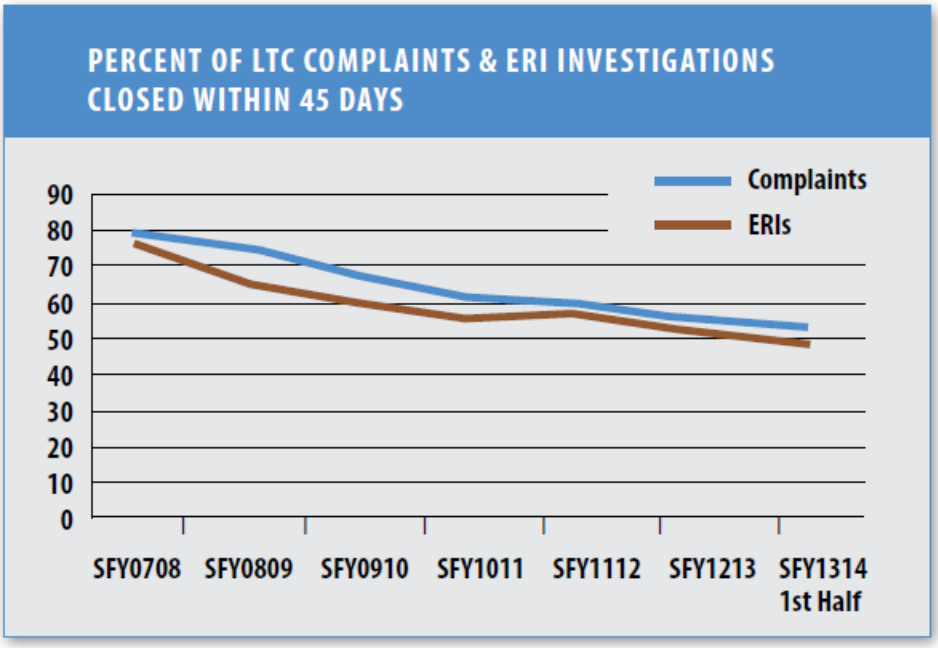


Figure 4 **Percent of LTC Complaints & ERI Investigations Closed within 45 Days**

The data reveal a similar trend in non-long term care complaints and ERIs as shown in Figure 5. However, timeliness for NLTC is significantly worse with 34% of complaint investigations and 37% of ERI investigations closed within 45 days. Notably, new reporting requirements were established for Adverse Events (2007) and Medical Breaches (2009), after which the Program experienced a significant increase in the number of ERIs received.

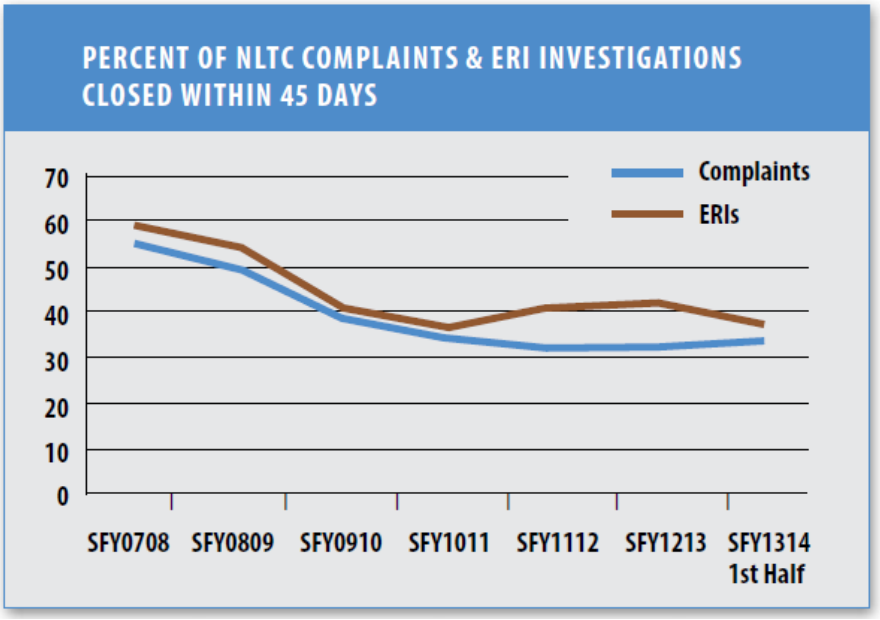


Figure 5 **Percent of NLTC Complaints & ERI Investigations Closed within 45 Days**

The L&C Program has accumulated a large backlog of complaints and ERIs that remain open. An internal management tracking report dated December 4, 2013, indicated there were 9,375 skilled nursing home complaints and ERIs that remained open, with some dating back to 2009. L&C launched a focused effort in December 2013 to address this backlog. District office managers were provided detailed information for each open complaint and were required to provide an explanation for complaints received in 2012 and prior years but not yet closed. It was determined that a significant number of these investigations had in fact been completed but that district office staff failed to log the record as closed in the database. After one week of data clean-up efforts, 8,235 open complaints and ERIs remained. Ongoing efforts to eliminate this backlog have continued and include headquarters monitoring and oversight through the use of a detailed tracking log, weekly reports, and follow-up by the Field Operations branch chiefs with each district office management team. Previous and recent efforts to address the backlog include:

- CMS Benchmark Work Plan Implemented in February 2012 and updated quarterly
- 60 Day tracking log implemented March 2012

- SharePoint Complaint Validation/EMTALA Tracking Log implemented May 2012
- Weekly Branch Chief/District Manager Worksheet updated to include Complaints in January 2013
- Upload clean up begun in August 2013
- Complaint Backlog Tracking Log implemented in December 2013

On March 12, 2014, the California Legislature's Joint Legislative Audit Committee approved Assemblymember Yamada's request to audit the state's oversight of long term health care facilities. The audit was requested after lawmakers received reports about a backlog of complaints about long term care facilities. In the L&C Program's March 28, 2014 response to the Assembly Committee on Aging and Long Term Care and the Assembly Committee on Health, it was reported that 34,790 complaints were received between fiscal years 2007- 2008 and February 3, 2014, and that 3,686 of these complaint investigations remained open.

Assembly Committee Hearing Letter (Received 2007-February 3,2014; remain open as of Feb 3, 2014)	
Complaints & ERIs	4,764
Complaints Only	3,686

Table 13 Reported Number of Open Complaints and ERIs

It is important to note that these data regarding timeliness of complaint investigations are only for long term care complaints and ERIs. While long term care facilities represent less than one-third of the total facilities under the jurisdiction of the L&C Program, they represent more than one-half of all complaints received. The 2014-2015 Annual Fee Report, for example, indicates there were 6,404 long term care complaints and 4,077 non-long term care complaints received in FY 2012-2013. Non-long term care facilities include hospitals (3,253 complaints in FY 2012-2013), clinics, home health agencies and hospices. There has been no apparent ongoing effort to eliminate the backlog for non-long term care facilities.

Investigating reported breaches are another example of the L&C Program's challenges regarding timely response. A report run in February 2014 indicated that more than 15,000 reports of medical breach have been reported since January 2009 with an average of about 4,000 cases per year. Of these, 6.3% (967) were considered to be "intentional or deliberate," almost half of which (46%) are pending investigation initiation and/or closure. There is no mandate or specified time period for opening or closing these investigations, nor does there appear to be an internally determined target that has been identified.

In addition to timeliness of complaint initiation and closure, state and federal entities have expressed concerns about the quality of the investigations completed by the L&C Program. A 2007 Bureau of State Audits report found the Program to be understating the severity of complaint allegations. Also, in 2012 CMS expressed concern regarding the percentage of substantiated complaints and self-reported incidents that resulted in a disproportionately low number of federal deficiencies being cited. Most recently, in federal fiscal year 2013, the L&C Program received a "NOT MET" on the CMS SPSS measure "Quality of Complaint/ Incident Investigation." Statewide trends and variation in the number and severity levels of deficiencies between L&C district offices were discussed earlier in this report. In addition, trends in the number and severity of state citations issued to long term care facilities are addressed in a subsequent section of this report.

Other important metrics to evaluate include the percentage of complaint investigations that are received versus investigated and the percentage substantiated. Trend and comparison analyses may provide useful information to support Program improvements.

An examination of root causes, best practices, and specific areas where recent improvements have been made are outlined below.

Facility Investigations

WORK SYSTEMS & PROCESSES

Strengths

- Clear guidelines for complaint and ERI investigation processes are provided in Chapter 5 of the federal State Operations Manual (SOM). L&C has required all district offices to use the federal process since early 2013.
- Several years ago, the Training Unit created a binder of policies and procedures for all District Office support staff on how to process complaints, citations, re-certifications and other processes.
- The East Bay and San Jose District Offices are examples of "best practices" in complaint investigation timeliness. While these two offices differ in their approach and processes, they share these key factors in common:
    - Standardized and efficient procedures for processing incoming complaints and ERIs.
    - Site-specific tracking sheets for monitoring the status of all complaints (in addition to the headquarters-mandated tracking logs).
    - Collaboration and communication among staff members at all levels of management.
    - Close monitoring and oversight by district office managers. Effective management and remarkable leadership promote an environment in which staff feel involved, expectations are clear, and performance is monitored.

Opportunities for Improvement

- There is a lack of standardized intake forms, processes, tracking, and reporting systems.
- Tracking logs are primarily focused on the backlog only.
- There is a lack of documentation for complaint tracking procedures, resulting in variable "on-the-job" training, work-arounds, and inconsistencies.
- Weak application controls in the ASPEN system may result in erroneous data entry and difficulty in detecting errors and omissions.

STAFFING

Strengths

- No notable strengths identified.

Opportunities for Improvement

- The absence of effective staffing analysis may result in staffing shortages.
- Turnover in analytical and support staff results in complaints remaining open for longer periods of time and inexperienced staff entering data incorrectly. For example, the turnover rate was 16% for AGPAs and 15% for Program Technician IIs in January 2014. Annual turnover for these classifications as of December 2013 was 16% and 14% respectively.
- Turnover in RNs results in more inexperienced survey teams and inconsistent output. For example, the turnover rate for HFENs was 18.18% in January 2014. Annual turnover for HFENs as of December 2013 was 16%.
- There is variation among district offices in approaches to assigning staff to complaint investigations. For example, several district offices have a specially designated "Complaint Team" while others do not. Clear guidelines and criteria for managing staff assignments are not evident. The use of Complaint Teams is being explored by L&C headquarters management as an emerging "best practice." Further evaluation of the options and benefits of different approaches is warranted.

TRAINING

Strengths

- No notable strengths identified.

Opportunities for Improvement

- In all district offices, interviewees stated that there is a lack of training regarding data analytics and the IT systems which results in longer response times and variable output. Refer to Training and IT Systems sections of this report for more details.

LEADERSHIP, MANAGEMENT & OVERSIGHT

Strengths

- Recent oversight and interventions by L&C headquarters management focused on improving the large complaint and ERI backlog had resulted in a significant decrease in the backlog. In March 2014, CDPH senior leaders began tracking all backlogged long term care complaints and ERIs, including those received since December 2013.

Opportunities for Improvement

- Management oversight has been primarily focused on eliminating the backlog in response to the Assembly committee hearings, with only recent focus on current complaints and ERIs.
- CMS requirement of 60 days to upload complaint investigation findings and documentation have been monitored. However, there is no mandated time frame for closing a complaint investigation, nor has L&C established and communicated a goal for timely closure (receipt of complaint to investigation complete).
- Performance measures for complaint investigation—received, investigated, substantiated, deficiencies cited, timely initiation, timely closure, communication with complainant—are not reported regularly.
- The current management structure is an obstacle to providing effective and timely oversight of district offices. Refer to the Organizational Structure and L.A. County contract management sections of this report for more details.

GAP ANALYSIS Facility Complaint Investigations				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Staffing		X		
Training		X		
Work Systems & Processes		X		
Leadership, Management & Oversight		X		

Table 14 Gap Analysis – Facility Complaint Investigations

4. Professional Certification Branch Investigations

The Professional Certification Branch (PCB) is responsible for all aspects of the certification, criminal conviction screening and investigation of complaints involving certified nurse assistants (CNA), home health aides (HHA), certified hemodialysis technicians (CHT), and nursing home administrators (NHA).

The Investigation Section (IS) of the PCB is headquartered in Sacramento and has a field office in Los Angeles. IS has the authority to conduct investigations of all allegations and complaints against CNAs, HHAs, and CHTs. The IS investigates allegations of abuse, neglect, unprofessional conduct, and misappropriation of resident/patient property. Unprofessional conduct also includes, but is not limited to: staff to staff threats or inappropriate behavior; abandonment; poor care; drug and/or alcohol impairment on the job; fraudulent certification; or use of an invalid Social Security number or identification. Initial review of each complaint received is completed within 3-5 days of receipt and a level is assigned indicating the severity and priority of the issue. Level A complaints are the most serious followed by levels 1, 2, 3 and 4.

FUTURE VIEW

The overall goal for PCB complaint investigations is to promote and protect the health, safety and welfare of residents, patients, and clients receiving health care services. This involves promoting patient safety and quality care, addressing complaints timely and effectively, and initiating administrative actions and referrals as indicated in order to serve as a trusted resource for vulnerable patients, family members, facilities, and the care community.

CURRENT VIEW

A backlog of complaints has been an issue for PCB for several years. As of April 14, 2014, L&C Program internal tracking reports indicated there were 1,036 allegations/complaints received from January 1, 2012, through April 14, 2014, for which an investigation has not yet been completed. An investigation by the Center for Investigative Reporting (CIR) alleged that in 2009 nearly 1,000 complaints of misconduct by nurse assistants and home health aides were dismissed. In January, the California Assembly Committee on Health and the Committee on Aging and Long Term Care held an oversight hearing in response to complaints about the L&C Program's ability to process abuse complaints against nurse assistants.

L&C's response was provided in a March 18, 2014, letter to the Assembly Committees. In this response, the L&C Program leaders stated that PCB staff investigates all allegations and complaints, and the appropriate action is taken based on available evidence. Moreover, the L&C Program leaders testified that there was never a directive or expectation that complaints or allegations be dismissed without an investigation. Moreover, the L&C Program leaders reported the following numbers for complaints received and remaining to be investigated as of February 28, 2014.

State Fiscal Year	Complaints Received	Remaining Investigations
SFY 11-12	938	45
SFY 12-13	939	378
SFY 13-14*	678	531
Total	**2,555**	**954**

Table 15 Number of Complaints Received and Remaining to be Investigated According to March 2014 L&C Letter

Working to decrease this backlog has been a focus for the L&C management team and the Investigation Section staff. Following is a description of actions taken to address this issue.

January - June 2007

Investigators worked over 650 hours of overtime.

FY 2008-09

BCP HQ-05, Professional Certification Branch (PCB) Staffing for Complaint Workload and Backlog authorized seven new positions for the Investigation Section (IS). The initial hiring for these positions took place in January 2009.

December 2009

Action Plan developed to address significant backlog. In 2010 Action Plan was implemented with limited success.

December 2009 – March 2011

Continued efforts were made to address the issue of the ongoing multi-year backlog in the IS. Subsequent action plans were developed which included but was not limited to the creation of a leadership team; the definition of backlog; implementation phases; tracking system requirement; and the introduction of a desk investigation.

2012-2013

New IS management structure implemented and hired.

August 2012

Created and implemented centralized processes for the intake of all complaints/allegations; mail; monitoring suspensions/denials/revocations/diversions; recording data in the Federal Healthcare Integrity and Protection Databank and the National Practitioners Databank; and custodian of record assignment(s). Created an Initial Assessment form, a process to assess and assign an initial level, and a definition of assessment levels (Level A – 4) for all complaints/allegations received.

December 2012

Recreated and enhanced spreadsheet to capture and monitor data and produce monthly statistical information.

2012 to Current

Improved case file tracking system and continued the development of action plans for each year with goals established, resources allocated, and lessons learned captured to inform subsequent year.

January 2013

Created standard report format that included a confidential names list and standardized letter templates. Created a hearing log to monitor requests for appeal and identify any trends with the hearings/hearing decisions.

September 2013

Developed a means of generating an electronic number in the database versus manual assignment by staff.

December 2013 to current

Overtime approved and being conducted on the weekend.

January 2014 to current

In process of hiring 10 additional staff to address the complaint investigations. As of April 2014, all but two have been hired and started.

February 2014

Created an email address for use by the District Offices to refer complaints (PCBInvestigations@cdph.ca.gov). Email was sent to all district managers to notify them of the new referral process.

March 2014

Designated staff/teams to work all current or all aging to take a two-prong approach to completing investigations. Streamlined statistical reports and instituted requirement for staff to update status on direct manager's tracking log on a weekly basis. Included Aging Report in monthly statistical report to monitor the age of pending investigations (receipt of complaint to date of statistical report). Created a team of existing investigators to represent IS at administrative appeal hearings so person who conducted the investigation can be witness at the hearing. Presenting information relating to PCB's roles and responsibilities at the Ombudsman Spring Conference as an outreach measure.

In addition to the interventions described above, L&C is undergoing efforts to conduct an evaluation and assessment of the Professional Certification Branch with a particular focus on the complaint backlog and ongoing complaint investigation processes. Because a statement of work (SOW) for contractor assistance to conduct this in-depth assessment has been prepared during the same time period as this comprehensive assessment, and internal PCB-related

initiatives have been accelerated, the Hubbert Systems team was asked to focus on other areas of the Program, as work on a gap analysis for PCB would be duplicative.

5. Los Angeles County Contract Management

CDPH L&C contracts with Los Angeles County (LAC) Department of Public Health, Health Facilities Inspection Division (HFID), to license and certify health care facilities located in L.A. County. Contractual requirements for L.A. County include carrying out CDPH policies, operating L&C Programs, conducting surveys, investigating complaints, issuing citations, assessing penalties, and providing information for regional operation as may be required by the state. The chief of the Health Facilities Inspection Division reports directly to one of the Field Operations Branch Chiefs.

Los Angeles County is home to more than a quarter of the statewide volume of health care facilities that L&C oversees. Its Health Facilities Inspection Division consists of four district offices: North LAC, West LAC, San Gabriel, and East LAC.

FUTURE VIEW

The goal for managing the LAC contract is to use proven best practices that will ensure quality services that are timely and on budget. Effective contract administration will involve a variety of activities to ensure both the state (L&C Program) and the contractor (LAC) are performing to meet the requirements of the contract.

The objectives for managing the LAC contract will be to maintain open and effective communication, timely delivery of quality services, responsive corrective actions to problems, compliance with all agreed upon terms and conditions, and to deploy effective change management practices. Effective contract management will begin with developing clear, concise performance measures, and includes preparing a contract administration plan that

monitors LAC performance. All work to be performed will be appropriately led, planned, scheduled, coordinated, communicated, tracked, evaluated, reported, and corrected, as necessary. Adequate resources will be devoted to these tasks and ongoing training provided as indicated.

This will be accomplished through the design and implementation of:

- Effective contract administration;
- Effective communication channels and methods;
- Enforcement and remediation action;
- Use of workload metrics and other data to evaluate performance;
- Effective resource management; and
- Adequate funding to support positions to conduct mandated workload.

CURRENT VIEW

L&C Program managers and LAC management staff report minimal contract oversight activity. Oversight for the LAC contract had been assigned to two different Field Operations branch chiefs during the time this assessment was been conducted (8 months). These branch chiefs also have additional assignments that represent a significant workload. For example, until recently, the branch chief assigned to provide oversight for LAC was also assigned the State Facilities Unit, managed the headquarters-based analytical and support staff, was designated as the subject-matter expert for hospice, and was assigned several other special projects including tracking the facility complaint backlog beginning in December 2013. The current branch chief responsible for LAC oversight also has oversight responsibilities of the SEQIS Section that provides training and quality assurance. As the home to nearly one-third of the facilities in the state, LAC represents a significant management workload and the current approach to assigning this responsibility does not allow for adequate oversight and contract management.

Compounding this workload problem, there is very little collaboration among headquarters staff in focusing on contract management for LAC. There are, for example, no regularly scheduled meetings to discuss LAC performance, contract issues, resource use, etc. The L&C Fiscal Unit prepares monthly financial statements and sends them to LAC, but not to the L&C Program's management team.

This lack of adequate contract oversight was highlighted most recently in an audit on the quality and integrity of nursing home investigations by the LAC Department of Auditor-Controller. This audit was prompted by a recent media report alleging that inspectors were told to close cases without fully investigating them. Senior LAC officials ordered the audit and an initial report was released in April 2014. While the focus of this audit was to examine the L.A. County nursing home complaint investigation backlog, it also illuminates both the challenges the L&C Program has experienced managing this contract and the opportunities for improving contract oversight. Many of the recommendations for the LAC Department of Public Health to improve overall management and oversight also apply to the L&C Program. Examples and an examination of the root causes of the deficiencies are provided below.

L&C leaders are discussing new approaches for improving contract oversight and enforcement activities, such as establishing benchmark goals and timelines for improvement that can be directly tied to the contract budget receivables.

Los Angeles County Contract Management

CONTRACT ADMINISTRATION

Strengths

- No notable strengths identified.

Opportunities for Improvement

- The CDPH/LAC contract stipulates that the state retains the responsibility to supervise and oversee the contracted services provided by L.A. County. However, the L&C

Program lacks a comprehensive and well-coordinated contract administration and monitoring plan.

- Structures for supporting collaboration and communication in providing contract oversight are absent, e.g., no committee, no standing meetings, no sharing of performance or resource use data, etc.
- While the L.A. County management team attends quarterly DA/DM meetings in Sacramento, the LAC district office managers do not attend (based on the three meetings at which a Hubbert Systems team member was present). Furthermore, there are no regularly scheduled joint management meetings to discuss contract performance.

ENFORCEMENT AND REMEDIATION

Strengths

- No notable strengths identified.

Opportunities for Improvement

- The CDPH/LAC contract requires LAC compliance with specific performance measures for survey and certification workload including complaints and entity-reported incidents. L.A. County is required by contract to follow CDPH policies, to submit a monthly workload and progress report, and to develop and implement a quality assurance process to review contracted workload for compliance with state standards. However, the L&C Program lacks adequate contract enforcement and remediation mechanisms to ensure compliance.
- The L&C branch chief who oversees L.A. County reviews a status report with each district office manager on a weekly basis. This provides some oversight on monitoring federal and state workload and identifying provider issues and Program challenges. There is, however, no evidence of monthly workload progress reports or related quality assurance or quality improvement activities.

- Although a recent memo was sent to L.A. County requesting an action plan to address the facility complaint backlog, the L&C Program lacks adequate contract enforcement and remediation mechanisms to ensure compliance.
- L.A. County has not been held accountable for centrally monitoring performance on long term care complaint investigations.
- L.A. County has not been held accountable for maintaining adequate staffing. In fact, the Los Angeles County Auditor's report found that HFID could not identify the number of positions currently performing investigations nor the number of positions needed to ensure timely completion of investigations.
- L.A. County was not held accountable for developing effective management tools to monitor workload requirements.

RESOURCE MANAGEMENT

Strengths

- No notable strengths identified.

Opportunities for Improvement

- The L&C Fiscal Unit Section monitors invoices and tracks expenditures for the L.A. County contract. Detailed monthly reports are prepared that include actual expenditures as compared to budget. However, there is no structure or process in place for management oversight of this contract from a fiscal or resource management perspective. In fact, the Fiscal Section staff work directly with the L.A. County management team to resolve issues that arise, often without the involvement of L&C management.

GAP ANALYSIS Los Angeles County Contract Management				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Contract Administration	X			
Enforcement and Remediation	X			
Resource Management	X			

Table 16 **Gap Analysis – Lost Angles County Contract Management**

6. Civil Monetary Penalties (Citations and Administrative Penalties)

When L&C finds a deficient practice in the course of conducting survey or investigation activities, the facility is issued a deficiency and is required to submit an acceptable plan of correction. Violations of federal and/or state regulations or statues that are very serious are subject to varying levels of monetary penalties. These monetary penalties may be issued as a result of a focused investigation of a complaint allegation, an entity reported event, or as a result of a violation identified during a recertification survey. Appropriate evidence is gathered and the nature of the violation is determined based on applicable state and/or federal statutes/ regulations. Upon completion of the on-site survey, an exit conference is held with the facility management and a notice of Intent to Issue a Citation is given to the facility. The types of monetary penalties that can be issued by L&C are described in Table 17.

Facility Types	State	Federal
Long Term Care (Skilled Nursing and Intermediate Care Facilities-ICF)	Citations • AA – Direct proximate cause of patient death ($25,000-100,000) • A – Imminent danger of death or serious harm to patients or a substantial probability of death or serious physical harm to patients ($2,000-20,000) • B – Direct or immediate relationship to patient health, safety, or security ($100-2,000)	Civil Monetary Penalties for substandard care. Penalty amount determined by CMS
ICF Developmentally Disabled	• AA – Direct Proximate cause of patient death ($5,000-25,000) • A – Imminent danger of death or serious harm to patients or a substantial probability of death or serious physical harm to patients ($1,000-10,000) • B-Direct or immediate relationship to patient health, safety, or security ($100-1,000) • Administrative Penalties for Medical Breaches and/or the failures to report a breach incident.	
Hospitals	• Administrative Penalty ($75,000-125,000, adjustable to $5,000) for deficient practices resulting in immediate jeopardy to the health and safety of a patient • Administrative Penalty for failure to report an Adverse Event • Administrative Penalties for Medical Breaches and/or failure to report a breach incident	
Other Facility Types	No statutory authority to issue monetary penalties other than for medical breaches in clinics, health facilities, home health agencies and hospices	
Dual Enforcement - A facility may receive both Federal and State citations for efficiencies. Typically, a Federal finding with a scope and severity of "F substandard" or "G or above" are elevated for potential issuance as an "A" or "AA" citation as appropriate.		

Table 17 Types of Monetary Penalties Issued by L&C

For AA and A citations, the review process includes several steps including review and approval by the district office manager, district office medical consultant, branch chief, chief medical consultant, and the L&C legal department. Typically, all AA and most A level citations are appealed.

FUTURE VIEW

The goal for the L&C Program is consistent, accurate, and timely issuance of citations and administrative penalties. This will be accomplished through addressing workflow barriers and bottlenecks in the process. Improvements will include a focus on:

- Adequate staffing to complete timely investigation and issuance of citations;
- Standardized, effective, and efficient work systems and processes;
- District office specific and system-wide tracking and monitoring activities and enhanced management oversight.

CURRENT VIEW

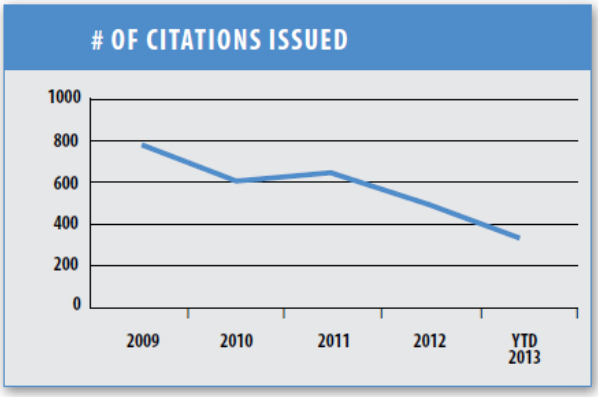
There are frequent complaints by providers and stakeholders regarding the L&C Program's timeliness in issuing citations. The process is lengthy and often results in long delays between the notice of intent to issue a citation and the actual issuance. For example, in a recent report dated December 2013, the average time interval for all citation levels statewide was 303 days for calendar year 2012 and 365 days for year-to-date calendar year 2013. The following table provides detailed information on the number of citations and the average time interval for issuing citations for calendar years 2009-2013.

Citation Class		Calendar Year				
		2009	2010	2011	2012	YTD 2013*
AA	Count	24	23	15	7	12
	Average time Interval	171	303	398	196	144
A	Count	141	105	90	83	49
	Average time Interval	145	141	343	345	517
B	Count	625	472	532	404	250
	Average time Interval	85	141	211	296	345
Total	**Count**	**790**	**600**	**637**	**494**	**311**
	Average time Interval	**98**	**147**	**234**	**303**	**365**

Table 18 **Reported Adverse Events for FY 2013-13**

*Through December 1, 2013

As illustrated in Figures 6 and 7, these data indicate both a decrease in the number of citations being issued and an increase in the number of days from the intent to cite notification to actual issuance of the citation.



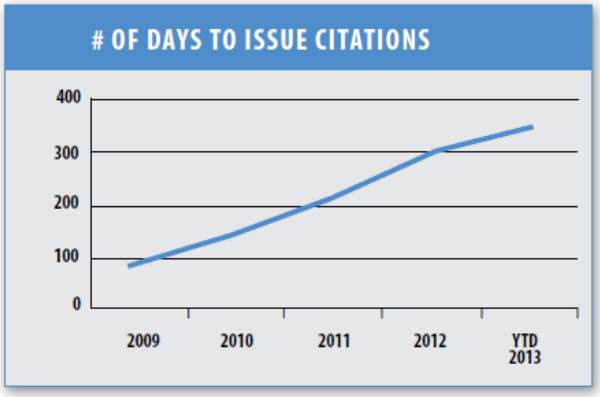


Figure 6 **Number of Citations Issued**

Figure 7 **Number of Days to Issue Citations**

For the most serious AA level violations—those for which the violation was found to be a direct proximate cause of death of a patient or resident of a nursing home—there has been an overall decrease in the number of citations issued between 2009 and 2013. For example, as shown in Figure 8 below, only half as many AA citations were issued in calendar year 2013 (through

December 1) compared to 2009. Figure 9 demonstrates improvement in the time interval for issuing AA citations.

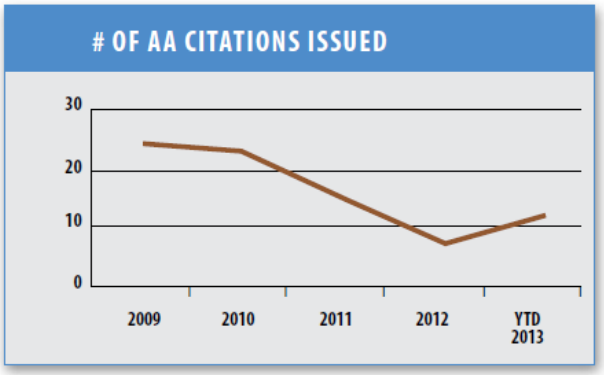


Figure 8 **Number of AA Citations Issued**

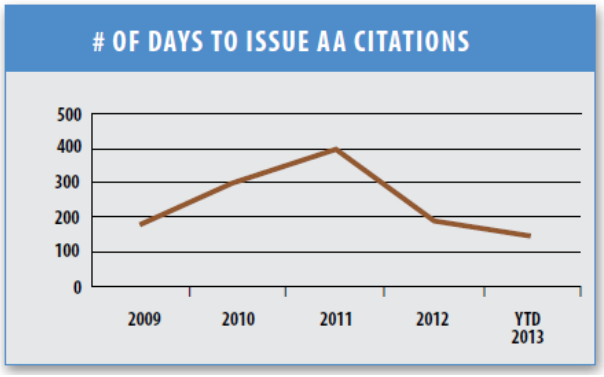


Figure 9 **Number of Days to Issue AA Citations**

Recent efforts to eliminate the citations backlog have been the focus of L&C headquarters management. A new tracking log was implemented in September 2013 and regular follow-up with each district office was started. As of March 17, 2014, management tracking logs indicated 133 pending citations, with the oldest dating to August 2010. This is down from 253 as of January 1, 2014. During that time, an additional 120 intent to cite notifications were issued. While these are statewide totals, it is important to note the variation in the number of pending citations by district office. Refer to Table 19.

District Office	Date of Oldest Intent to Cite	Number of Intents Open
Orange	N/A	0
Riverside	12/2/2010	15
San Diego – North	N/A	0
San Diego – South	2/9/2010	2
Sacramento	N/A	0
Ventura	N/A	0
San Francisco	N/A	0
East Bay	N/A	0
San Jose	N/A	0
Bakersfield	12/2/2011	12
Chico	11/8/2012	10
Santa Rosa	8/6/2010	19
Fresno	1/16/2014	2
San Bernardino	1/20/2012	6
State Facilities Unit	2/6/2012	37
Lost Angeles	2/6/2011	30
Total		**133**

Table 19 Number of Pending Citations by District Office

The process for issuing citations involves multiple levels of review and approval. Following is a description of the typical process for issuing citations.

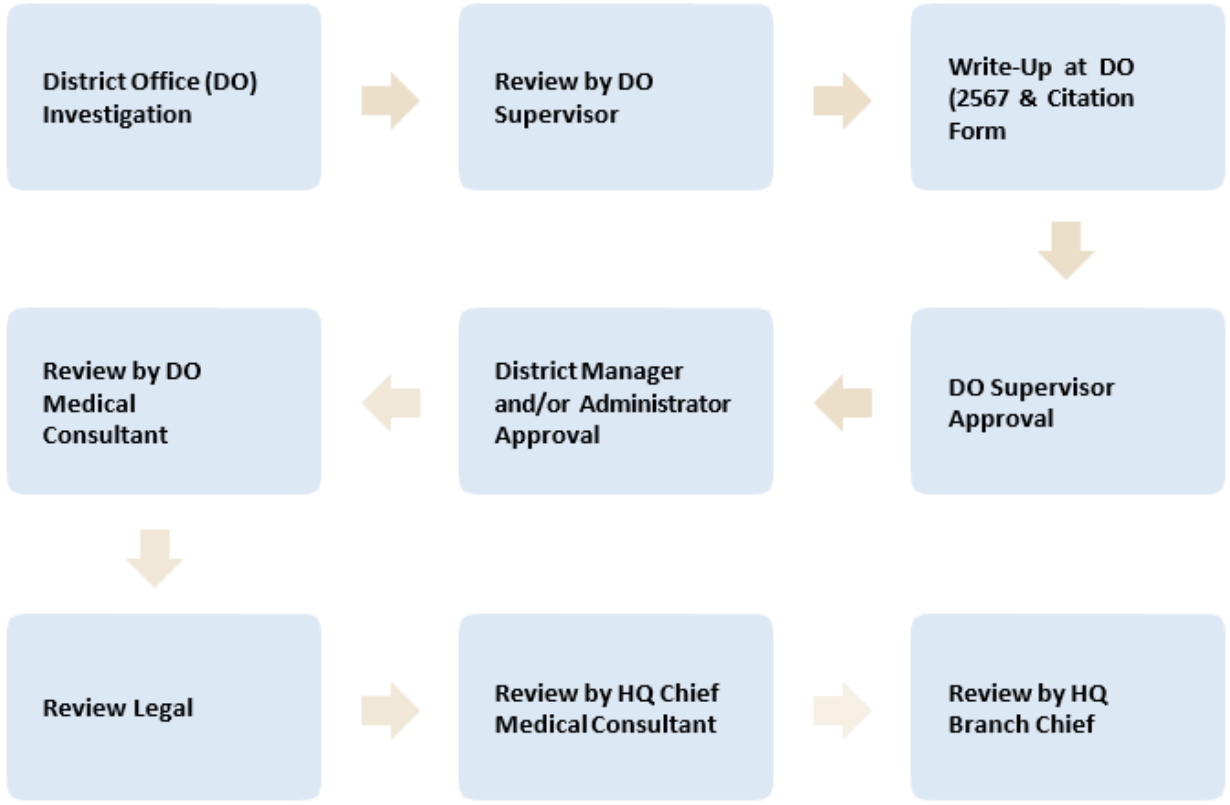


Figure 10 Citation Process

Administrative penalties follow a similar process with some exceptions. For example, for immediate jeopardy (IJ) and breach penalties, the district office issues the statement of deficiencies, obtains an acceptable plan of correction, and then submits the information to headquarters for administrative penalty consideration. While citations are issued as they occur and are approved, administrative penalties are batched and issued quarterly with a press release.

Trends for administrative penalties are similar to those reported above for citations. The majority, typically 70% or more, of administrative penalties are generated from hospital reported adverse events.

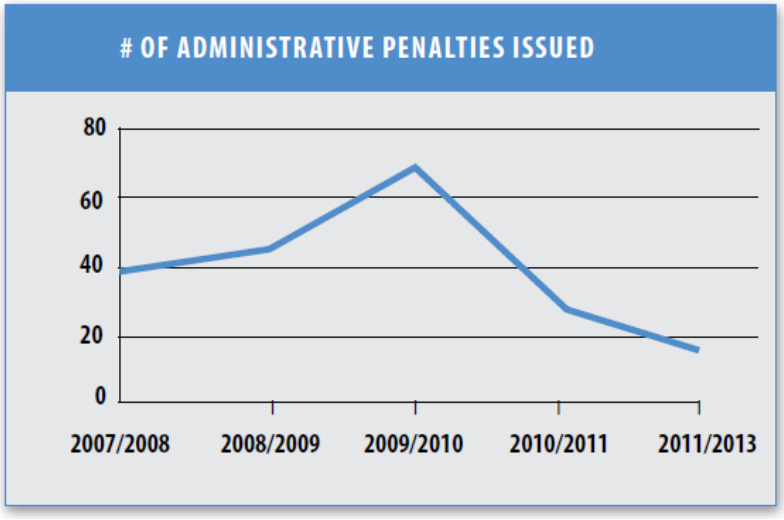


Figure 11 **Number of Administrative Penalties Issued**

As shown in Tables 20 and 21, an examination of the number of citations issued by district office reveals significant variation. This unexplained variability in the number and rate of citations suggests an opportunity to address inconsistencies among district offices in practices related to citation issuance.

Citations per 1,000 Beds* SFY 2011 – 2012 (as of Jan 2013)	
District Office	**Citations per 1,000 Beds**
Fresno	1.4
LAC North	2.5
San Francisco	3.3
East Bay	3.3
LAC West	4.5
San Diego South	4.7
Riverside	4.9
Orange County	5.5
LAC San Gabriel	6.1
LAC Acute	6.1
San Diego North	6.1
LA East	6.9
Bakersfield	8.9
Ventura	10.0
Sacramento	11.0
San Jose	15.2
San Bernardino	16.8
Santa Rosa	18.2
Chico	31.6
STATEWIDE*	7.8

* excludes State Facilities Unit

Table 20 Citations per 1,000 beds FY 11|12

A & AA Citations* SFY 2011 – 2012 (as of Jan 2013)	
District Office	**Total A&AA Citations**
Fresno	0
Chico	1
San Diego South	2
Riverside	2
San Diego North	3
LAC Acute	4
East Bay	5
San Jose	5
LAC North	6
San Francisco	6
Santa Rosa	6
Bakersfield	8
LAC West	9
Orange County	9
LAC San Gabriel	10
Sacramento	11
LA East	15
Ventura	16
San Bernardino	17
STATEWIDE*	135

* excludes State Facilities Unit

Table 21 A & AA Citations SFY 11|12

An examination of root causes, best practices, and specific areas where recent improvements have been made are outlined below.

Civil Monetary Penalties (Citations and Administrative Penalties)

STAFFING

Strengths

- No notable strengths identified.

Opportunities for Improvement

- HFEN staff who conduct a survey or investigation where citation-level deficiencies are identified must write the statement of deficiencies as well as a separate citation report. Staffing assignments for HFENs typically involve being on-site for a survey one week followed by a week in the office to complete documentation. Then, they are often assigned to another on-site provider survey again the following week. Completing the Statement of Deficiencies (From 2567) is the priority so that federal survey timeframes are met. For citation documentation, feedback from a HFE Supervisor is typically not received within the same week it is submitted due to workload. Therefore, the citation documentation is delayed until the next time the HFEN is in the office and has free time. It is not uncommon for many weeks or even months to pass before the HFEN can find the spare time to complete the citation documentation.
- There are similar workload issues as described above for the HFE supervisors, district administrators and district managers.

WORK SYSTEMS & PROCESSES

Strengths

- The Citations Policy & Procedure is currently in the process of being revised to reflect changes in statutes and regulations, and to reorganize and format it with a new policy and procedure template.
- The immediate jeopardy adverse event (IJAE) administrative penalty process is clearly defined and well-documented. A detailed log of all IJ adverse events is maintained by headquarters and reviewed by the lead Field Operations branch chief.

Opportunities for Improvement

- As described above, two separate write-ups are required—one for the statement of deficiencies (2,567) and one for the citation documentation.

LEADERSHIP, MANAGEMENT & OVERSIGHT

Strengths

- A new tracking log for citations was implemented in September 2013. A weekly report is prepared for review by a Field Operations branch chief and the information is distributed to each district office.

Opportunities for Improvement

While recent citation backlog clean-up efforts have been successful, it is not clear that the root causes of delayed issuance of citations have been identified and addressed. There is, for example, no analysis to identify the key reasons for delay so that process improvements can be implemented.

- A summary report is prepared each time a "batch" of administrative penalties are issued that includes both current and historical data. In the past there has been no reporting that provided aging information for pending enforcement actions. However, in March 2014, L&C headquarters began requiring the district offices to enter information beginning with the date of the incident in a SharePoint log. Going forward, this will provide information and allow for monitoring the time required to complete and submit documentation for APs to headquarters.
- Variation in the number of citations and administrative penalties by district office may indicate inconsistency in enforcement. These data are not reported or examined for possible patterns and root causes.

NOTE: Opportunities for Improvement in developing performance metrics, performance measurement and management are discussed in detail in the Performance Management section of this report.

GAP ANALYSIS **Civil Monetary Penalties**				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Staffing		X		
Work Processes & Systems		X		
Leadership, Management & Oversight		X		

Table 22 **Gap Analysis – Civil Monetary Penalties**

FINDINGS: Organizational Systems & Processes Analysis - Performance Management Perspective

7. Strategic Planning

Strategic planning is a management activity that involves setting priorities for the organization so that employees and other stakeholders are working toward common goals. A strategic plan provides the foundation for focusing resources and establishing agreement on desired outcomes or results. Strategic initiatives are identified so that the organization's attention is on the most important improvement projects and align to strategy and culture with results. Strategic management involves processes aimed at transforming the plan into management processes and activities that support decision making and enable the plan to evolve as circumstances change.

FUTURE VIEW

To optimally address current and future performance management needs, the L&C management team will be clear about the organization's strategic goals to provide focus and help managers understand how to direct their resources and make decisions on a daily basis. Characteristics of strategic planning in a highly functioning organization include:

- Identifying strategic goals to drive innovation and "out-of-the-box" thinking;
- Embracing a continuous improvement philosophy and planning processes that are evolving and flexible;
- Formal communication of the strategic plan;
- Emphasizing action;
- Cascading and linking strategic objectives throughout the organization; and
- Ongoing evaluation.

CURRENT VIEW

Recent efforts to begin strategic planning were started by L&C's previous deputy director in December 2013. L&C has indicated it is committed to launching a strategic plan again in 2014 but is awaiting the hiring of its new Deputy Director. An examination of root causes, best practices, and specific areas where recent improvements have been made are outlined below.

Strategic Planning

Strengths

- There is a focus on strategic planning at the Department level, and a commitment to support the process at all levels of the organization. For example, the CDPH Quality Performance Council has recently been formed and includes representation from L&C.
- There is consensus opinion among the Program's senior leadership that strategic planning and performance management represent a significant opportunity for improvement going forward.
- Individual managers have taken the initiative to begin a strategic planning process within their sections or units. For example, HAI leadership has developed a comprehensive strategic plan using the Balanced Scorecard methodology.

Opportunities for Improvement

- The current CDPH strategic plan mentions the L&C Program, yet the Program should have its own strategic plan to guide needed transformational changes. The L&C Program's role in supporting the Department's mission is identified primarily by the inclusion of "Enforce Laws and Regulations to Ensure Safety and Protect Health" as one of 19 strategic objectives.
- The CDPH plan was developed with participation from the Program's Deputy Director and Assistant Deputy Director. These two executives were invited to provide input and make changes to the CDPH Strategic Plan. Other members of L&C's management team and representatives from its various business areas should be involved directly in both updates to the CDPH plan and development of the L&C Strategic Plan. CDPH priorities

and objectives could translate and be helpful to L&C as it develops and aligns its own plan.

- The L&C Program's current strategic planning efforts are very limited in scope. A complete set of strategic goals, priorities, performance measures and operating initiatives at the Program, branch, section, and unit levels has not been developed. Strategic goals are not proactively identified, communicated, nor linked to organizational and individual performance management.
- L&C needs a broad and meaningful strategic planning process that includes active participation of senior management and other key staff in the development of a comprehensive, long term strategy for the Program.
- Individual staff or a team has not been identified as responsible for the oversight of a comprehensive, enterprise-wide program of strategic planning and execution.
- The lack of strategic planning was made evident by interviewees and observed in meetings. Numerous individuals described L&C as "always putting out fires."
- The Program has not yet developed or deployed an effective process for ongoing strategic management.

GAP ANALYSIS **Strategic Planning**				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Identifying Strategic Goals		X		
Flexible Processes		X		
Communication		X		
Emphasizing Action		X		
Cascading	X			
Evaluation		X		

Table 23 Gap Analysis – Strategic Planning

8. Performance Management

L&C supervisors, executives, control agencies and advocacy groups need access to decision-aiding information that helps them understand factors driving Program trends. These decision-makers need timely, accurate and consistent data about Program performance so they can make the best recommendations about Program and policy implementation. This section of the assessment identifies opportunities to improve the Program's analytic capacity and help the organization become more responsive to internal and external stakeholder information needs.

Well-functioning L&C performance management capabilities enable the Program to apply its technical and human resources to meet analytic and performance measurement demands to produce timely, accurate and insightful reports about the L&C operations. These capabilities also ensure L&C data assets are well-utilized by staff and leadership and properly configured to adequately assess key trends. The availability of decision-aiding data to support policy development, fiscal analysis and Program evaluation are essential to sustaining the Program's performance management capabilities.

Performance management capabilities are closely aligned with other Program functions described in this report. For example, L&C organizational structure and staff development activities can support or inhibit the Program's performance measurement and analysis capabilities. In addition, performance management activities are significantly influenced by the organization's collaboration and strategic planning processes, including its selection and implementation of quality improvement initiatives.

FUTURE VIEW

This future view of L&C performance management capabilities describes what a well-functioning Program requires to identify performance priorities, create measurable objectives, and track improvements over time. Comparing the current actual performance management

practices to a future view of L&C's potential capabilities helps identify potential infrastructure enhancements that can support high priority Program improvements.

The future of L&C's performance management capabilities can be viewed through three capability domains: monitoring Program priorities, knowledge management, and technical resources. Within these domains are various capability dimensions that describe an ideal array of "optimal practices." These three domains of performance management and their eleven capability dimensions are described below. Related content can also be found in the sections of this report that address strategic planning, organizational structure, leadership, information technology and communication.

Monitoring Program Priorities

The purpose of L&C's performance management activities is to support decision-making that advances progress toward internal and external stakeholder priorities. Executives need to approve and implement new policies; staff need to respond to emerging trends; and patients, providers and their advocates need the organization to be responsive and accountable. L&C's performance management capabilities can be significantly impeded or enhanced by the degree of alignment between the Program's stated goals and the actual analytic priorities upon which its staff are focused.

Within this "priorities" domain are three dimensions that describe the future view of L&C's performance management capabilities:

- ***Meaningfulness***: The organization's supervisors and executives are actively establishing, updating and communicating priorities, goals and objectives consistent with the Program's stated vision and mission. In addition, executives, supervisors, staff and external stakeholders are clearly articulating their data, information and reporting needs for these key performance indicators through well-established governance forums. A portfolio of resource, process and outcome measures is regularly updated in

collaboration with internal and external stakeholders. These measures are selected and designed to align directly with internal and external stakeholder priorities, as do any ad hoc L&C measurement and analysis activities. Updated information on L&C's key performance indicators are readily available to all internal and external stakeholders.

- ***Purposefulness***: Information provided to internal and external L&C stakeholders includes root causes, actionable recommendations and data displays with trends, benchmarks, and exception lists. The Program provides transparent public access to actionable analyses that highlight performance against targets, regulatory requirements, or other comparative standards. Performance measurement and analysis support forecasting activities and planning for future initiatives. In addition, the organization tracks measurable improvements resulting from data-driven decision-making by evaluating the impact of past interventions.
- ***Collaboration***: External stakeholders regularly interact with Program leadership and staff on current and upcoming initiatives. There is significant interaction between internal and external stakeholders to establish objectives, monitor performance, and prioritize improvements. Staff from different business units participate in internal forums to share information on Program operations, best practices, and Program improvement projects.

Knowledge Management

Whereas the organization's capabilities for monitoring Program priorities can address demands for decision-aiding information, L&C's knowledge management practices support development of the staff capacities, experience and skill to meet those demands. For example, to optimally address current and future performance management needs, staff who participate in these functions should engage in regular training linked to their job requirements. The allocations of positions and classifications throughout the various business areas also should support the analytic needs of the internal and external L&C stakeholders. In addition, regularly updated documentation on databases, measures and policies should be readily available. Note that

while this section addresses how L&C manages its data and performance information, the Program's broader leadership and workforce training capabilities are addressed elsewhere in this report.

L&C's knowledge management capabilities in the future include the following characteristics:

- ***Proficiency***: To support optimal performance analysis practices, training on data sources, analytic tools, methodological techniques, and L&C policies is provided regularly in a coordinated manner across the Program. A significant number of courses are available on intermediate or advanced analytic topics (e.g., Excel pivot tables, data visualization). Training linked to L&C's performance management requirements is regularly available. In addition, applicable job candidates are tested on specific position responsibilities related to performance measurement and analytics.
- ***Resource Adaptability***: The Program allocates adequate budget and staffing throughout the organization to ensure that analytic capabilities are available to support performance management activities. These allocations are regularly updated according to the expected analytic priorities or relative demands of all business areas, and the distribution and mix of staffing among L&C business units flexibly supports the Program's evolving analytic demands. Resources that deliver more advanced analytic capabilities are deployed on the projects, topics or business areas where they are needed most at any given time. Succession planning and promotional tracks ensure the sustainability of L&C performance measurement and analytic capacities.
- ***Documentation***: Data dictionaries, measurement methodologies, technology requirements, and L&C business policies/procedures are well-documented, updated regularly, and available to all internal and external stakeholders in electronic format. These up-to-date references support continuity of business operations, particularly for functions associated with performance management.

Technical Resources

To ensure that L&C staff are able to monitor progress toward Program priorities, data accuracy for the Program's primary data sources are regularly assessed. Data are available without significant lag time from the date of the events analyzed, and they are stored in a standardized electronic format. Users also are able to access data via a single portal on the Internet or internal web site. Additional information on related capabilities is described in the information technology section of this report.

For internal and external stakeholders to acquire the decision-aiding information they need, and for the staff to capably deliver that information, the future view of the organization includes support for the following technical infrastructure dimensions:

- ***Accuracy***: Attention to data integrity ensures dependable decision-aiding analytic output. A standardized data reliability assessment is regularly scheduled and broadly circulated for the data sources L&C uses to monitor performance. The Program supports mechanisms to evaluate, broadcast and improve data quality for the various data sources that staff use for performance analysis. L&C provides technical assistance on improving data quality to those responsible for entering or delivering raw data.
- ***Efficiency***: L&C makes best use of limited resources for its analytic and performance measurement priorities by ensuring a single, electronic source of data is available for staff to readily access. Staff are able to link and merge data originating from inside the enterprise with analytically valuable data from external sources. Hardware and software deployments make economical use of limited Program resources, and technology helps staff maximize their productivity.
- ***Standardization***: L&C uses consistently formatted reports based on data sets that follow industry-standard specifications. Data and documentation are stored in a standardized format. Analytic and data management practices are regularly audited to verify that staff follows enterprise-wide conventions, which are based on national standards where

applicable. Governance processes and structures are in place to support standardization of data and performance management activities.

- ***Accessibility***: Internal and external stakeholders have reliable access to rich and regularly updated summary data in electronic format that can be used to generate performance reports. Regularly scheduled Program performance summaries are available on the Internet, and they include narrative, graphics, and contact information. Electronically readable data and the tools or software required to analyze them are user-friendly and readily available to staff responsible for supporting performance management functions.
- ***Timeliness***: Data from all sources are available to internal analysts with minimal time lag, and the Program is easily and quickly able to provide internal and external stakeholders with frequent updates on performance against targets. Standard summary reports that analysts and internal / external stakeholders use to monitor performance are available monthly and are posted soon after the end of the month. Ad hoc data requests are available to internal or external stakeholders through a standardized request process that describes the prioritization process and turnaround timeframe expectations.

CURRENT VIEW

As part of the initial assessment phase of the project, the Hubbert Systems team interviewed supervisors, executives, staff and external stakeholders about a variety of topics, including how the Program conducts its performance measurement and analysis activities. In addition, the team reviewed various documents that describe these activities, including examples of reports that support performance management functions.

Based on this initial assessment, Hubbert Systems conducted additional interviews and reviewed additional documents to obtain a more comprehensive view of current Program

capabilities. This helped the assessment team identify patterns in the current state of L&C's capability to generate meaningful information about Program performance.

This current view of L&C performance measurement functions describes the Program's actual capabilities based on surveillance of current L&C practices. The team looked for themes that surfaced repeatedly, appeared commonly across the Program's business units, and were supported by multiple interview participants. These patterns enhanced the preliminary assessment findings and are described in eleven dimensions of performance measurement capability maturity outlined below, which are cast within three categories:

- ***Monitoring Program Priorities***: These capability dimensions describe how L&C internal and external stakeholders currently obtain, report and use performance information to help internal and external stakeholders guide policy development, implement new initiatives, address emerging issues, and respond to the needs of external parties.
- ***Knowledge Management***: The current view of capabilities within this domain describes how L&C supplies knowledge, experience and skill to meet the performance measurement demands of the Program. This domain also describes the degree to which the Program is flexible in its allocation of performance measurement resources. In addition, documentation of structures, methods and processes related performance management is assessed here.
- ***Technical Resources***: This current view of L&C's technical resources describes the Program's data acquisition, data delivery, and information technology practices related to performance management.

An examination of best practices, specific areas where recent improvements have been made, as well as opportunities for improvement (i.e., gaps) is outlined below.

Performance Management

MONITORING PROGRAM PRIORITIES: MEANINGFULNESS

Strengths

- CMS has defined State Performance Standards that outline some objectives and related performance measures for the Program's federal survey activities. These measures are monitored regularly by Program executives and supervisors.
- Despite the apparent absence of a Program-wide approach to creating a meaningful collection of standardized L&C performance metrics, a handful of isolated but promising practices were found that could be expanded more broadly within the Program:
    - HAI uses a "Balanced Scorecard" approach to manage Program activities that support clearly stated priorities.
    - PCB has established goals in various operational categories, tracks performance, and regularly reports results to executives, supervisors and staff.
    - Recently there has been increased focus on reducing complaint backlog, and new reports that compare performance against measurable objectives are being used to track complaint responsiveness.

Opportunities for Improvement

- There is limited evidence that a single cohesive set of Program goals or objectives exists which, for all of L&C's operational responsibilities outlined in state and federal regulation, clearly and consistently communicate L&C priorities and targets to internal or external stakeholders. More specifically, while dozens of potential or actual measurable objectives may be available to help internal and external stakeholders assess the effectiveness of L&C's activities, the Program does not appear to have established a concise portfolio of key performance indicators that communicates a standardized view of L&C operational outcomes either at a statewide level or by district office.
- Most notably absent from a formal set of goals and objectives are those related to its state-level activities (i.e., unrelated to CMS requirements). HAI is the notable exception,

and infection-related measures are included in the high-level CDPH performance metrics compiled by Quality Performance and Accreditation.

- Instead of leading the conversation about performance and L&C business process improvements underway that address known performance shortcomings, the Program appears to be applying most of its analytic resources responding to questions from the press, advocacy groups, CMS, the legislature, and other control agencies.

MONITORING PROGRAM PRIORITIES: PURPOSEFULNESS

Strengths

- HAI publishes reports on the Department's Internet site that include succinct narratives describing the background, methods and results for its reports on infection rate trends.
- PCB regularly tracks trends for key operational performance indicators against targets for various metrics on call center activity, complaint investigations, backlog, and workload. These internal reports are shared regularly with branch leadership and staff to identify potential performance improvement opportunities.

Opportunities for Improvement

- Evidence of comparative data or trending to support L&C operational and strategic decision-making appears limited.
- With the possible exception of the State Performance Standard reports, there are not regularly scheduled reports that provide trended or compared performance against targets.
- The Program does not appear to make significant use of graphics in reports to help visualize trends, outliers or benchmarks.
- There does not appear to be a great deal of analytic narrative that accompanies standard or ad hoc reports that would describe a report's background, methodology or findings.

MONITORING PROGRAM PRIORITIES: COLLABORATION

Strengths

- HAI takes advantage of its advisory committee to support decisions related to priorities, measurement methods, report content and presentation format. This input helps the HAI Program ensure that it meets the information needs of its internal and external stakeholders.

Opportunities for Improvement

- There is evidence of some effort to promote interaction and cooperation between headquarters and district offices related to performance monitoring. However, recent employee survey results suggest that there is room to improve communication among leaderships, staff and other internal and external stakeholders.
- There is limited Program-wide performance data shared regularly with external stakeholders on the L&C Internet site or elsewhere. Available metrics developed and shared with internal stakeholders would be readily amenable to packaging for external feedback and consumption.
- The Program does not consistently, nor in a structured manner, share information on priorities and best practices within headquarters and among district offices. There does not appear to be a deliberate means to identify successful business process improvement initiatives nor to facilitate adoption of promising process enhancements elsewhere in the organization.
- The CDPH Quality Performance and Accreditation function is working to improve collaboration among business areas to identify measurable objectives that align with the Department's Strategic Map. However at this time, L&C has no specified performance measurement linkages to the Strategic Map, with the notable exception of HAI.
- As the CDPH Strategic Map undergoes revision, there will be an expectation for CHCQ to report performance measures.

KNOWLEDGE MANAGEMENT: PROFICIENCY

Strengths

- Recent improvements to L&C performance measurement capabilities can be attributed to new training Programs developed in response to CMS Benchmark Measure monitoring.
- The Program relies heavily on Research and IT classifications to support data analysis and performance measurement. Having a high standard for candidates that may be performing advanced analytic functions helps screen the applicant pool for potentially under-qualified data analysts.

Opportunities for Improvement

- With the possible exception of nurse evaluators, training and orientation for new staff involved in performance assessment appears limited.
- Staff analytic capabilities are largely acquired over time without formal training. "Learning by doing" is the norm, and with experience over time, staff are able to understand the data sources, measurement methods, and anomalies, which do not appear to be documented or transmitted to coworkers in any meaningfully structured manner.
- The responsibility for offering, tracking and delivering training to L&C staff is diffused throughout CDPH. This topic also is addressed in the section of this report devoted to the Program's training and staff development capabilities.
- Because the Program relies heavily on Research and IT classifications for its data analytics, there is a risk of overlooking talented AGPA or SSA candidates for positions that are supporting performance management activities (i.e., position prerequisites may be difficult for otherwise qualified individuals to meet).

KNOWLEDGE MANAGEMENT: RESOURCE ADAPTABILITY

Strengths

- Supervisors and executives report that processes for position redirection and reclassification are well understood, and reallocating positions to where they are needed most is not a serious barrier to adequately supporting performance measurement or improvement activities.

Opportunities for Improvement

- Although employee vacancy rates have improved in recent years, L&C does not appear to show strong evidence of workforce planning focused on sustaining its performance management capabilities. Also, the Program's recruiting and promotion cycles appear to operate slowly.
- Because talented staff devoted to data management, performance analysis and reporting functions appear primarily focused on satisfying ad hoc requests for information, L&C cannot apply these resources to developing and sustaining the capabilities required to support ongoing performance measurement infrastructure.

KNOWLEDGE MANAGEMENT: DOCUMENTATION

Strengths

- Some ad hoc reports include detailed descriptions of the methodology used to compile the request data set.

Opportunities for Improvement

- The Program appears inconsistent in its approach to data collection, analysis, and reporting, which likely in part is due to a lack of well-maintained documentation on L&C performance measurement practices.
- There does not appear to be clear alignment between regulatory requirements, policies, business processes, data entry, data storage, training and performance reporting. This misalignment makes it difficult for staff in various functions to consistently perform,

track and report their activities so that Program leaders can reliably monitor performance.

- Lack of documentation, training and feedback on how various L&C business processes operated, including their inter-relationships, appear to be among the root causes of unexplained performance variability within the Program. Another of this report's sections addresses L&C's operational capabilities.

TECHNICAL RESOURCES: ACCURACY

Strengths

- Key staff at L&C have formed a Data Integrity Group, which has drafted a charter that defines roles and responsibilities. However, it appears that this group has stalled, as interest from key internal stakeholders (including internal report consumers) has waned.
- The Program is auditing survey findings to help improve the quality (and reduce the unexpected variability) of survey output so that data abstracted from them can be used more dependably for Program performance monitoring.
- IT staff are generating some ad hoc data quality reports. Although such efforts are episodic and based on temporary reporting or operational priorities, these reports are helpful for district offices to identify areas where they can improve business processes and data reliability. The reports also include data on event exceptions that report users can act on immediately to clean up erroneous data, reduce backlog, identify failed business process steps, or enter missing data.
- IT representatives are holding periodic meetings with district office and headquarters staff on how users of IT applications (e.g., TEAM, ASPEN, ELMS) should input the results of their work so that reports accurately reflect their district office accomplishments.

Opportunities for Improvement

- Data quality issues have continued to hamper the reliability of reports used by L&C leadership and external stakeholders to evaluate Program performance. Data users

describe how they often must apply their own personal, experience-based filters to determine whether a report "looks right." Staff involved in data analysis should work more closely with staff involved with operational aspects of the Program to assess the quality and reliability of the reports produced.

- The interaction between IT application interfaces, back-end databases, and reporting requirements does not appear to be well-documented or understood by many staff who are responsible for developing performance metrics. In some cases, the flow of survey or complaint data from the application users in the field to the performance reports used by Program leaders cannot be clearly mapped, which can result in misrepresentation of actual performance. It is difficult to attribute the causes of data quality degradation to operational events in the field or to the methodologies using for reporting results to leadership. However, as described above, some of the root causes of poor data quality are inadequate documentation, training and feedback.

TECHNICAL RESOURCES: EFFICIENCY

Strengths

- No notable strengths identified.

Opportunities for Improvement

- A significant number of L&C processes appear to be overwhelmingly paper-based and labor intensive (e.g., survey data collection), with multiple methods used for collecting and reporting data about similar Program activities (e.g., timekeeping). These redundant and inconsistently performed data collection steps are not only inefficient, they also impact the reliability of the data input into the various IT applications (also see comments above on Accuracy).
- There is no single data store that combines all the key data sources used for reporting on the Program's performance. Linkages between the various internal or external data sources required for Program monitoring are not maintained centrally -- often these

indexes are created, updated and used by individual staff for their own ad hoc performance reporting assignments.

- How L&C uses electronic systems and information technology to manage key data sources also is described in the information technology section of this report.

TECHNICAL RESOURCES: STANDARDIZATION

Strengths

- HAI, PCB, and the MERP programs are regularly tracking a consistent portfolio of standardized performance measures.

Opportunities for Improvement

- L&C appears to lack common processes or methodologies in its data collection, analysis and reporting functions. The Program does not appear to have developed or deployed a focused, standardized, data-driven approach to measuring its performance.
- It appears that, for most ad hoc reports, few previous methodological resources are reused toward future ad hoc requests. Each new ad hoc report appears to be generated independently despite seemingly similar and previously existing measurement concepts that could be applied across multiple types of standard or ad hoc reports.

TECHNICAL RESOURCES: ACCESSIBILITY

Strengths

- A great deal of L&C data related to its federal surveillance mandates are available on the Internet. CMS provides detailed and up-to-date information on their CASPER Internet site about each nursing home and each of their federal deficiencies, and it can be filtered to only show California providers.
- HAI has a significant amount of detailed information posted to the CDPH website.
- The Program makes a variety of data available electronically and on-demand to decision-making executives and district office leadership via an internal SharePoint site.

Opportunities for Improvement

- The availability of the previously mentioned SharePoint reports is not known to all staff or supervisors who many benefit from accessing it.
- Information available on the CDPH website about state-level survey, complaint and incident findings is difficult to summarize, as it is only available one facility at a time on HCFIS. Users of the CDPH website data report that it is not as up-to-date as the federal data found in CASPER.
- Although rich data on PCB activities are readily available to internal staff, these performance data (even reports without readily identifiable information) are unavailable on the Internet.
- Assignment of user rights to various data sources does not appear to be based on a "need to know." Most Program staff have a need to know about the Program's overall performance and the events (e.g., complaints or surveys) contributing to performance, but they may not be able to access these data. Rather, it appears that access to L&C data is based on personal relationships or authorizations that may have pre-dated transfers within the organization (e.g., access to DHCS or OSHPD provider data).

TECHNICAL RESOURCES: TIMELINESS

Strengths

- L&C leaders appear responsive to ad hoc requests from key external stakeholders, and report turn-around usually occurs within 30 days, if not sooner.
- PCB looks at some of its operational performance indicators daily, and some Program operations can be monitored weekly or monthly.
- While actual workload backlog is a known issue (e.g., complaint investigation timeliness), actual data entry backlog is not commonly reported as a significant data quality issue.

Opportunities for Improvement

- Real-time, up-to-the-minute data do not appear essential for Program performance monitoring. However, survey, enforcement and reporting backlogs can reduce the usability and comparability of L&C performance data.

GAP ANALYSIS **Performance Management**				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Monitoring Program Priorities: Meaningfulness		X		
Monitoring Program Priorities: Purposefulness		X		
Monitoring Program Priorities: Collaboration		X		
Knowledge Management: Proficiency	X			
Knowledge Management: Resource Adaptability	X			
Knowledge Management: Documentation	X			
Technical Resources: Accuracy		X		
Technical Resource: Efficiency	X			
Technical Resources: Standardization		X		
Technical Resources: Accessibility		X		
Technical Resources: Timeliness		X		

Table 24 **Gap Analysis – Performance Management**

9. Performance/Quality Improvement Capabilities

Performance Improvement involves incorporating learning and feedback to promote long- term improvement. Competency and skill in managing both small and large performance improvement initiatives is a key characteristic of high performing organizations. Typically, improvement initiatives are cross-functional and require simultaneous changes to process, technology, and even structure.

FUTURE VIEW

To optimally address current and future performance management needs, the L&C Program needs to establish an environment and build a system that is conducive to improvement. In developing performance improvement capability, L&C will need to move to a level of development in which strategic goals are communicated and deployed and where improvement activity is guided by a process of monitoring and measuring against these strategic objectives. Establishing a system of improvement that provides a framework for leading change needs to be a high priority for L&C. The following activities will provide the structure for driving, managing, and supporting L&C improvement efforts:

- Establishing and communicating the mission and vision for the L&C Program;
- Viewing the organization as a system;
- Designing and managing a system for gathering information for improvement;
- Conducting planning for improvement; and
- Deploying and managing individual and team improvement activities.

Establishing and communicating the mission and vision of the organization provides a broad aim for all improvement efforts. Resources must be allocated for research, education and training, and everyone in the organization must be provided an opportunity to participate in improvement. The L&C Program's efforts to implement change should be continuous, coordinated, and focused on a common purpose or aim. This requires viewing the organization as a system where diverse components of the Program are integrated so that they accomplish

the shared purpose of the organization. Proactive gathering of information to support improvement will allow the L&C Program to monitor the quality of the services provided.

This topic was addressed in detail in the previous section of this report. Planning for performance improvement efforts will allow the L&C leaders to establish direction and focus and to allocate resources to address key strategic priorities. Planning for improvement will enable the L&C Program to remain focused on satisfying the needs of its customers and stakeholders. Finally, it all comes together when the L&C leaders deploy and manage the necessary resources to accomplish the state performance improvement goals.

Learning in organizations is a continuous process of testing, sharing, and implementing experience and knowledge throughout the organization. And, it is about incorporating experience in ways that relate to the organization's core purpose on a daily basis. In learning organizations there is a continuous cycle of reflection, awareness, dialogue, and inspiration that refreshes and shifts the organization to higher levels of performance. The organization's leaders and staff, through their interactions, must adjust and learn from each new input. Healthy, vital, honest relationships among the employees of an organization provide the fuel and energy required to enable learning.

CURRENT VIEW

Following is an analysis of the L&C Program's capabilities and efforts in planning, deploying, and managing performance improvement efforts.

Performance/Quality Improvement Capabilities

PLANNING

Strengths

- The CDPH 2013/2014 Workforce Development and Succession Plan includes three deliverables for developing and deploying both mandatory web-based Basic Quality

Improvement Training for all employees and a nine-month Intermediate/Advanced Quality Improvement Training for a cohort of 20 CDPH employees.

- There are isolated examples, such as the HAI program, where planning for improvement is well integrated into day-to-day activities.

Opportunities for Improvement

- L&C Program leaders demonstrate the ability to respond to various stakeholder and legislative requests about improvement that is needed. However, there is limited evidence of system-wide proactive planning for improvement efforts, and it appears that most newly initiated activities are in response to imminent external demands.
- In an employee survey conducted in October 2013, only 44% agreed with the statement "CDPH has a Quality Improvement Plan." Only 36% of respondents agreed that "CDPH aligns its commitment to quality performance with most of our efforts, policies, and plans."

DEPLOYING AND MANAGING

Strengths

- In response to CMS demands to address poor performance on its national State Performance Standards, L&C Program leaders developed and implemented a focused plan for improvement. As described in the Federal Survey and Certification workload assessment, significant improvement has been made in this area. Other examples include L&C Program responses to inquiries regarding complaint backlogs for facilities and in the Professional Certification Branch.
- The SEQIS Section conducts quality improvement activities focused on improving performance on CMS performance standards.

Opportunities for Improvement

- There is little evidence of the L&C Program providing education and training to enhance performance improvement capabilities. For example, in an employee survey conducted in October 2013, only 25% of the 364 L&C respondents agreed with the statement "Key

decision makers in CDPH are trained in basic methods for evaluating and improving quality, such as Plan-Do-Check-Act." Similarly, only 29% agreed that "CDPH currently has a high level of capacity (staff and program support) to engage in quality improvement efforts."

It is important to note that per state statue, the L&C Program maintains a Quality Improvement and Accountability account that is funded by fines collected from facilities. These funds are to be used for internal quality improvement activities. As of June 30, 2013, $11,707,000 has been deposited in this account and $542,000 has been spent since July 1, 2009.

GAP ANALYSIS **Performance/Quality Improvement**				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Planning		X		
Deployment & Management		X		

Table 25 Gap Analysis – Performance/Quality Improvement

FINDINGS: Organizational Systems & Processes Analysis

10. Organizational Design & Structure

As described in the Program Profile section of this report, L&C is part of the Center for Health Care Quality and is the largest program within CDPH, consisting of about 1,200 managers and staff located at headquarters in Sacramento and 14 district offices throughout the state. In addition, the Program contracts with the Los Angeles County to provide federal and state survey and certification services throughout that area.

FUTURE VIEW

Organizational design is the process of aligning an organization's structure with its vision and mission. This means looking at the complex relationship between tasks, workflows, responsibilities and authorities, and making sure these all support the overall vision and mission. Good organizational design for the L&C Program will support improved communication, productivity, and innovation and help to create an environment where people can work effectively.

Organizing principles that will support accountability in the L&C Program include:

- ***Clarity***: Roles and responsibilities are clearly defined with limited overlaps of responsibilities to avoid confusion and increase efficiency.
- ***Doable Roles***: The number and level of responsibilities is balanced with skills, competencies and resources made available.
- ***Empowerment***: Decision-making authority is made explicit and is commensurate with responsibilities in order to empower people to be innovative and take an appropriate level of risk.

CURRENT VIEW

An examination of root causes, best practices, and specific areas where recent improvements have been made are outlined below.

Organizational Design & Structure

CLARITY

Strengths

- No notable strengths identified.

Opportunities for Improvement

- The Central Applications Unit (CAU) was established in order to centralize and standardize facility licensure application processes and to ensure the review of these applications is done in a timely and consistent manner. However, many functions and/or facility types have not been centralized and these responsibilities remain with district office staff. This results in overlap and confusion regarding roles and responsibilities between the headquarters-based CAU and district office staff, in particular the AGPA analysts. More than one-half of the analysts interviewed in the 14 district offices reported confusion and overlapping responsibilities with the CAU. In addition, consumers, facility staff, and stakeholders report confusion in understanding who to contact for licensure issues and questions. L&C Program leaders have identified opportunities for decreasing processing times, eliminating redundant processes and standardizing procedures. They are currently planning to engage a consultant to assist with restructuring and work redesign in this area.
- Recently, the role of Field Operations branch chief has been a challenging one for the L&C Program. All seven of the Field Operations branch chiefs interviewed report frustration with role clarity. For example, these branch chiefs (Manager III level) have little administrative or analytical support and consequently spend a considerable portion of their time performing tasks normally assigned to an AGPA, SSA, or even a Program/Office Technician.

- District office assignments are made without a clearly defined organizing principle. For example, regions are not defined geographically, resulting in Branch Chiefs having oversight for district offices that are spread far apart, making it difficult to facilitate the sharing of best practices, support one another through sharing staff, or complete priority survey activities. Refer to Appendix J for the current Field Operations Branch Chief assignments.
- Field Operations Branch Chief assignment changes are made frequently. This is due, in part, to turnover in three of the seven positions over the last five months. Each time there was a change, however, the make-up of each region was redefined, resulting in multiple changes for district office oversight and a related lack of continuity.
- The rationale for combining the Staffing Audits Sections with the Research group is unclear.
- There is no defined entity within the L&C organizational structure that is responsible for performance measurement, management, and improvement. While the SEQIS Section conducts quality improvement activities, their focus is limited to survey processes and compliance with federal mandates. There is no evidence of a leadership role to initiate, oversee, and support the development of a comprehensive performance improvement program. This issue is discussed in more detail in the Performance Management, Strategic Planning, and Performance Improvement Capabilities sections of this report.
- The rationale for defining the geographic area and volume for each district office is unclear. For example, two district offices are located one mile apart in Riverside and San Bernardino. Similarly, two San Diego district offices are located in the same building and have duplicate staffing for management, analyst, and support staff roles. Facility counts per district office vary significantly and do not provide a logical rationale for how the district offices are structured. Refer to Appendix I for a facility count by district office.
- The number of overall positions and HFEN positions assigned to each District Office varies significantly, as do various staffing ratios, e.g., HFENs per facility, HFENs per 1,000 beds, Non-HFEN positions per HFEN. Although the number of facilities or SNF beds in a

District is somewhat correlated with staffing, these primary drivers of workload only explain about half (or less) of the variability in position counts. There may be other factors that explain the high degree of staffing variability, e.g., geographic dispersion, disproportionate burden of poor performing facilities, mix of provider types, etc. However, the L&C Program's workforce planning and staffing plan methodologies do not appear to adequately ensure appropriate staffing levels across all District Offices.

- There appears to be significant variation in roles, responsibilities and processes for assigning work across the district offices. For example, the approach for survey team assignment varies, with some district offices choosing a team-based approach whereby the same surveyors work together over time. In other district offices, surveyors are assigned to different teams for each survey. Similarly, some district offices assign surveyor teams to specific facilities while others rotate facility assignment on a random basis.

DOABLE ROLES

Strengths

- No notable strengths identified.

Opportunities for Improvement

- The Field Operations Branch Chiefs have responsibility for oversight of the district offices, a critical role for the L&C Program. In addition to this oversight role, these individuals are also assigned various other duties and areas of responsibility as described in Appendix J. Moreover, a listing of these additional responsibilities, which can be found in Appendix K, reveals that in addition to providing oversight for between 2 and 5 district offices, each Branch Chief is also assigned between 2 and 5 other areas of focus and responsibility. In some cases, they also are assigned oversight of headquarters-based units. In particular, the rationale for combining field operations oversight with the management of large statewide functions is unclear. For example, in November 2013, oversight of statewide training and quality improvement (SEQIS

Section) was assigned to a Field Operations Branch Chief who oversees three district offices who was also assigned to be the "subject matter expert" and stakeholder liaison for End Stage Renal Disease, Medical Information Breaches, and Skilled Nursing Facilities. The other Branch Chiefs have similar assignments.

- As described in the Policy and Procedure section of this report, the L&C Policy Section staff have the primary responsibility for reviewing proposed legislation and are assigned to policy revision in the legislative "off season." This is a contributing factor to poor outcomes with respect to releasing updated policies in a timely manner. In addition, the Policy Section staff cite difficulty with getting SME input and participation in policy review and revision.
- In an employee survey conducted in October 2013, only 53% of the 360 L&C respondents stated that they agree with the statement "My program has reasonable expectations of me." Similarly, only 49% agreed with the statement "The pace in my program enables me to do a good job."

EMPOWERMENT

Strengths

- No notable strengths identified.

Opportunities for Improvement

- Most of the Field Operations Branch Chiefs reported a centralized decision-making structure that does not allow for them to function at a Manager III level much of the time. This lack of empowerment results in job dissatisfaction.
- Statewide training is the responsibility of the SEQIS Section and the primary focus is on training for HFENs. As described above, oversight of SEQIS is assigned to a Field Operations branch chief. This structure and reporting relationship does not adequately support the development of training for all L&C staff, in particular, those that are not HFENs.

- In an employee survey conducted in October 2013, only 54% of the 362 L&C respondents stated that they agree with the statement "My supervisor/manager empowers me to take initiative to make improvements in my work." Similarly, only 23% of the respondents agree with the statement "When trying to facilitate change, staff has the authority to work within and across program boundaries."

GAP ANALYSIS Organizational Structure				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Clarity	X			
Doable Roles	X			
Empowerment	X			

Table 26 Gap Analysis – Organizational Structure

11. Regulations

Title 22 California Code of Regulations (CCR) Division 5 provides the rules, order, or standards of general application adopted by the CDPH L&C Program that implement, interpret, or make specific health care facilities licensing laws enforced by the L&C Program. Each of the state licensure categories regulated under Title 22 CCR Division 5, has its own designated chapter that includes several articles containing numerous requirements. Articles generally cover definitions pertinent to the licensure category, the process to apply for a license, basic or required services, supplemental services, special permits, administration, and the requirements for the facility's physical plant. According to the L&C Policy and Enforcement Branch Chief, an acceptable standard of adopting regulations under the Administrative Procedures Act is 2-3 years depending upon the complexity of the regulations.

FUTURE VIEW

Regulations help the public, providers, and stakeholders find requirements quickly and understand how licensed facilities are held accountable under the law. They provide the basis for consistent application of statutory requirements and should keep pace with changes in state and federal laws. This will be accomplished through ensuring the following:

- A comprehensive set of current regulations;
- Timely release of regulation updates; and
- Stakeholder engagement and collaboration.

CURRENT VIEW

Many of the existing regulations for the licensure categories are decades old and should be updated. However, it would take many years to do a comprehensive overhaul of the regulations because of the volume of requirements and limited staffing resources. Therefore, the L&C Program's current approach is to prioritize the updates and establishment of new requirements where none exist, based on the impact to the health and safety of patients. The Registered Nurses Unit is assigned to draft L&C regulations, however there are currently only two nurses and a nurse supervisor who obligate 50% of their time to the development of regulations. There is also an analyst position that assists with regulations development. Departmental attorneys work with the L&C Program on all draft regulations and may serve as lead on regulations.

An examination of root causes, best practices, and specific areas where recent improvements have been made are outlined below.

Regulations

COMPREHENSIVE SET OF CURRENT REGULATIONS

Strengths

- L&C made progress in 2013 on several important regulations packages that provide updated or new guidance to licensees and surveyors on the consistent application of state licensing standards.
    - Regulations establishing the methodology for calculating administrative penalties imposed against hospitals become effective April 1, 2014.
    - Regulations clarifying the testing methods for TB were filed May 2013.
    - Regulations to expand cardiac catheterization laboratory services were effective December 2013.
    - Regulations amending Title 22 to reflect current titles of health care professionals consistent with their licensing boards were filed May 2013.
    - Regulations updating licensing fees and specifying testing schedules for diesel generators to be consistent with the statute were filed January 2013.

Opportunities for Improvement

- Many of the existing regulations for licensure categories are decades old and should be updated. Ideally, the Title 22 CCR regulations should keep pace with changes in state and federal laws. However, it would take many years to do a comprehensive overhaul of the regulations because of the volume of requirements and limited staffing resources.

TIMELY RELEASE OF REGULATIONS UPDATES

Strengths

- Five regulation packages were filed and/or became effective in 2013.
- Four regulation packages are projected to be released in 2014.

Opportunities for Improvement

- More staff is needed to be more productive in regulations development. The RN Unit is working to re-class two of the RN Unit HFEN vacancies to an AGPA position that will be solely dedicated to writing regulations.

COLLABORATION WITH STAKEHOLDERS

Strengths

- For regulations that are anticipated to be controversial or extensive in scope, the L&C Program will hold public hearings to secure stakeholder input into the development of the regulations.

Opportunities for Improvement

- Due to insufficient staffing resources, the L&C Program has not been able to begin working on updating the hospital regulations for which many stakeholders provided input in 2011. That input will be considered when the Program begins working on the hospital project. Program leaders report that it is anticipated this work will begin during fourth quarter of 2014 or the first quarter of 2015.

GAP ANALYSIS Regulations				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Current Regulations	X			
Timely Release of Updated Regulations			X	
Collaboration with Stakeholder		X		

Table 27 **Gap Analysis – Regulations**

12. Policies & Procedures

As previously described in detail, the L&C Program performs survey activities on behalf of CMS for which the State Operations Manual (SOM) provides CMS policy regarding all survey and certification activities. In addition, CMS issues Survey and Certification memoranda, guidance, clarifications, SOM revisions, and other instructions to state survey agencies. This provides the Program with comprehensive policies for completion of L&C's federally mandated workload.

In addition to the SOM, L&C develops policy and procedure documents to provide additional guidance and direction for L&C staff on state mandated activities as well as interplay between state and federal policies or requirements. These policies, distributed via email at the time of publication and posted on an internal SharePoint site for access by all L&C staff, are reviewed and updated by the Policy Section staff. In addition to policy and procedure documents, the L&C Program issues All Facility Letters (AFLs) to health facilities that are licensed or certified by L&C. The information in an AFL typically addresses changes in licensing requirements, enforcement of requirements, new technologies, scope of practice, or other general information that affects health facilities. AFLs are posted on the L&C website for all staff, and they also are distributed to district offices and stakeholders. Additional guidance to L&C's Field Operations staff in the district offices is provided by district office memorandum (DOM). The information contained in a DOM typically addresses clarifications of policy and/or law for the purposes of implementation.

FUTURE VIEW

Effective workplace policies and procedures play a foundational role in governing and guiding an organization's operations. Policies are statements of principles and practices dealing with the ongoing management and administration of an organization. The L&C Program needs well written, up-to-date policy and procedure manuals that guide managers, supervisors, and staff in making decisions and handling day-to-day operations. Moreover, the benefits to L&C of having up-to-date policies and procedures include:

- Improved communication;
- Greater efficiency and productivity;
- Uniformity and consistency in decision-making and operational procedures;
- Fostering continuity and stability;
- Providing direction in a time of change; and
- Assessing performance and establishing accountability.

The desired future view for the L&C Program includes providing current, easily accessible, and relevant policies and procedures for all employees. This should be supported by a comprehensive and centralized policy management system. L&C will create a proactive and connected policy management program and supporting framework that is agile enough to monitor and respond to changing regulatory and internal requirements. This will be accomplished through ensuring:

- Comprehensive and up-to-date policies;
- Easy access to policies for all employees; and
- Effective policy management processes.

CURRENT VIEW

L&C's policy and procedure documents number in the hundreds, and currently include numerous overlapping, redundant, and out-of-date policies. L&C released just six new or updated policies between 2010 and 2013, one of which was withdrawn from circulation. There are currently 11 policies that have been assigned for review and updating in 2014. In addition to these 11, there are many more that have been worked on in previous years but have not yet been completed or released.

An examination of root causes, best practices, and specific areas where recent improvements have been made are outlined below.

Policies & Procedures

COMPREHENSIVE SET OF CURRENT POLICIES AND PROCEDURES

Strengths

- As described above, the SOM is the resource for federally mandated survey activities and is maintained by CMS.
- The Policy Section works with Field Operations Branch Chiefs to identify the priorities for policy updates each year.
- There are some managers that have developed comprehensive policy and procedure manuals for their specific section or unit.

Opportunities for Improvement

- In all of the 14 district offices, personnel including HFENs supervisors, managers, analysts, and support staff reported the lack of current policies and procedures as a key barrier.
- In an employee survey completed in October 2013, 55% of the 359 L&C respondents agreed with the statement "Written procedures and/or protocols exist to help me do my job" and 46% agreed with the statement "I have clearly defined policies and procedures."
- In November 2013, a recommendation was made to implement a process improvement team to investigate and propose ways to improve and streamline the development, review, and release of policies and procedures. It is not clear, however, when this proposed approach will be implemented.

EASY ACCESS

Strengths

- AFLs are posted on the web and distributed to district offices and stakeholders.

Opportunities for Improvement

- While HFENs have access to the federal SOM, they typically carry a hard-copy of this manual in a binder. This creates a challenge in ensuring that more than 500 HFENs have

the most current and updated version of the SOM. Updates are posted to an internal website and training is provided for some of the policy changes issued by CMS, however comprehensive and standardized processes for distribution and validation of receipt of policy changes are not in place system-wide.

- In July 2013, the L&C policies were uploaded to an internal SharePoint site for access by all employees. However, policies are very difficult to find on this site due to a user interface that is not intuitive, has no search function, has confusing numbering changes, and has overlapping and redundant policies.
- While the SOM is available on the CMS website and the L&C policies and procedures are available on an internal web site, it is important to note that the more than 500 nurse surveyors do not have access to the Internet or internal L&C network while onsite during a survey. The use of IT systems to support L&C surveyors is addressed in the Information Technology section of this report.

POLICY MANAGEMENT

Strengths

- The Policy Section is transitioning the current numbering system of the Policy & Procedure Manual to a new system which correlates to the health facility type. As policies and procedures are updated, the new numbering system will be implemented.

Opportunities for Improvement

- The overall framework, timeline, and structures in place to coordinate and manage internal policy and procedure update efforts are underdeveloped and under-resourced. Policies do not appear to be systematically prioritized for review. When policies are presented for review, they are not prepared to conform to the new L&C format. In addition, the Policy Unit staff assigned to work on policy revisions have a primary assignment of legislative bill analysis which as a result of the legislative process, do not have flexible due dates. Consequently, the completion of policies and procedures is often delayed due to the need to complete more time sensitive work.

GAP ANALYSIS Policies and Procedures				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Current Policies & Procedures		X		
Easy Access		X		
Policy Management		X		

Table 28 Gap Analysis – Policies and Procedures

13. Communication & Collaboration

Communication and collaboration are vital activities that we engage in to promote, develop, and achieve the goals of the organization. There are many benefits to effective communication and collaboration in the workplace. These include increased team building, enhanced innovation, improved employee morale, and improved performance. Effective communication supports the development of highly efficient teams who work to achieve high productivity, integrity and responsibility. Employees appreciate good communication coming from management and it produces a healthy work environment. Failing to communicate effectively, on the other hand, often leads to frustration and confusion among employees. Fostering a collaborative atmosphere encourages innovation and improved employee morale. Collaboration involves bringing together different voices from within an organization to bring about creative solutions and ensure that decisions made are ones that consider the effect of all the interested parties.

FUTURE VIEW

Program leaders have an overall obligation to “set the tone at the top” in terms of the standards of conduct and performance expected. Developing and implementing an internal

communication strategy will provide the L&C Program with a number of important benefits, such as:

- Motivation and engagement: Sharing clear, consistent messages in a timely manner will keep L&C employees motivated and engaged.
- Supporting teamwork: Good communication will enable L&C employees to forge and sustain productive relationships.
- Performance and productivity: Communication will affect satisfaction and productivity among L&C staff. Clear communication allows employees to meet manager's expectations, choose their priorities carefully and, thus, be more productive.
- An internal communications plan helps organizational leaders to be intentional about the communication with their employees, leading to increased levels of trust, morale, goodwill, and productivity. After developing a communication plan, disciplined execution of the plan is essential. There should be a focus, for example, on how messages are managed effectively across a wide range of delivery channels, aligned with L&C's overall objectives, and timed for maximum relevance and impact.
- A well-defined and effectively deployed communication strategy for external stakeholders and customers is also important for the L&C Program. The L&C Program will develop a communications and stakeholder engagement strategy that starts with a good understanding of the needs and concerns of different stakeholders. Then, through a shared understanding of common goals and objectives, L&C will work collaboratively with stakeholders to achieve those goals.
- Good communication strategies include:
    - Keeping everyone up-to-date on changes.
    - Conducting regular formal and informal meetings.
    - Using multiple communication channels including frequent face-to-face meetings.
    - Listening. Setting aside time for questions.
    - Adopting an open, collaborative approach.

Planning and coordination are the foundation for ensuring good communication. This involves making sure that internal communications are carefully planned for the year, that messages are prioritized, and that they are delivered in a way that encourages not only consumption, but action. To promote optimal organizational performance, traditional command-and-control management styles need to be abandoned and a collaborative, open leadership approach that engages and empowers employees should be adopted. These best-practice strategies also apply to communication with the public, other agencies, and external stakeholders and partners.

CURRENT VIEW

Communication is a challenge for organizations such as L&C wherein a large workforce works remotely and in regional offices over a large geographic area. Many of the L&C staff work in a mobile environment on a frequent basis, posing challenges to effective communication. Developing a wide-range of communication skills and being prepared to adapt to needs of various situations is an integral component of professional development and organizational performance. Effective communication requires a wide range of skills and strategies to meet all of the needs and requirements of the L&C workplace.

An examination of root causes, best practices, and specific areas where recent improvements have been made are outlined below.

Communication and Collaboration

CLEAR AND TIMELY COMMUNICATION

Strengths

- No notable strengths identified.

Opportunities for Improvement

- In an employee survey conducted in October 2013, less than one-half (44%) of the 374 L&C respondents agreed with the statement "CDPH clearly communicates decisions it makes." And only 41% agreed "CDPH is committed to an environment of transparency (sharing information)."
- In order to hold the organization accountable for achievement of desired results, Program leaders have an obligation to clearly define and communicate expectations for performance goals, measures, and standards. Such expectations have not been clearly stated in written format across the entire Program. In an employee survey conducted in October 2013, 64% of the 346 L&C respondents agreed with the statement "My supervisor/manager has clearly communicated performance expectations for my job."
- In an employee survey conducted in October 2013, 68% of the 348 L&C respondents agreed with the statement "My supervisor/manager communicates with me on a regular basis." Similarly, 61% agreed with the statement "My supervisor/manager disseminates information to me in a timely manner." And 48% agreed with the statement "I am involved in decisions that affect my work."

MEETINGS

Strengths

- Regular face-to-face meetings are conducted by some Field Operations Branch Chiefs in the district offices.
- Stakeholder meetings are conducted on a regular basis.
- Program executives deliver presentations to external stakeholders at conferences and regional events.

Opportunities for Improvement

- Meetings involving representatives from health care facilities are conducted by some district office managers. However, this is not done consistently throughout the state.
- L&C meetings often start late and are conducted without an agenda.

- Program-wide regular management team meetings are scheduled for 60 minutes each week and are frequently canceled. When the meeting is held, there is typically no agenda.

CHANNELS

Strengths

- Written employee performance expectations used by the Professional Certification Branch.

Opportunities for Improvement

- The Field Operations Branch conducts quarterly face-to-face meetings and monthly conference calls with district office management team. However, other managers at headquarters are included only on an as-needed basis.
- There is a high dependence on email as a primary means of communicating all types of information. L&C managers reported that they are often expected to check email as frequently as every 10-15 minutes on their smart phones, even during meetings. While these practices may increase the communication efficiency and flexibility, the attention is often divided and there is a decrease in the level of engagement and participation in meetings and other face-to-face discussions.

LISTENING & COLLABORATION

Strengths

- Best practices are shared at meetings with district managers and district administrators.
- Some Field Operations Branch Chiefs conduct regular face-to-face meetings with their district offices to facilitate the exchange of best practices.

Opportunities for Improvement

- District office management staff in the 14 district offices report that managers and staff at headquarters do not actively engage them or leverage their knowledge and experience to support performance improvement efforts. Many interviewees described

communication as being "one-way," i.e., headquarters pushing information to the field. They also describe an environment where innovative solutions are dismissed without consideration. While there was some recent improvement in this area over the last two years, there remains significant opportunity for improvement.

- In an employee survey conducted in October 2013, 62% of 348 L&C respondents agreed with the statement "My supervisor/manager encourages open dialogue to express ideas and concerns."
- Delegations of authority for routine management decisions are limited and frequently require the approval of senior leaders. Several interviewees in the district offices and at headquarters reported a top-down management and decision-making approach that prioritizes productivity and urgent ad hoc solutions over piloting bottom-up initiatives that could solve underlying performance issues.
- Many interviewees in the district offices, in particular managers and supervisors, reported that headquarters appears to make quick decisions without consulting impacted staff or supervisors, whose input could have been instrumental in the decision-making.
- In an employee survey conducted in October 2013, 33% of the 372 L&C respondents agree with the statement that "CDPH effectively collaborates with external stakeholders." Multiple stakeholders report that communication is not always effective and the L&C Program leaders are non-responsive to their concerns.

PLANNING

Strengths

- No notable strengths identified.

Opportunities for Improvement

- The organization lacks a comprehensive communication strategy and plan to facilitate the flow of information both internally and externally.

- To date, a Program-wide structure and process for the engagement in the establishment of standards, processes and procedures for performance planning and management have not been developed or implemented.
- There is no standardized practice or structure for coordination and collaboration. The lack of a formalized process for planning and problem solving reinforces silos and results in poorly coordinated practices.

GAP ANALYSIS Communication and Collaboration				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Clarity and Timeliness		X		
Meetings	X			
Channels	X			
Listening & Collaborative Approach		X		
Planning	X			

Table 29 Gap Analysis – Communication and Collaboration

14. Information Technology Systems

The L&C Program staff use several different IT systems and applications to accomplish and document their work. A brief description of these systems is provided in Table 30 below.

L&C IT Systems and Applications		
State Systems		
ELMS	Electronic Licensing Management System	An internal application that allows L&C district offices and headquarters personnel to capture health service providers' applications, issue licenses, document facility ownership, generate license renewal notices, assists in the development of license fees, issue and track state citations, and generate management reports.
HAL	Health Applications Licensing	A mainframe application that stores the certified nurse assistants (CNA), home health aides (HHA), certified hemodialysis technicians (CHT), and nursing home administrators (NHA) license/certification expiration dates and generates renewal notices that are mailed to the individual. A file containing the licensee/certificate holder's information is created and provided to a third party vendor for printing and distributing the certificate/license to the certified/licensed individual. Selected data from the HAL system, such as license/certificate and application status, is extracted and uploaded to an Integrated Voice Response (IVR) system, allowing applicants, certificate holders, and licensees to check their status over the telephone. The IVR system is very old and outdated and can longer be repaired according to the vendor (AT&T).
TEAM	Time Entry and Activity Management	An internal timekeeping system used by surveyors, auditors, supervisors, and consultants for tracking time on various L&C activities. TEAM data are used to prepare standard average hours used for development of: budget estimates, develop facility licensing fees, prepare the federal grant budget, and allocate Program expenditures.
CABS	Caregiver Applicant Background System	Used by the Professional Certification Branch (PCB) and shared with the Department of Social Services (DSS). Pulls data from DOJ and national databanks to track applications of professional certifications (certified nurse assistants (CNA), nursing home administrators (NHA), and home health aides (HHA).
CalHEART	California Healthcare and Event Report Tool	A web portal used by health facilities (i.e., hospitals, skilled nursing facilities, clinics) to facilitate reporting of adverse events and patient medical information breaches. Also used to distribute HAI reports to hospitals.
HAI Map	Healthcare-Associated Infections Map	Publicly available interactive map of hospital-acquired infections.
HFCIS	Health Facilities Consumer Information System	Publicly available web application that provides information on California's Skilled Nursing Facilities, Intermediate Care Facilities, and hospitals. HFCIS displays information such as: facility location, ownership information, contact information, services provided, survey outcomes, and complaint investigations reports for Skilled Nursing facilities.
MEDSET	Medication Systems Event Tracker	Used by L&C's Pharmaceutical Consultants (approximately 15 staff) to track medication errors reported by health facilities.

L&C IT Systems and Applications		
NHIPPD	Nursing Hours per Patient Day	Used by approximately 40 auditors to support auditing activities for compliance with 3.2 NHPPD in skilled nursing facilities.
Federal Systems		
QIES	Quality Improvement and Evaluation System	An integrated and comprehensive data system of survey, certification, and clinical information obtained from several sources including health care provider submissions and state health facility survey, certification, complaint and workload activity submitted into ASPEN.
ASPEN	Automated Survey Processing Environment	The umbrella term that is used when referring to all 5 applications that comprise the ASPEN suite.
ACO	ASPEN Central Office	Used by L&C to enter all survey and facility data. Also used to upload survey data on CMS's certified activities to the National Repository (Server). ALL survey data is entered in ACO but only federal surveys are pushed to the National Repository. State surveys remain on the State ACO server located in Sacramento.
AEM	ASPEN Enforcement Manager	Enables both L&C and CMS to efficiently manage all tasks related to federal nursing home enforcement.
ACTS	ASPEN Complaints/ Incidents Tracking System	Used to track and process State and federal complaints and incidents and subsequent investigations.
ASE-Q	ASPEN Survey Explorer-Quality	Used by surveyors in their district office to document state and federal findings (deficiencies). After review by a supervisor, the approved version is exported to ACO. A component of the survey documentation is the 670 form, which states the amount of time spent on the federal activities and the time of day the activities occurred (e.g., morning, afternoon, evening).
AST	ASPEN Scheduling and Tracking System	Used to facilitate scheduling and monitoring of survey process for federal certifications, complaint investigations, enforcement cases, and state licensed only facilities.
OSCAR	Online Survey & Certification Automated Reporting	A legacy reporting tool retired in 2011, replaced by QIES and accessible through CASPER.
CASPER	Certification and Survey Provider Enhanced Reporting	Online reporting application that provides state agencies, nursing homes, and home health agencies with the capability to generate various reports related to quality measures.

L&C IT Systems and Applications		
MDS	Minimum Data Set	Part of the federally mandated process for clinical assessment of all residents in certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems and plan for care.
OASIS	Outcome and Assessment Information Set	Part of the federally mandated process for clinical assessment of all patients receiving care from certified home health agencies. This process provides a comprehensive assessment of each patient's functional capabilities and helps home staff identify health problems and plan for care.

Table 30 L&C IT Systems and Applications

FUTURE VIEW

The information systems that support the L&C Program mission and workforce provide a critical infrastructure for data entry, collection, and analysis as well as Program management and communication. The future of L&C's information system capabilities can be viewed through the following five capability domains:

- Accessibility: the degree to which necessary hardware and/or software applications are available to those who need it to perform their work.
- Speed: refers to the speed of accessing and using IT applications.
- Ease of Use: the degree to which IT systems and applications are easy to use, support and make one's work more efficient.
- Training: refers to initial and ongoing training on IT applications used in one's day-to-day work.
- Support: refers to the timeliness and quality of support services for IT systems and applications.

CURRENT VIEW

HFENs represent nearly one-half of the L&C workforce and conduct the core work of on-site federal and state surveys and complaint/ERI investigations. While all HFEN's are provided a laptop/tablet computer, it is rare that they use them while conducting an on-site survey or investigation. Hence, all documentation related to the survey activities and findings, as well as

the employee's record of time spent, are hand-written and later entered into the IT application when returning to the office. For a federal re-certification survey in a nursing home, the survey team of four to five surveyors is typically onsite for a full week. The HFENs return to the office the following week to complete the survey documentation and key in the information in the ASPEN ASE-Q application. With more than 500 HFENs statewide, this labor-intensive and redundant process represents significant waste in human resources.

An online survey was conducted by Hubbert Systems in March and April 2014 with more than 220 responses statewide. Many of the HFENs who responded described their frustration with the current paper-based processes. Following are some of their responses to questions about the expanded use of technology.

I would enter information directly into the laptop and quickly be able to edit instead of the EXTREMELY INEFFICIENT current practice of writing with a pen on HUNDREDS OF PAPER FORMS.

There would be a huge increase in productivity from documenting in the computer instead of using tons of paper to write everything down only to transcribe what is written on paper into the computer. Twice as much time and work without the use of a laptop.

I would use it to start my paperwork and fill in some of the information. I would not have to wait until the next week and do everything that week.

Enter information when obtained or immediately after. WOULD ELIMINATE duplicate writing.

The use of modern IT hardware and software to conduct their work is not the current practice for HFENs in the L&C Program. When asked whether a laptop or tablet is taken out on survey visits, 95% responded "No."

21. Do you take a tablet or laptop with you when you are conducting an on-site facility survey?		
Answer Options	**Response Percent**	**Response Content**
Yes	3.8%	8
No	95.3%	201
N/A – No response	0.9%	2
Answered Question		211
Skipped Question		11

When asked why not, the following reasons were cited.

22. If you answered "NO" to question #21 above, please indicate reason. (check all that apply)		
Answer Options	**Response Percent**	**Response Content**
Not Permitted	58.6%	99
Too heavy	34.3%	58
Applications not available	31.4%	53
No Internet Access	32.0%	54
Other (please specify)		73
Answered Question		169
Skipped Question		53

The majority (79%) of HFENs indicated that they would like to use mobile technology to conduct on-site surveys.

23. Would you like to use mobile technology (tablet, laptop, iPad) when conducting an on-site facility?		
Answer Options	**Response Percent**	**Response Content**
Yes	79.0%	166
No	13.3%	28
N/A – No response	7.6%	16
Answered Question		210
Skipped Question		12

CMS has developed an electronic means of conducting nursing home inspections. The Quality Indicator Survey, or QIS, application provides for the collection, recording and analysis of information and documentation of findings to be done electronically using a tablet computer rather than the traditional paper-based method. After conducting demonstrations and evaluating the results of studies, CMS has determined that the QIS should be implemented nationwide by 2018, using a phased implementation. QIS has been implemented in more than 25 states. A target implementation date has not yet been set for California.

It is not clear that transitioning to QIS will result in increased HFEN efficiency. In fact, some state survey agency officials found surveyors experienced difficulties with using QIS software and tablet computers due to a learning curve or a lack of computer skills needed to operate these tools. In many cases, states have developed additional training materials related to basic computer skills or general information on the QIS in order to improve state surveyors' proficiency with using the QIS tools.

However, even without implementation of QIS, there are many opportunities for increased efficiency. When asked how mobile technology would be used to conduct their work, the HFENs responded with many suggestions for streamlining and increasing the efficiency of the survey process. Following are a sampling of the many survey responses.

It would be great and I believe more cost effective in the long run to have everything on a tablet, i.e.; our SOM, Title 22 reference, worksheets, etc. A lighter tablet version as opposed to a laptop would be best and would help to cut down on Worker's Comp. injuries (carrying/ rolling around huge binders in large rolling brief bags).

Documentation could be streamlined and entered immediately into a system; access information resources (regulations, clinical info e.g. CDC guidelines). Some info could be entered ONCE, instead of putting name of facility on 300 pieces of paper. Would allow for better collection and analysis of data.

An iPad or tablet would be best to use because of its light weight and easy use to look up information. It also could be used to take pictures of any documentation needed instead of printing too much paper work or take any pictures when indicated. It also would be more convenient to carry and store. It would also be nice to have our forms accessible on the tablets so that we can type our findings easily. And it would be better to have the SOM and Title 22 accessible with the tablet or iPad instead of dragging our suitcases with the SOM and title 22 in them, which are heavy and can cause strain on our arms and shoulder.

For everything!! Time keeping, survey and complaint investigation documentation, reference information available on-line, GPS, communication with supervisor, checking and staying current on e-mail

All surveyors carry the CMS State Operations Manual (SOM) with them. When asked specifically about the SOM, 90% responded "Yes" they would prefer to have this important resource available electronically.

26. Would you like to have the SOM on your laptop or tablet?		
Answer Options	**Response Percent**	**Response Content**
Yes	90.0%	189
No	2.9%	6
Not Sure	7.1%	15
Answered Question		210
Skipped Question		12

In addition to the lack of modern IT systems for use during on-site visits, L&C Program staff at all levels deal with challenges and barriers in using the federal ASPEN applications. Details are provided below. An examination of root causes, best practices, and specific areas where recent improvements have been made in IT systems and applications are also outlined below.

Information Technology Systems

ACCESSIBILITY

Strengths

- Currently CMS offers an IT application for survey documentation for ESRD surveys only. There are a few district offices that have HFENs trained by CMS to document these ESRD surveys on a tablet.
- Staff who conduct the nursing home staffing audits have Internet and internal network access to forms and other tools needed to do their jobs.

Opportunities for Improvement

- Some district office managers do not allow surveyors to take their assigned tablets out of the office. The rationale is that since they can't conduct a survey on the tablet, there's no need to take it and risk breaking it, losing it, or having it stolen. 56% of the HFEN survey respondents indicated they are allowed to take their tablets out of the office.

- There have been recent discussions about loading the SOM and L&C policies and procedures onto the surveyor's tablets and the impact of ongoing maintenance is being considered.
- Access to the policies and procedures could be via a shortcut available on tablets to the internal network where L&C policies are stored. However, access is available only when connected to the CDPH network, which can be done via Citrix, but requires web access. Surveyors don't have cell phones or another device for web access. The SOM can be accessed via the Internet but again, this requires web access. Surveyors, when in the field, do not have web access, even though the tablets they have are Wi-Fi capable. Obtaining cellular access (even though it would be used for only data and not for cell phone calls) counts against the Department's restricted number of cell lines.

SPEED

Strengths

- Several tests have been conducted on all levels of the network topology and the results indicate significant network capacity at all levels of technology.

Opportunities for Improvement

- Speed of system has been an often-cited challenge. However, a recent informal phone survey with seven of the 14 district offices showed that one-half of those queried reported slowness, primarily with the ASPEN applications. Users routinely experience about 6-8 minutes of waiting time while running reports, exports and imports between ACO, ACTS and ASE. The L&C IT Support Section is in the midst of testing VDI (Virtual Desktop Interface) and preliminary testing shows there may be a slight increase in speed. More thorough testing is being conducted.
- A detailed analysis by CDPH IT staff found that ASPEN speed is at the maximum of technical efficiency limited only by the design and architecture of the software itself. Staff survey ratings indicate dissatisfaction with application performance.

- In a survey conducted in March/April 2014, 50% of district office analysts agreed or strongly agreed with the statement "The speed of the ASPEN system is a major barrier in completing my work."
- PCB staff use a very old database, HAL. Staff report satisfaction with the reliability of this application. Staff also report frustration about its very limited data validation and how it is extremely difficult to modify due to its COBOL-based technology.

EASE OF USE

Strengths

- No notable strengths identified.

Opportunities for Improvement

- In a survey conducted by HSC in March/April 2014, less than 50% of HFENs, 60% of support staff, and only 22% of district office analysts responded that they agree/strongly agree with the statement "I am satisfied with how easy it is to use the ASPEN system."
- The more than 500 L&C HFENs currently record their time in three systems:
    - TLRS. The payroll system that is required to capture employee time off. This is on a Lotus Notes-based system that doesn't communicate with .net based systems (which is what TEAM is).
    - The ASPEN 670: CMS requires surveyors to record the amount of time spent performing a survey and won't allow automatic uploads into ASPEN.
    - TEAM: Used to record individuals surveyors' time spent performing survey activities.
- The L&C IT Support Section is looking into putting more detail into TEAM to capture the 670-required information. This will mean the two systems will have the same data requirements and formats, however manual entry into ASPEN will still be required.
- As described above, nurse surveyors are unable to access information on the internal L&C network or on the Internet while out of the office conducting a survey. This is due

to the lack of internet access. It's important to note that the tablet computers are Wi-Fi capable but the HFENs do not have Internet connectivity options.

TRAINING

Strengths

- The L&C Support Section developed a "Technology Thursdays" training program that was initiated in January 2014. All district office managers, support staff, SSAs, AGPAs, and branch chiefs were invited to participate in these monthly webinars. The topics, prioritized based on end-user needs and feedback, included various ASPEN, ELMS, and TEAM functions.

Opportunities for Improvement

- In May/June 2013, the Federal System Support (FSS) team emailed a survey to L&C district office management, staff, and surveyors. The survey covered three key areas of interest: ASPEN Speed, Training, and Customer Service. 59% of the 97 users responding to the survey ranked ASPEN training as average or below.
- The training methodology used is typically on the job training, with webinar trainings being implemented recently. In the aforementioned survey, staff expressed a preference for hands-on, face-to-face classroom training with exercises and follow up.

SUPPORT

Strengths

- In an employee survey conducted in October 2013, 71% of the 323 L&C respondents rated timeliness of services provided by the IT staff as "very timely or timely." In the same survey, 67% rated the quality of services as "very good or good."
- In the FSS team survey only 2-6% of users reported being dissatisfied or very dissatisfied in response to questions regarding support received from the ASPEN support desk.

Opportunities for Improvement

- HFEN staff in several district offices reported frustration with internal (district office) practices for accessing IT support services. For example, the process in some district offices is to require all help desk tickets to be submitted by office support staff.

GAP ANALYSIS IT Systems				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Accessibility	X			
Speed			X	
Ease of Use	X			
Training		X		
Support			X	

Table 31 **Gap Analysis – IT Systems**

15. Timekeeping System & Estimate Process

In order to capture and report workload data by category (survey activity and facility type) the L&C Program developed and implemented the Surveyor Timekeeping System (STS). In June 2011, the STS system was automated and renamed to Time Entry and Activity Management (TEAM). The TEAM system captures data on the number of survey counts and the total hours spent for each survey activity to determine the standard average hours it takes to accomplish a specific workload. This information is used in the L&C Program's estimate process to determine the Program's fiscal needs for budgeting, in the annual Fee Report that sets licensing fees for all facility types, and to support the development of the annual CMS grant. Accurate, timely and detailed timekeeping is essential to the L&C budgeting process, workload estimation, workforce planning, and performance monitoring. The reliability of timekeeping data are impacted by the

ease of data capture, standardization of timekeeping procedures, and timely feedback to staff on unexpected variability or discrepancies in timekeeping data.

FUTURE VIEW

The overall goal for the timekeeping and estimate process is to provide accurate information for the determination of fiscal needs for Program budgeting, determination of licensing fees, and CMS grant funding requests.

CURRENT VIEW

L&C is undergoing efforts to conduct an evaluation and assessment of the Timekeeping System and Estimate Process and is considering procuring the assistance of an external contractor. Because internal timekeeping-related initiatives have been accelerated, the Hubbert Systems team was asked to focus on other areas of the Program, as work on a gap analysis on the timekeeping system and estimate process would be duplicative

16. Hiring & Promotion Processes

Health facilities evaluator nurses (HFENs) represent the largest category of established positions. After AGPAs (associate governmental program analysts), Health Facility Evaluator II (supervisor) positions are the next largest group. Vacancies in these key positions have been an ongoing challenge for the L&C Program. Although employee satisfaction, retention and turnover impacts vacancies (see Employee Satisfaction and Retention section of this report), a well-functioning hiring and promotion processes can help ensure that these positions are filled.

Hiring was particularly difficult for L&C during 2008-2013, as the ability to hire and retain staff was significantly impacted by several executive orders. Executive Order S-09-08 mandated a hiring freeze and layoffs of student assistants, temporary employees and retired annuitants. Staffing also was impacted by Executive Order S-16-08, which initiated two furlough days per

month beginning in February 2009. The furlough program limited the work week to 32 hours and prohibited overtime during the two furlough weeks each month. In addition, the executive order indicated that the work not done due to furloughs was not to be compensated for with additional staff or contracts. Executive Order S-13-09 expanded the number of furlough days to 3. Furloughs remained in effect until June 2013.

The hiring freeze, furloughs and layoffs resulted in staff shortages affecting L&C's ability to conduct mandated federal and state workload requirements. After the hiring freeze was lifted, the L&C Program was able to begin aggressive recruitment efforts. Since the hiring freeze was lifted, L&C reduced its vacancy rate from 22% to 7% as of May 2014.

In May 2012, the L&C Program was placed on a corrective action plan by CMS with the requirement to attain several specific benchmark objectives, some of which were related to L&C hiring and promotion processes. The first of these objectives addressed "Management Structure and Personnel Stabilization." A short- and long term timeline was requested for hiring, with regular reports focused on achieving a full complement of staff including Health Facilities Evaluator II (supervisor) positions; district administrator/district manager positions; health facility evaluator nurse (surveyor) positions; and professional and administrative staff. CMS also required substantial progress in the reclassification and pay differential modification for HFENs and the HFE II supervisors.

FUTURE VIEW

In order to meet the demands of the L&C Program, staff must have the appropriate knowledge, experience and skills. To optimally support current and future demands, staff should be recruited and hired based on their relevant experience and ability to complete the requirements of the position. The allocations of positions and classifications throughout L&C should support the needs of the Program. Vacancy rates, particularly in the HFEN, HFE II supervisor, district administrator, and district manager positions must be kept at a minimum so

that the L&C Program can meet its federal and state mandated workload requirements. This will be accomplished by implementing the following:

- An efficient, timely and effective process for recruiting and hiring new staff.
- An efficient, timely, and effective process for promotions for Field Operations supervisory and management positions.

CURRENT VIEW

The L&C Program continues to face challenges with hiring and promotion. Improvement was made and most of these objectives were met in 2013. The CMS Benchmark reports showed a vacancy rate of 29% in 2011 that decreased to 7.64% in March 2013, and was at 10.29% in September 2013. As of March 2014, the vacancy rate was 8.5%. It is important to note that this vacancy rate represents all L&C positions, not just HFENs, supervisors, or managers. This rate is calculated by dividing the current number of vacant positions by the total number of established positions. Vacancy rates for these key supervisor and manager positions are presented below in Tables 32 and 33 below.

L&C Vacancy Rates		
Classification	**As of 12/13/2013**	**As of 3/31/2014**
HFE II Supervisor	8.1%	5.5%
HFE Manager I (District Administrator)	15.6%	19.2%
HFE Manager II (District Manager)	11.1%	5.5%

Table 32 Vacancy Rate – Supervisors and Managers

For HFENs the vacancy rate is reported using the same calculation: number of vacant positions divided by the total number of established positions. Table 33 below is the L&C Program reported vacancy rate for all positions and for just HFENs as of December 2013.

All Vacancies		HFEN Positions	
Total Current Vacancies	**83**	Vacant HFEN Positions	**33**
Tentatively Filled Positions	**23**	Tentatively Filled HFEN Positions	**14**
Remaining Vacancies	**60**	Remaining Vacant HFENs	**19**
Total Authorized Positions	**1,058.25**	Total Authorized HFEN Positions	**471.2**
Current Vacancy Rate	**5.67%**	Current HFEN Vacancy Rate	**4.03%**
Overall Vacancy Rate	**7.84%**	HFENVacancy Rate	**7.00%**

Table 33 Vacancy Rate– All Positions and HFEN Only

An examination of root causes, best practices, and specific areas where recent improvements have been made in hiring and promotion processes are outlined below.

Hiring and Promotion Processes

INITIAL HIRES

Strengths

- The Program maintains detailed tracking logs that provide information on average time frames for each of the more than 20 steps in the hiring process.
- Detailed hiring policies and procedures have been prepared for L&C staff
- The Program has initiated a postcard recruitment campaign to increase the number of qualified candidates for open L&C positions.
- Statements of Qualification assist with the hiring process

Opportunities for Improvement

- Interviewees reported that the hiring and on-boarding processes are time-consuming and serve as significant barriers to posting vacancies and hiring appropriate candidates. Many L&C managers and supervisors reported hiring to be inordinately slow and a key barrier to completing mandated workload within required time frames. A period of 4-6

months was described as the typical period of time required to complete the hiring process. Detailed logs kept by the Program's reveal the average time from completion of the recruitment request form to the final step of the hiring process. Although timeframes have improved over the past year, during the period from July 1, 2013, through December 31, 2013 the hiring process took an average of 77 business days (nearly 4 months).

- A Department-wide workforce development and succession plan was developed for 2013/2014, with the first strategic objective of "recruit and retain a skilled, diverse, and empowered workforce." However, this plan does not directly address recruitment needs of the L&C Program and retention appears to be the primary focus on this plan.

PROMOTIONS

Strengths

- No notable strengths identified.

Opportunities for Improvement

- Interviewees reported excessive wait times for supervisor testing results and promotion paperwork. L&C managers and supervisors reported a similar timeframe for completing the personnel process for internal promotions. During site visits to district offices, four newly promoted HFE II supervisors reported they had been waiting for 3 - 4 months for the personnel paperwork for their promotions to be processed.
- Salary compaction is a barrier to recruiting supervisors. In addition to the slow processing of promotions, L&C has been working for many years to adjust the rate of pay for HFE II supervisors. Since January 2007, CDPH has been working on revising the classification specification for the health facilities evaluator classification series. The most concentrated of these efforts began in February 2012, when the Department partnered with the California Department of Human Resources (CalHR). This proposal is anticipated to be completed and effectuated by the summer of 2014.

GAP ANALYSIS Hiring and Promotions				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Initial Hire Process		X		
Promotion Processes		X		

Table 34 Gap Analysis – Hiring and Promotions

17. Training & Staff Development

Training for the L&C Program is the responsibility of the Staff Education and Quality Improvement Section (SEQIS), which reports to one of the Field Operations Branch Chiefs. The focus for the training program provided by SEQIS is on preparing staff for conducting the Program's survey and certification workload requirements, both federal and state. Training for other L&C Programs such as PCB, Staffing Audits, the Resource and Operations Branch, etc., is developed and provided by managers in those areas.

Since HFENs represent nearly one-half of the L&C workforce and conduct the core mandated workload, HFEN training is understandably a primary focus for SEQIS. HFEN training includes several components and takes about one year to complete. All new surveyors hired by L&C attend the New Surveyor Academy which is a structured program that includes self-study assignments and face-to-face classroom sessions. The classroom instruction is three weeks in length and is provided in one-week sessions over a three month period. The purpose and focus of this training is to teach the newly hired HFEN the basics of conducting federal re-certification surveys and complaint/ERI investigations in long term care facilities.

After the L&C New Surveyor Academy the HFEN must complete a comprehensive CMS training course, referred to as the Basic Long Term Care Course (BLTCC). This training begins with a

series of online sessions covering the basics of surveying Medicare and Medicaid- eligible facilities. Once these sessions are completed, HFENs move on to a classroom lecture. While the Basic LTC training course provides fundamentals of survey practice, it does not provide all of the information that a surveyor needs to successfully complete the Surveyor Minimum Qualification Test (SMQT). It is the combination of pre-Basic (mentoring and web-based training), basic (video conferencing and on-site classroom), and post-basic training and mentoring (such as specialized and tailored learning experiences) that ensures surveyors are prepared to successfully complete the SMQT and to conduct CMS-required surveys of providers.

There are five CMS-contracted trainers for the CMS Basic Long Term Care Course (CBLTCC) to cover training for all 50 states. These trainers travel to planned locations and conduct the training. Due to the number of surveyor staff in California, it has been difficult for CMS to meet California's need for surveyor training. Typically, only a few slots are offered for each training session. To address this training need, CMS implemented the Magnet Area Training (MAT) program to expand training resources by preparing state survey agency personnel to assist with providing the mandated basic training (BLTCC) under the supervision of federal-contracted trainers.

In addition to the Basic Long Term Care course, CMS provides training on hospital, home health, hospice ESRD, and several other provider types. In order to be eligible to conduct a survey or investigation in a hospital, for example, the HFEN must complete the federal Hospital Certification course. Additional CMS required courses and meetings include the State Agency Directors Leadership Summit, Training Coordinators Conference, and the Learning Management System Fundamentals class. For all job classifications other than HFENs, the L&C Program is responsible for providing new hire and ongoing training and staff development.

In addition to attending training courses, each district office has a designated training supervisor who is responsible for providing and overseeing on-the-job training and mentoring.

FUTURE VIEW

Training and staff development are essential to L&C Program operations. In order to build an efficient and high-functioning workforce, training and professional development programs must be strategically designed to provide the necessary skills and opportunities to staff. L&C Program staff must have the appropriate training and development so they can contribute to meeting the demands of the Program's federal and state mandated survey and certification workload. Staff should be provided comprehensive and timely training when hired and on an ongoing basis. This will be accomplished by the following:

- Comprehensive new-hire orientation program for all job classifications;
- Maintain and implement a workforce development plan that addresses the ongoing training needs of the staff and the development of core competencies; and
- Annual analysis of staffing needs in order to provide sufficient human resources for accomplishing L&C goals.

CURRENT VIEW

The L&C Program places strong emphasis on HFEN Training. This is a lengthy, time-consuming, and resource-intensive process. The table below provides details on the number of surveyors completing each of the major training milestones for 2012 through 2014 year-to-date.

HFEN Training							
	Academy	BLTCC	SMQT	Hospital	HHA	Hospice	ESRD
2012	24	24	22	99	15	12	8
2013	85	61	50	16	16	49	22
2014 YTD	24	74	6	0	0	0	0

Table 35 HFEN Training

As described above, the Program must rely on CMS to provide the key components of HFEN training. In addition, Program leaders and training coordinators must attend periodic mandatory meetings. In May 2011, CMS communicated in a letter to Program leaders their concern that surveyors had not been attending CMS in-person classes and meetings. This was due to state budget issues at the time and the related restrictions on travel for state employees in spite of the fact that a portion of the CMS funding for the L&C Program is allocated for training related travel.

In May 2012, the CMS Benchmark requirements included the following four objectives:

Benchmark Goals	Status
Assign and train the required number of MAT instructors.	This goal is met. There is one certified MAT instructor and seven are in the process of being trained.
Complete a detailed schedule to accommodate new hires attending the Program's New Surveyor Academy within six months of date of hire and the CMS BLTCC training within one year.	This goal is met. A data sheet is updated monthly to include the dates the new HFEN starts, projected and start and finish dates for both the New Surveyor Academy and CMS BLTCC course, and the date the SMQT test is successfully completed. Additionally, attendance for the Advanced Academy is captured. This course is generally provided every two years.
Complete an assessment of basic and specialty training needs to identify federal training needs and a detailed schedule to accommodate surveyors being cross trained in LTC and non- LTC surveys to attend both in-state and out-of- state mandatory trainings.	This goal is met. The assessment tool used is the biannual Staff Employee Training (SET) report. The next report is due May 2014. Training issues are also solicited via a monthly teleconference or quarterly meeting with the field training supervisors.
Stabilize the training supervisor position.	The section chief (HFEM II) was hired for SEQIS in October 2012. Two supervisors were hired in January 2013. In August 2013, both supervisors were promoted to manager (HFEM I) for the two units (Field Training and Development and Quality Improvement and Training Unit). Two replacement supervisors were hired by December 2013. There are seven specialty trainers. Only one has been with the unit prior to 2013. There are four quality specialists. Only one has been with the unit prior to 2013.

Table 36 CMS Benchmark Goals May 2012

Program leaders identified challenges in obtaining access to the required CMS training sessions. Each year the L&C Program is required by CMS to project training needs. The table below

provides a comparison of projected training needs and the actual number of HFENs who attended training for the BLTCC and the specialty hospital training. For calendar years 2012 and 2013, 100% of the projected need for BLTCC training was met. However, for other provider types this is not the case. As shown below, 71% of hospital training needs were met, 66% for hospice and 37% for ESRD.

CMS HFEN Training Courses								
	BLTCC		Hospital Training		Hospice		ESRD	
	Projected Need	Actual Attendees	Projected Need	Actual Attendees	Projected Need	Actual Attendees	Projected need	Actual Attendees
2012	24	24	100	99	40	12	29	8
2013	54	54	39	0	52	49	52	22
%	100%		71%		66%		37%	

Table 37 CMS HFEN Training Courses

According to L&C leaders, the barriers to obtaining needed training are both a limited number of openings for training provided by CMS and the state restrictions on out-of-state travel. Notably, the expense for this travel is included in the grant funding received from CMS. However, state travel restrictions and budget limitations often prevent the L&C Program from participating in training sessions even when they are given a "slot" by CMS.

Hubbert Systems conducted an online survey in March/April 2014 that included several questions related to initial and ongoing training. Following is an overview of the targeted groups and response rates. The survey questions are provided in Appendix E.

Targeted Group	# Sent to Training	# Completed Training	Response Rate
HFEN	522	222	43%
HFE Supervisors	89	48	54%
DA/DM	42	29	69%
DO Analysts	28	19	68%
DO Support Staff Supervisors	15	11	73%
DO Support Staff	62	27	44%
HQ Managers & Supervisors	32	15	47%

Table 38 Groups and Response Rates for March/April 2014 Survey

An examination of root causes, best practices, and specific areas where recent improvements have been made in training and staff development is outlined below. Survey results are included where indicated.

Training and Staff Development

NEW EMPLOYEE ORIENTATION & TRAINING

Strengths

- The New Surveyor Academy (NSA) provides a good foundation for new HFENs. In the HSC survey, 65% of the HFEN respondents reported that the NSA prepared them very well/well for the SMQT examination. 57% reported that the time spent in NSA was "just right."
- California is one of the few states with a State-run Training Academy. Many other states do not provide training prior to CMS BLTCC attendence.
- The Program has no difficulty in getting new surveyors into CMS or MAT training for Basic Long Term Care.
- The training supervisor manual is a resource for on-boarding new surveyors, however it was last updated in 2008. The training supervisors participate in three-day face-to-face meetings annually for updates and professional development. The last meeting was in April 2014.

- Some district offices have structured mentoring programs for new HFENs.

Opportunities for Improvement

- L&C currently has just one certified MAT trainer and seven more are in the process of becoming certified as MAT trainers. One of those individuals will finish in September 2015, and the others will finish in approximately two and a half years. Because becoming a MAT trainer is a lengthy process, and because of the lack of authorization for out-of-state travel, it is difficult to increase the number of MAT trainers more quickly.
- There is no enterprise-wide formal mentoring process for HFENs. Of the 222 HFENs who responded to the HSC HFEN survey, 71% indicated there is no formal mentoring program in their district office. Also, 20% indicated they had participated in no surveys prior to attending the first NSA training session (which could be in part based on when these respondents were hired). 37% reported having observed or participated in only 1-2 surveys. Also, nearly one-half of the HFENs reported the length of time between hire date and attendance at the first NSA training session to be more than 3 months. Similarly, 28% of HFEN respondents reported having participated in 0-4 surveys by the end of the three-month NSA training. It is important to note that 40% of the respondents attended the NSA in 2012-2013 and 62% had attended since 2010.
- Training on the ASPEN system is limited and may not be as effective as is needed. Just one-half of the HFEN survey respondents reported that training on ASPEN/ASE-Q prepared them well to use this software application for documenting their survey findings.
- While each district office is allocated the position of one training supervisor, 15% of the HFEN respondents reported there is no training supervisor in their district office. Vacancy rates are not available for training supervisors specifically because they are in the same job classification as “regular” HFE II supervisors. It was reported by several district offices, however, that even when they have a designated training supervisor, it’s not uncommon for this individual to be assigned other responsibilities that limit their

ability to focus 100% of their time on training. 18% of HFEN respondents to the HSC survey reported that a training supervisor had not been out on a survey with them at all and another 40% had a training supervisor accompany them 1-2 times during their time in training. It's also interesting to note that 74% of HFENs reported that their supervisors accompany them on a survey rarely or never.

- Interviewees at headquarters and in all district offices reported that the majority of new-hire orientation, with the exception of the HFEN Academy, is on-the-job training. For example, many analysts and support staff reported receiving no training when hired. 37% of the district office analysts and 41% of support staff who responded to our survey reported not receiving an initial orientation. It is important to note that 37% of the respondents have started in the analyst role since 2010 and a total of 84% have started since 2006. Similarly, 77% of the support staff have started in their roles since 2010. Of the analysts and support staff who did report receiving initial orientation, just 50% and 48% respectively indicated they felt well-prepared to do their job. For all respondents, the majority of initial orientation training was on-the-job training.
- There is limited Program-specific training or development for managers and supervisors. This is addressed in detail in the Leadership section of this report.

CONTINUING EDUCATION & TRAINING

Strengths

- WebEx trainings are offered by SEQIS. 78% of HFENs, 68% of Analysts, and 73% of Support Staff reported the WebEx trainings to be useful/very useful.
- Face-to-face training sessions are provided periodically for DA/DMs, supervisors, and training supervisors, and field office support staff. These sessions occur every 1-3 years. Ongoing training and updates are often provided during monthly teleconferences and quarterly face-to-face DA/DM meetings.
- A new surveyor General Acute Care Hospital (GACH) Licensing Academy Training is in development for fall 2014.

Opportunities for Improvement

- Less than one-half (44%) of HFENs rated training and staff development as good or very good.
- Training on updates and changes could be improved. 23% of HFENs reported that they either receive no training on updates and changes or receive training from another HFEN. 47% of Analysts and 23% of Support Staff reported receiving either no training on updates and changes or relying on word of mouth.
- An academy is typically provided for HFE II Supervisors every two years. However, the last session was held in 2013 and the next is scheduled for 2016. 78% of the HFE II supervisors indicated they would benefit from a face-to-face meeting at least annually. Supervisor and manager training is discussed in more detail in the Leadership/ Management Skills section of this report.

STAFF NEEDS ASSESSMENT & PLANNING

Strengths

- SEQIS completes the annual CMS-required Surveyor Employment and Training (SET) report which provides detailed information on attendance in CMS training courses, HFEN turnover rates, and projections for future training needs. In addition, monthly updates are provided for L&C management and CMS Benchmark reports.
- The L&C IT Support Division has conducted surveys to assess and plan for IT-related training needs.

Opportunities for Improvement

- There does not appear to be a comprehensive, system-wide effort for assessing staff needs and planning for training for all job classifications.
- Manager and supervisor training needs assessment and planning is limited. This is discussed in detail in the Leadership/Management Skills section of this report.

GAP ANALYSIS Training and Staff Development				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
New Employee Orientation		X		
Staffing Training Needs Assessment		X		
Continuing Education & Training		X		

Table 39 Gap Analysis – Training and Staff Development

18. Employee Satisfaction and Retention

Employee satisfaction is essential to the success of business operations. Statistically, satisfaction and retention are directly related. Meaningful work and the ability to make a difference and a contribution are key aspects of employee satisfaction. Communication, recognition of achievement, and opportunity for growth also contribute to employee job satisfaction. High rates of turnover create higher expenditures for human resources, and ultimately result in a Program with less experienced staff. More time and effort go into training when there is higher turnover, and frustration can lower employee morale.

CDPH conducted an employee survey in October 2012 and again in October 2013. There were 389 L&C Program respondents for the 2013 survey. In addition, CHCQ leaders sent a similar survey in April 2013 with 401 respondents. Results of these surveys will be discussed in this section. Turnover is tracked and reported on a monthly basis for all job classifications/ positions in the L&C Program.

FUTURE VIEW

A high degree of employee satisfaction and a low turnover rate are essential to L&C Program success. Low turnover for L&C will enhance performance and support improved timeliness in meeting Program mandates. In the future, the L&C Program will create an environment where employees at all levels are encouraged to contribute suggestions for improving staff morale and satisfaction. This will be accomplished by a focused, collaborative, and ongoing approach by L&C leaders to address both employee job satisfaction and retention.

CURRENT VIEW

Results for the October 2013 employee survey were sorted for just L&C Program staff. Overall, there were 389 respondents representing a 37% response rate. Of the 389 respondents, 20% were based at headquarters and the remaining were staff based in the district offices, including L.A. County. Longevity with CDPH is described below in Table 40. Nearly one-half of the respondents have worked for CDPH for less than five years.

How long have you been employed with CDPH?	
Less than 1 year	16.4%
1-5 years	32.6%
5-10 years	27.9%
10-15 years	7.3%
15-20 years	7.0%
More than 20 years	8.9%

Table 40 Employee Longevity With CDPH

As described above, there have been several efforts to assess employee satisfaction. It is not evident, however, that there has been an effort to address the findings. In fact, in a recent meeting (April 2014) with the district managers and district administrators representing all L&C district offices (including those in L.A. County), it was reported that survey results had not been

shared with them at all. Specific findings and opportunities for improvement are discussed below.

Turnover statistics are reported on a monthly basis. State fiscal year 2013-2014 details for key Field Operations positions and total L&C Program positions are provided below in Table 41.

Selected Classifications	# of Established Positions	# of Separations 7/1/2013-3/31/2014	Reported Annual Turnover Rate to Date
HFEN	486	105	19.6%
HFE II Supervisor	91	23	25.3%
HFE Manager I (District Administrator)	27	2	7.4%
HFE Manager II (District Manager)	17	4	23.5%
Total: HFEN, HFE II, HFE Manager I and II	**621**	**134**	**20.0%**
AGPA (Associate Government Program Analyst)*	143.5	26	18.1%

Table 41 Statistics on Key L&C Positions *includes Headquarters-based AGPAs

An examination of root causes and specific examples of strength and opportunities for improvement in employee satisfaction and retention is outlined below. Survey results are included where indicated.

Employee Satisfaction and Retention

EMPLOYEE JOB SATISFACTION

Strengths

- CDPH collects survey data on employee satisfaction and retention on a regular basis, and the employee response rate is significant.
- 70% of survey respondents agreed or strongly agreed with the statement "I understand the connection between the department's mission and vision and the work I do."

Opportunities for Improvement

- Interviewees in the field report a culture where there is little recognition of professional success and acknowledgment from headquarters management only when an error occurs.
- Many staff reported feelings of burnout and low morale and not feeling supported by headquarters.
- Less than one-half (48%) of the survey respondents rated the work environment as good or very good. Similarly, less than one-half (48%) rated their job satisfaction as good or very good. While 62% rated their overall satisfaction with their employment at CDPH as good or very good, 17% rated overall satisfaction as poor or very poor.
- The CDPH employee survey could be updated to capture more meaningful and actionable data.

RETENTION/TURNOVER

Strengths

- Turnover data are tracked monthly, and trends are reviewed by Program executives.
- CDPH collects survey data on employee satisfaction and retention on a regular basis, and the employee response rate is significant.
- The Program reports recent implementation of an exit survey to understand reasons staff are leaving.

Opportunities for Improvement

- 18% of the October 2013 L&C survey respondents reported to be "actively seeking employment outside of CDPH."
- The Program does not appear to have a comprehensive retention strategy or succession plan. This may be of significant importance in light of recent survey findings indicating that 65% of the survey respondents are over the age of 50, 58% of all CDPH managers and supervisors are over the age of 50, and 36% of survey respondents report plans to retire within the next five years. Furthermore, only 45% of respondents agreed or

strongly agreed with the statement "CDPH is committed to recruiting and maintaining a workforce that produces high quality public health services."

LEADERSHIP, MANAGEMENT & OVERSIGHT

Strengths

- No notable strengths identified.

Opportunities for Improvement

- A staff retention survey was conducted by L&C Program leaders in the spring of 2013; however there is no evidence of an action plan having been developed by L&C leaders to address the findings. As described above, there is no evidence of planning for follow-up activities or interventions related to either the 2012 or 2013 employee survey findings. In fact, the results have not even been shared with key Program leaders such as the Field Operations district managers.
- Efforts by L&C leadership initiated in FY12-13 to address and understand factors related to employee retention have not yet effectively impacted turnover rates. There is a nearly 20% turnover in HFEN positions and similar turnover rates in district office supervisor and manager positions.
- There are no current processes, programs or initiatives that explicitly seek to create, reinforce, or sustain a strong, congruent culture (refer to Organizational Culture section for more details). However, as of April 2014, L&C reports that the Program has initiated a plan to reduce hiring barriers and improve employee development, recruitment and retention efforts.

GAP ANALYSIS Employee Satisfaction and Retention				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Retention		X		
Employee Job Satisfaction		X		
Leadership, Management, & Oversight	X			

Table 42 Gap Analysis – Employee Satisfaction and Retention

19. Leadership Development and Management Skills

Management is concerned with a focused agenda of tasks, while leadership is for everyone in the organization. The manager's job is to plan, organize and coordinate the resources of the organization such that the task can be successfully completed. Leaders, on the other hand, are charged with inspiring and motivating people to perform the work necessary to successfully reach the organization's goals. As might be obvious, a manager who can also lead – that is, can both organize and inspire – will have a much greater chance of seeing his or her planning successfully implemented.

Leadership means setting the example and building relationships throughout the organization as an example for everyone else. Leaders must be able to take their vision of the future and get everyone else to see that same potential. They must speak the language of the employees, understand their concerns, and exchange ideas. And, they are concerned with creating a climate within their organizations where innovation is encouraged.

Management is defined as the practice of understanding, developing, and deploying people and their skills. The evidence is overwhelming that successful organizations have managers with

well-developed people skills. It is important to understand that management skills are behavioral. This means that these skills are identifiable actions that lead to certain, predictable outcomes. The skills required to be an effective manager, therefore, can be enhanced and developed, and can be observed in others.

FUTURE VIEW

Nothing is more important to an organization's performance than the cultivation of its leaders. Leadership development is recognized as a key attribute of high performing organizations. Likewise, the effectiveness of people management is a major determinant of organizational performance. There is a strong relationship between the effectiveness of how people are managed and employee satisfaction, retention, productivity, and organizational performance.

A high performing organization deploys comprehensive leadership development and management skills training programs. Attributes of these programs include:

- Assessment - to better understand the organization's needs to guide the development of the program.
- Framework - a clearly articulated framework for developing leaders and improving management skills including defining key competencies for leaders and managers.
- Deployment - offering a variety of formal and informal programs and activities focused on developing leaders and enhancing management skills.
- Evaluation - obtaining feedback and designing measurement strategies to determine the effectiveness and value of leadership development and management skills training programs.

CURRENT VIEW

The L&C Program has significant opportunities for improvement in the important areas of leadership development and management skills training. During the more than 200 interviews and countless hours of observation by Hubbert Systems over six months, the need for better

developing, training, and supporting the Program's leaders and managers was a frequently identified opportunity for improvement for the L&C Program. These findings, shown below in Table 43, are supported by the results of an employee survey conducted in October 2013 in which 340 L&C personnel responded.

Employee Survey – October 2013	
Question	**% Agree or Strongly Agree**
My supervisor/manager has clearly communicated performance expectations for my job.	64%
I feel my job performance is objectively evaluated by my supervisor/manager.	57%
I receive acknowledgment from my supervisor/manager when I do a good job.	62%
My supervisor/manager communicates with me on a regular basis.	68%
My supervisor/manager follows through on commitments.	61%
My supervisor/manager disseminates information to me in a timely manner.	61%
My supervisor/manager encourages open dialogue to express ideas and concerns.	62%
My overall relationship with my supervisor/manager is positive.	71%
My supervisor/manager keeps me well informed about my program's goals and objectives.	54%
My supervisor/manager keeps me well informed about progress made towards accomplishing my program's goals and objectives.	52%
My supervisor/manager gives me ongoing feedback and/or coaching to help me improve my performance.	48%

Table 43 Employee Survey – October 2013

Additional analysis was completed on written responses to the following survey questions:

- List one thing that you would like to see changed in your Office, Center, Division, Program, or overall at the Department. (268 respondents)
- If you are actively seeking employment outside of CDPH please tell us why so that we can improve our employee satisfaction and retention. (65 respondents)

- The 21% of respondents who answered “Poor” or “Very Poor,” to the question “What is your overall rating of CDPH’s organizational image?” were asked to “Please tell us what we can do to improve CDPH’s organizational image.”
- The 27% of respondents who answered “Poor” or “Very Poor” to the question “What is your overall rating of the work environment at CDPH?” were asked to “Please tell us what we can do to improve the work environment at CDPH.”

The role of leaders and managers was frequently identified in responses to these questions. In particular, these responses point to the need for initial and ongoing training for L&C leaders and managers. As would be expected, responses to the question, “List one thing that currently works well that you think should be continued in your Office, Center, Division, Program, or overall in the Department” also resulted in a key theme regarding the important role of leaders and managers. When asked to cite that “one thing,” many respondents mentioned their supervisor or manager, sometimes by name.

In March/April 2014 an online survey was conducted by Hubbert Systems that included questions on leadership development and management skills training. A summary of the findings provided in Table 44 below demonstrates the significant number of managers and supervisors who have received no orientation to the role nor any ongoing training and development in leadership and management skills.

Question	Response	HFE II Supervisors (n=49)	District Manager & Administrators (n=28)	HQ Managers (n=15)
Who provided your initial orientation to the HFE Supervisor position/role?	No one, I was on my own	13%	36%	31%
How well did your orientation to the Manager/Supervisor role prepare you for the job?	Not very well, not well at all No orientation provided	43% 8%	18% 36%	27% 33%
Before or after the New Supervisor Training (Cal HR course), who provided additional mentoring or training on personnel processes and issues?	No one, I was on my own	33%	33%	61%
What Leadership Development training and/or mentoring programs have you participated in since becoming Manager/Supervisor?	None	45%	46%	50%
What Management Skills training (such as Decision Making, Delegation, Planning & Goal Setting, and Building Effective Teams) have you participated in since becoming a Manager/Supervisor?	None	53%	64%	64%

Table 44 Survey Responses on Leadership Development and Management Skills Training

An examination of root causes, best practices, and specific areas where recent improvements have been made in leadership and management skills development is outlined below. Survey results are included where indicated.

Leadership Development and Management Skills

ASSESSMENT

Strengths

- In preparation for submitting an application for PHAB accreditation, CDPH developed a Workforce Development and Succession Plan in October 2013.

Opportunities for Improvement

- While the CDPH plan does include a focus on leadership development and management competencies, it does not appear to include assessment activities to determine specific needs.
- The length of time it takes to fill key management positions makes a comprehensive succession plan of the utmost importance for the CDPH L&C Program.

FRAMEWORK

Strengths

- Leadership development has been provided to some CDPH leaders in recent years. A new competency-based training program was launched in March 2014. This training has been customized for CDPH and is made up of select classes from the CSUS, CCE Portfolio, Leadership for the Government Manager, and Leadership for the Government Executive. The selected classes complement the previous leadership program that was provided.
- The Workforce Development and Succession Plan includes a deliverable of providing leadership development training to 50 employees by June 2015. In addition, a pilot mentorship program is planned for implementation in June 2014.

Opportunities for Improvement

- The Program lacks a documented executive competency model and no formalized leadership development program currently exists. There is a lack of clearly defined competencies and standards expected of managers and supervisors. CDPH deliverables

outlined in the Workforce Development and Succession Plan mentioned above include developing a competency framework by December 2014.

DEPLOYMENT

Strengths

- CHHS and CDPH offer leadership development programs to improve the skills of program supervisors, managers and executives
- Between 2011 and 2013, 14 L&C leaders attended a leadership development program that included individual assessments, 22 hours of classroom training, and 3 one-hour coaching sessions. Two of the participants were district managers and the remaining were headquarters-based senior leaders.
- Four headquarters-based L&C managers are currently enrolled in the new CDPH leadership development program that includes individual assessments, 56 hours of classroom training, and 2 one-hour coaching sessions.

Opportunities for Improvement

- Many managers and supervisors report receiving no training after being promoted. This was supported by the results of an online survey conducted in March/April 2014 as described above.
- State regulations require that new supervisors are to be provided with a minimum of 80 hours of basic supervision training within the term of their probationary period or within 12 months of appointment. At least 40 hours of this training must be structured training, provided by a qualified instructor. Topics included are the role of the supervisor; techniques of supervision, planning, organizing, staffing, and controlling; performance standards and appraisal; civil rights, discipline, labor relations, and grievances. Up to 40 hours may be provided on the job by a qualified higher level supervisor or manager. CDPH tracks attendance in this training and as of April 2014 the L&C Program has a 40.9% compliance rate.

EVALUATION

Strengths

- The CDPH Workforce Development and Succession Plan describes an approach to evaluation that involves assigning each of the 12 deliverables to an "owner" who will be responsible for establishing evaluation criteria, taking action to ensure tasks are completed on schedule, and engaging internal and external stakeholders as needed.

Opportunities for Improvement

- While there is an evaluation plan for the Workforce Development and Succession Plan, the scope, impact, and timeframe for both deployment and evaluation are very limited and unlikely to have a significant impact on the L&C Program in the near future.

GAP ANALYSIS **Leadership Development & Management Skills**				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Assessment	X			
Framework		X		
Deployment		X		
Evaluation		X		

Table 45 Gap Analysis – Leadership Development & Management Skills

20. Organizational Culture

Organizational culture can be defined as shared values (what is important) and norms (how things work) that interact with an organization's structures and control systems to produce behavior (the way we do things around here). Underlying assumptions and beliefs, shared by members of an organization, are reflected in values, which in turn, result in observable behaviors – learned responses to forces in both the external and internal environment that allow an organization to adapt and survive.

Culture guides how employees think, act, and feel, and it is at the core of what drives how an organization operates. Individuals, groups, and teams are all influenced by the context in which they perform, and organizational culture provides that context. The culture of an organization sends signals, explicit or implicit, about what is important, about what is valued, how issues should be managed, and how relationships among colleagues should be managed. It influences people's ideas about appropriate goals, practices, standards of behavior and expectations.

FUTURE VIEW

A culture characterized by continuous learning and active collaboration contributes to improved organizational performance and requires a strong emphasis on empowerment, autonomy, and risk taking. Aspects of an effective organizational culture for the L&C Program are described below.

- Customer Results Focus: In a results-focused approach, emphasis is placed on defining the results employees are expected to produce or the outcomes they are responsible for influencing. This approach will require a high level of involvement on the part of L&C Program management. The Program's vision will be defined, and ways to measure how well the needs of the customer and key stakeholders are being met will be developed. Then, all L&C employees will set goals that support the vision, either directly or indirectly, and will be held accountable for meeting those goals.
- Accountability: A culture of accountability is one where people demonstrate high levels of ownership to think and act in the manner necessary to achieve organizational results. At every level of the L&C Program, staff will be personally committed to achieving key results targeted by their team or the Program leaders. They will work continually to find answers, develop solutions, and overcome obstacles. In a high performance organization team members are individually accountable to each other and mutually accountable to their customers. When the L&C Program leaders and managers routinely hold themselves and their staff accountable for results the Program will experience

greater accuracy of work, better response to role obligations, more vigilant problem solving, better decision making, more cooperation and collaboration, and higher team satisfaction.

- Trust: Trust can be understood from both an external and internal perspective. From an external perspective, social trust is the role that trust plays in our interactions with others. From an internal perspective, psychological safety is the feeling that we can be safe in being sincere and honest with others. Both of these forms of trust are characteristic of what is termed a "just culture" - an organizational culture that balances non-punitive practices with shared accountability, founded in social trust. The L&C Program will create a culture that fosters improvements in performance and outcomes. L&C will be characterized by a culture of support where individuals feel they have a chance to succeed.
- Teamwork: Every organization's success is dependent upon its members working together cohesively and effectively. The L&C Program will develop a culture where staff work together effectively and share a common understanding of values and priorities. L&C staff will act with care, consistency, and purpose in a conscientious and purposeful manner with each other in their contributions to the common goal. Moreover, supportive social interaction among L&C staff will foster organizational relationships that facilitate important knowledge-sharing and higher levels of commitment and job satisfaction among members.
- Change and Learning: A learning organization acquires knowledge and innovates fast enough to survive and thrive in a rapidly changing environment. The L&C Program will create a culture that encourages and supports continuous employee learning, critical thinking, and risk taking with new ideas; allows mistakes and values employee contributions; learns from experience and experimentation; and readily disseminates new knowledge throughout the organization for incorporation into day-to-day activities. To sustain a vibrant and effective culture, the L&C Program will embrace an approach that includes periods of action that are complemented by periods of reflection involving

time to talk to one another, identify and solve problems, and share knowledge. These action and reflection cycles will support a collaborative culture of continual learning for the L&C Program.

CURRENT VIEW

There are no current processes, programs or initiatives that explicitly seek to create, reinforce, or sustain a strong, congruent culture. Many staff reported feelings of burnout and low morale. L&C's Workforce Satisfaction survey results indicate the lack of a positive culture. In an employee survey conducted in October 2013, only 48% of the 362 L&C respondents rated strengths and opportunities for improvement for the L&C Program's organizational culture.

Organizational Culture

CUSTOMER & RESULTS FOCUS

Strengths

- L&C employees generally possess strong technical expertise, extensive content knowledge, and a desire to serve. Overwhelmingly, the depth and breadth of staff subject matter knowledge and expertise were cited as a key strength of the Program.
- There is widespread clarity and commitment to L&C's mission. In a district manager/ district administrator survey, 86% agree/strongly agree with the statement "I know my organization's mission (what it is trying to accomplish)." Likewise, 70% of the 376 L&C respondents in a 2013 employee survey agreed with the statement "CDPH clearly conveys its mission, goals and objectives."

Opportunities for Improvement

- As described in the Strategic Planning section of this report, the Program has not articulated a clearly defined vision that addresses the needs of its key customers and stakeholders.
- Employees want to be responsive to the needs of the populations they serve, but many report having difficulty translating the notion of "collaboration" to the activities and

obligations of government regulation. During the interviews with district office management teams, many references were made to the importance of being "enforcement-minded" as a key characteristic of the Program and a critical success factor.

- There is no evidence of a comprehensive and systematic assessment of the needs of L&C customers and key stakeholders.

ACCOUNTABILITY

Strengths

- No notable strengths identified.

Opportunities for Improvement

- Several interviewees, including both L&C staff and external stakeholders, described the Program's district offices as "fiefdoms" with little standardization or accountability.
- A survey conducted as part of a leadership training course in 2012 included accountability as a team performance indicator. 45% of the respondents agreed that "All members of the team are held accountable to high standards for performance and behavior." Similar findings were revealed during the interviews, observation and record review aspects of this assessment.
- In June 2012 the CDPH Human Resource Branch established the Performance Management Unit (PMU) to improve efficiency and provide better services. The PMU is responsible for providing consultation services to the Department's supervisors and managers on all matters relating to employee performance, conduct and discipline. However, numerous supervisors and managers at both headquarters and in the district offices reported a lack of support in dealing with employee performance issues including implementing progressive discipline measures and rejecting an employee on probation. When presented with this feedback, CDPH senior leadership acknowledged the feedback and noted that there is also a need to emphasize with managers the need for timely documentation of employee performance issues.

TRUST

Strengths

- No notable strengths identified.

Opportunities for Improvement

- Many L&C employees, including management staff, describe a culture characterized by a strong sense of hierarchy, blame, and distrust.
- Interviewees in most of the district offices report a culture where there is little recognition of professional success and acknowledgment from headquarters management only when an error occurs. Consequently, many of the managers and supervisors in the field do not feel supported by headquarters. These findings were validated in interviews conducted for this assessment as well as in many of the comments recorded in the October 2013 employee survey.

TEAMWORK

Strengths

- Good teamwork was overwhelmingly cited as a strength among the staff at the majority of district offices.

Opportunities for Improvement

- In an employee survey conducted in October 2013, only 57% of the 358 L&C respondents agreed with the statement “I feel valued as a team member.”
- Opportunities for improvement in communication and collaboration are discussed in detail in a previous section of this report.

CHANGE AND LEARNING

Strengths

- No notable strengths identified.

Opportunities for Improvement

- The Program is limited in its use of performance review findings to develop priorities for continuous improvement and innovation. The lack of an enterprise-wide performance measurement and management system prevent the management team from setting priorities for improving performance. This is discussed in detail in the Performance Management section of this report.
- L&C personnel at headquarters and in the district offices frequently describe an environment where innovative solutions are dismissed without consideration. In an employee survey conducted in October 2013, only 39% of the 363 L&C respondents agreed with statement "CDPH currently has a pervasive culture that focuses on continuous quality improvement." This is discussed in detail in the Performance Improvement Capabilities section of this report.
- The L&C Program does not always respond quickly and adapt to change. For example, there has been no training or evaluation of work processes in consideration of the shift to Electronic Medical Records (EMRs) among health care facilities. There is no evidence of comprehensive evaluation and planning for changes related to implementation of the Affordable Care Act.

GAP ANALYSIS **Organization Culture**				
Subject Area	**No Evidence of Defined Approach or Implementation**	**Isolated Examples But No Program-Wide Approach**	**Early Program-Wide Approach**	**Aligned & Integrated Program-Wide Approach**
Customer Focused Results		X		
Accountability	X			
Trust	X			
Evaluation		X		
Change and Learning	X			

Table 46 Gap Analysis – Organizational Culture

APPENDIX A: Interview Participants

Interview Participants

L&C Organizational Assessment Data Collection

Interviews	
40+ Headquarters Managers and Staff Director, Chief Deputy Directors Deputy Director, Assistant Deputy Director All Branch Chiefs Manager I and IIs L&C Analysts ITSD Managers & Staff **100+ Managers and Staff during 14 District Office Site Visits** District Managers, District Administrators Supervisors Nurse Evaluators (HFENs) Analysts (AGPAs) Support Staff LA County Management Team	**Stakeholders & Partners** Centers for Medicare & Medicaid Services Region IX Management Team California Association of Health Facilities (CAHF) California Advocates for Nursing Home Reform (CANHR) California Hospital Association (CHF) University of California San Francisco (UCSF) Nursing Health Policy Professor AHCA (American Health Care Association) State Ombudsman Office of Statewide Health Planning & Development (OSHPD) CalOSHA Department of Justice (DOJ) Bureau of Medi- Cal Fraud & Elder Abuse

APPENDIX B: Observation Activities

L&C Organizational Assessment Data Collection
Observation
Numerous meetings at Headquarters and in District Offices including Branch Chief Meetings, Field Operations Branch Chief Meetings, Quarterly, Department Manager & Supervisor Meeting, DA/DM Quarterly Face-to-Face meetings and Monthly Teleconferences
Training Sessions for HFENs and DO Supervisors & Managers, SPSS Webinar
Nursing Home Complaint Investigation
Quarterly Advocacy Meetings - Long Term Care, Home Health & Hospice, Clinics
IT Applications (in use and demos): Electronic Licensing Management System (ELMS), Automated Survey Processing Environment (ASPEN), Time Entry and Activity Management (TEAM), CMS Certification And Survey Provider Enhanced Reports (CASPER), CMS Nursing Home Compare
California Assembly & Senate hearings

APPENDIX C: Review of L&C Documents

L&C Organizational Assessment Data Collection

Document Review	
CDPH and L&C website L&C Briefing Documents	Consultant Reports
CMS Mission & Priority Document CMS Benchmark Reports	L&C Policies & Procedures
CMS State Performance Standards (SPSS) Reports	CDPH Strategic Plan & Performance Improvement Plan (2013)
Bureau of State Audit Reports and Action Plans	CDPH Internal Operations & Performance Plan (2013)
Recruitment & Retention Reports	Work Environment & Staff Satisfaction Survey Results
Hiring Roles & Responsibilities (including timeliness data)	Budget Estimate & Fee Reports
CMS Tier 2 2014 Summary Weekly Reports	PCB Aide and Technician Certification Section Workload & Performance Reports
Complaint Validation/EMTALA workload reports	PCB Investigation Section tracking logs, reports, and Complaint Backlog Action Plan
Citation Tracking Logs & Reports SNF Intake	CHCQ 2013 Accomplishments
Monitoring Reports Surveys Not in an AEM Case	Field Operations Facility Complaint Action Backlog Action Plan
report CMS Benchmark Work plan #3 CMS	Complaint/Entity Reported Incident tracking log
Benchmark Work plan #4	District Office Meeting Worksheet
Tier I Master Summary for FFY 2012-2013 Tier II master	11 GAO Studies on Variation in SSA Findings (1999-2011)
Summary FFY 2012-2013	Academic Studies : Variation in the Use of Federal and State Civil Money Penalties for Nursing Homes, Five-Star Health Inspections Survey Domain: Within-State Variation in Health Inspection Ratings, The Effects of Regulation and Litigation on a Large For-Profit Nursing Home Chain
Summary report for FFY 2012-2013 for complaint validations, full validations, and EMTALA surveys	DA/DM Academy Needs Assessment
HAI Program Strategy Map & Performance Management Plan	Licensing and Certification Position Stats - Classification (including Vacancy Report)
Final 2013 MPD from CMS	Recruitment & Retention Reports
2013 Final workload spreadsheet and Final 2013 Expenditure Calculation Worksheet	
2013 Quarterly and Cumulative Reports submitted to CMS	
RAES Recurring Assignment Log CHCQ Personnel Liaison Unit	
CHCQ Staff Retention Survey	

APPENDIX D: Baldrige Performance Excellence Assessment

Performance Excellence Assessment

Leadership					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
I know my organization's mission (what it is trying to accomplish).					
I know my organization's vision (where it is trying to go in the future).					
Senior leaders understand what I do and consider the impact of their decisions.					
Senior leaders create a work environment that helps me do my job.					
My organization's leaders share information about the organization.					
My organization asks what I think.					

Strategic Planning					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
My organization is proactive.					
As it plans for the future, my organization asks for my ideas.					
My organization encourages totally new ideas (innovation).					
I know the parts of my organization's plans that will affect me and my work.					
I know how to tell if we are making progress on my work group's part of the plan.					
My organization is flexible and can make changes quickly when needed.					

Customer Focus					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
I know who my most important customers are.					
I regularly ask my customers what they need and want.					
I ask if my customers are satisfied or dissatisfied with my work.					
I am allowed to make decisions to solve problems for my customers.					
I also know who my organization's most important customers are.					

Measurement, Analysis, and Knowledge Management					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
I know how to measure the quality of my work.					
I can use this information to make changes that will improve my work.					
I know how the measures I use in my work fit into the organization's overall measures of improvement.					
I get all the important information I need to do my work.					
I know how my organization as a whole is doing.					

Workforce Focus					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
The people I work with cooperate and work as a team.					
My manager(s) encourage me to develop my job skills so I can advance in my career.					
I am recognized for my work.					
I have a safe workplace.					
My manager(s) and my organization care about me.					

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
I am committed to my organization's success.					
Operations Focus					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
I can get everything I need to do my job.					
We have good processes for doing our work.					
I have control over my work processes					
Policies and procedures are current, easy to understand and available to me.					
Results					
	Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
My work products meet all requirements.					
My customers are satisfied with my work.					
My organization has the right people and skills to do its work.					
My organization removes things that get in the way of progress.					
My organization practices high standards and ethics.					
My organization is a good place to work.					

APPENDIX E: Gap Analysis Surveys

HQ Managers & Supervisors

Initial Orientation

#	Questions	Possible Responses				
1	I know my organization's mission (what it is trying to accomplish).	A designated Mentor	Another Supervisor	No one- I was on my own	Other	
2	I know my organization's vision (where it is trying to go in the future).	Very well	Somewhat well	Not very well	Not well at all	n/a – no orientation provided
3	Senior leaders understand what I do and consider the impact of their decisions.	DA or DM	A designated mentor	Another Supervisor	No one – I was on my own	Other
4	Senior leaders create a work environment that helps me do my job.	Free Text				

Ongoing Training

		Possible Responses				
5	How do you receive information on updates and changes that impact your Section or Unit? (check all that apply)	Written memos	Email	Staff Meeting	Word of Mouth	I don't consistently receive updates
6	Who is your primary source for receiving training on changes, updates, and new issues?	Branch Chief	Another Manager or Supervisor	No one- I'm mostly on my own	Other	
7	How useful do you find training webinars?	Very useful	Somewhat useful	Not very useful	Not useful at all	N/A – don't or haven't participated
8	How could training for Managers/ Supervisors on updates and changes be improved?	Free Text				

Leadership Development & Management Skills						
		Possible Responses				
9	What Leadership Development training and/or mentoring programs have you participated in since becoming a Manager or Supervisor?	Programs offered by L&C	Programs offered by CDPH	State (calHR) programs	Outside Programs (sponsored by CDPH)	None
10	What Management Skills training (such as Decision Making, Delegation, Planning & Goal Setting, Building Effective Teams) have you participated in since becoming an Manager or Supervisor?	Programs offered by L&C	Programs offered by CDPH	State (calHR) programs	Outside Programs (sponsored by CDPH)	None
11	What other suggestions do you have related to improving training for Managers and Supervisors?	Free Text				

Gap Analysis Surveys

CDPH L&C HFE II Supervisors

Initial Orientation

#	Questions	Possible Responses				
1	Who provided your initial orientation to the HFE Supervisor position/role?	A designated Mentor	Another Supervisor	No one- I was on my own	Other	n/a – no orientation provided
2	How well did your orientation to the HFE Supervisor role prepare you for the job?	Very well	Somewhat well	Not very well	Not well at all	n/a – no orientation provided
3	Before or after the New Supervisor Training (Cal HR course), who provided additional mentoring or training on personnel processes and issues?	DA or DM	A designated mentor	Another Supervisor	No one – I was on my own	Other
4	Would you recommend a face-to-face Academy for HFE Supervisor orientation?	Yes	No	Not Sure		
5	Is there a formal or structured mentoring program for new HFE Supervisors in your District Office?	Yes	No	Not Sures		
6	Who reviews/reviewed your written work during your first year as a HFE Supervisor?	DA or DM	A designated mentor	Another supervisor	No one – I was on my own	Other
7	Who provided training on using ASPEN in your HFE Supervisor role? (check all that apply)	DA or DM	A designated mentor	Another Supervisor	No one – I was on my own	Other
8	How well did the ASPEN training prepare you to use the software?	Very well	Somewhat well	Not very well	Not well at all	No training received
9	How could orientation for new HFE Supervisors be improved?	Free Text				

Gap Analysis Surveys

CDPH L&C HFE II Supervisors

Ongoing Training

#	Questions	Possible Responses				
10	How useful do you find the HFE Supervisor Academy in providing updates and ongoing training?	Very useful	Somewhat useful	Not very useful	Not useful at all	N/A (don't or haven't participated)
11	How often would recommend having an HFE Supervisor Academy for updates and training?	Yearly	Twice a year	Quarterly	Not at all	Not Sure
12	Would you be interested in attending a virtual HFE Supervisor Academy?	Yes	No	Not Sure		
13	Who do you go to for guidance? (check all that apply)	DA or DM	Headquarters	Another Supervisor	No one – I'm mostly on my own	Other
14	How do you receive information on updates and changes to survey processes? (check all that apply)	Reading the AFLs	Reading S&C Letter	Reading updates to the DOM	District Office Meetings	Word of Mouth
15	Who is your primary source for receiving training on changes and updates, changes and new issues?	DA/DOM	Headquarters	Another Supervisor		I don't generally receive updates
16	How useful do you find the training webinars ?	Very useful	Somewhat useful	Not very useful	Not useful at all	N/A (don't or haven't participated)
17	How could training for HFE Supervisors on updates and changes be improved?	Free Text				

Gap Analysis Surveys

CDPH L&C HFE II Supervisors

	Leadership Development & Management Skills					
#	Questions	Possible Responses				
18	What Leadership Development training and/or mentoring programs have you participated in since becoming an HFE Supervisor?	Programs offered at my District Office	Programs offered by Headquarters	State (calHR) programs	Outside Programs (sponsored by CDPH)	None
19	What Management Skills training (such as Decision Making, Delegation, Planning & Goal Setting, Building Effective Teams) have you participated in since becoming an HFE Supervisor?	Programs offered at my District Office	Programs offered by Headquarters	State (calHR) programs	Outside Programs (sponsored by CDPH)	None
20	What other suggestions do you have related to improving training for HFE Supervisors?	Free Text				
	IT Systems					
#	Questions	Possible Responses				
21	The speed of the ASPEN system is a major barrier to completing my work.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
22	Overall, I am satisfied with how easy it is to use the ASPEN system.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

Gap Analysis Surveys

CDPH L&C HFENs

	Initial Orientation (First Year)					
#	Questions	Possible Responses				
1	When did you complete the New Surveyor Academy?	2012-2013	2010-2011	2007-2009	2006-2000	Prior to 2000
2	How many surveys did you observe or participate in prior to attending the first week of the New Surveyor Academy?	0	1-2	3-4	5 or more	
3	How many complaint investigations did you observe or participate in prior to attending the first week of the New Surveyor Academy?	0	1-2	3-4	5 or more	
4	About how long was if from your hire date to attending the first week of the New Surveyor Academy?	Less than 6 weeks	6-8 weeks	2-3 months	3-4 months	More than 4 months
5	The amount of time spent in New Surveyor Academy training (3 weeks) was	Too long	Just right	Too short		
6	How well did the New Surveyor Academy prepare you for the LTC SMQT course?	Very well	Somewhat well	Not very well	Not well at all	N/A (not yet taken the SMQT course)
7	How many surveys and/or complaint investigations did you observe or participate in by the end of the 3rd New Surveyor Academy session?	0-4	5-7	8-10	More than 10	
8	Who provided training on using ASEQ? (check all that apply)	Training Supervisor	Supervisor	Another HFEN	Analyst (AGPA)	Headquarters IT Staff
9	How well did the ASEQ training adequately prepare you to use the software to document your surveys?	Very well	Somewhat well	Not very well	Not well at all	No training received
10	Do you have a Training Supervisor at your District Office?	Yes	No	Don't Know		
11	If no Training Supervisor, who do/did you go to for guidance?	Supervisor	My Mentor	Another HFEN who is available at the time	No one is typically available	N/A

Gap Analysis Surveys

CDPH L&C HFENs

#	Questions	Possible Responses				
12	How many surveys did the Training Supervisor go out with you on?	0	1-2	3-4	5 or more	N/A
13	Who reviews/reviewed your written work during your first year as a HFEN?	Training Supervisor	My mentor	Another HFEN who is available at the time	Often, there is no one available	
14	Is there a formal or structured mentoring program for new HFENs in your District Office?	Yes	No	Don't Know		
	Ongoing Training					
#	Questions	Possible Responses				
15	How do you receive information on updates and changes to survey processes? (Check all that apply.)	Reading the AFLs & S&C Letters	Reading updates to the DOM	District Office Meetings	Word of Mouth	I don't consistently receive updates
16	Who is your primary source for receiving training on changes and updates, changes and new issues?	Training Supervisor	Supervisor	Analyst (AGPA)	Another HFEN	I don't consistently receive updates
17	How useful do you find the training webinars?	Very useful	Somewhat useful	Not very useful	Not useful at all	N/A (don't or haven't participated)
18	How often does your Supervisor observe or participate in a survey or complaint investigation with you?	More than once each year	Once each year	Every 2 years	Rarely	Never
19	How could training on updates and changes be improved?	Free Text				
20	What other suggestions do you have related to improving training for HFENs?	Free Text				

Gap Analysis Surveys

CDPH L&C HFENs

IT Systems

#	Questions	Possible Responses				
21	Do you take a tablet or laptop with you when conducting an on-site facility survey?	Yes	No	N/A No Response		
22	If you answered "NO" to question #21 above, please indicate the reason. (check all that apply)	Not permitted	Too heavy	Applications not available	No internet Access	Other
23	Would you like to use mobile technology (tablet, laptop, iPad) when conducting an onsite facility survey?	Yes	No	N/A No Response		
24	If you answered "YES" to question #234 above, how would you use it?	Free Text				
25	If you answered "NO" to question #23 above, please indicate the reason.	Free Text				
26	Would you like to have the SOM on your laptop or tablet?	Yes	No	Not Sure		
27	What other applications or information would be useful if placed on your tablet or laptop?	Free Text				
28	What other hardware or software would be helpful in completing your work?	Free Text				
29	The speed of the ASPEN (ASE-Q) system is a major barrier to completing my work.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
30	Overall, I am satisfied with how easy it is to use the ASPEN (ASE-Q) system.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

Gap Analysis Surveys

CDPH L&C District Office Analyst

Initial Orientation (First Year)						
#	Questions	Possible Responses				
1	When did you start in your current role?	2012-2013	2010-2011	2007-2009	2006-2000	Prior to 2000
2	Did you receive orientation to your role?	Yes	No			
3	If yes, how was it provided?	Formal training (classroom, webinars, online)	On the Job Training by a designated mentor	On the Job Training by another person in my District Office	On the Job Training by someone at HQ or another District Office	N/A: I did not receive any initial orientation
4	How well did your initial orientation prepare you to do your job?	Very well	Somewhat well	Not very well	Not well at all	N/A: I did not receive any initial orientation
5	Who provided training on using OSCAR, ASPEN and/or ELMS? (check all that apply)	A designated mentor	Another person in my District Office	Someone at headquarters or another District Office		N/A I did not receive training on ASPEN or ELMS
6	How well did the OSCAR, ASPEN and/or ELMS training adequately prepare you to use the software to complete your work?	Very well	Somewhat well	Not very well	Not well at all	No training received
7	Is there a formal or structured mentoring program for in your District Office?	Yes	No	Don't Know		
8	Describe any additional initial training you received.	Free Text				
9	What can L&C do to improve new employee training for analyst?	Free Text				

Gap Analysis Surveys

CDPH L&C District Office Analyst

	Ongoing Training					
#	Questions	Possible Responses				
10	How do you receive information on updates and changes that impact your work? (check all that apply)	Formal training programs(classroom, webinar, online)	Reading the AFLs, S&C Letters, DOM Updates	Emails from Headquarters	District Office Meetings	Word of Mouth
11	Who is your primary source for receiving training on changes and updates, changes and new issues?	A designated mentor	Another person in my District Office	Someone at HQ or another District Office	Word of Mouth	I don't generally receive training on updates and changes
12	How useful do you find the training webinars ?	Very useful	Somewhat useful	Not very useful	Not useful at all	N/A (don't or haven't participated)
13	How could training on updates and changes be improved?	Free text				
14	What other suggestions do you have related to improving ongoing training for analysts?	Free text				
	IT Systems					
#	Questions	Possible Responses				
15	The speed of the ASPEN system is a major barrier to completing my work.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
16	Overall, I am satisfied with how easy it is to use the ASPEN system.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
17	What other hardware or software would be helpful in completing your work?	Free text				
18	What changes could L&C make to IT systems that would significantly improve the effectiveness and efficiency of your work?	Free text				

Gap Analysis Surveys

CDPH L&C District Office Analyst

	Work Environment					
		Strongly Disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
19	We have adequate Analytical Staff to accomplish the required workload at my District Office.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
20	We have the equipment and supplies needed to complete our work effectively and efficiently.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
21	If you answered "Disagree" or "Strongly Disagree" to Question #20, please specify what equipment or supplies are needed.	Free text				
22	I am treated with respect as a valued member of the team.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
23	Please describe additional issues, challenges, and barriers that impact your ability to complete your work in an effective and efficient manner.	Free text				

Gap Analysis Surveys

CDPH L&C District Managers and Administrators

Initial Orientation (First Year)						
#	Questions	Possible Responses				
1	Who provided your initial orientation to the District Manager/ Administrator position/role?	My Manager	My Peers	No on – I was on my own	Other (please specify)	
2	How well did your orientation to the District Manager/ Administrator role prepare you for the job?	Very well	Somewhat well	Not very well	Not well at all	No training received
3	Before or after the New Supervisor Training (Cal HR course), who provided additional mentoring or training on personnel processes and issues?	My Manager	My Peers	No on – I was on my own	Other (please specify)	
4	How could initial orientation for new District Managers and District Administrators be improved?	Free Text				
Work Environment						
#	Questions	Possible Responses				
5	How do you receive information on updates and changes to survey processes	Reading the AFLs	Reading the S&C Letters	Reading updates to the DOM	DA/DM Meetings	Word of Mouth
6	Who is your primary source for receiving training on changes, updates and new issues?	My Manager	My Peers	No on – I was on my own	Other (please specify)	
7	How useful do you find the training webinars	Very useful	Somewhat useful	Not very useful	Not useful at all	N/A (don't or haven't participated)
8	How could training for District Managers / Administrators on updates and changes be improved	Free Test				

Gap Analysis Surveys

CDPH L&C District Managers and Administrators

	Leadership Development & Management Skills					
#	Questions	Possible Responses				
9	What Leadership Development training and/or mentoring programs have you participated in since becoming a District Manager / Administrator?	Programs offered at my District Office	Programs offered by Headquarters	State (calHR) programs	Outside Programs (sponsored by CDPH)	None
10	What Management Skills training (such as Decision Making, Delegation, Planning & Goal Setting, Building Effective Teams) have you participated in since becoming a District Manager / Administrator?	Programs offered at my District Office	Programs offered by Headquarters	State (calHR) programs	Outside Programs (sponsored by CDPH)	None
11	What other suggestions do you have related to improving training for District Managers / Administrators?	Free Text				
	IT Systems					
#	Questions	Possible Responses				
12	The speed of the ASPEN system is a major barrier to completing my work.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
13	Overall, I am satisfied with how easy it is to use the ASPEN system.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

Gap Analysis Surveys

CDPH L&C Field Operations – Support Staff

Initial Orientation (First Year)

#	Questions	Possible Responses				
1	When did you start in your current role?	2012-2013	2010-2011	2007-2009	2006-2000	Prior to 2000
2	Did you receive orientation to your role?	Yes	No			
3	If yes, how was it provided?	Formal training (classroom, webinars, online)	On the Job Training by a designated mentor	On the Job Training by another person in my District Office	On the Job Training by someone at HQ or another District Office	N/A I did not receive any initial orientation
4	How well did your initial orientation prepare you to do your job?	Very well	Somewhat well	Not very well	Not well at all	N/A I did not receive any initial orientation
5	Who provided training on using OSCAR, ASPEN and/or ELMS? (check all that apply)	A designated mentor	Another person in my District Office	Someone at headquarters or another District Office		N/A I did not receive training on ASPEN or ELMS
6	How well did the OSCAR, ASPEN and/or ELMS training adequately prepare you to use the software to complete your work?	Very well	Somewhat well	Not very well	Not well at all	No training received
7	Is there a formal or structured mentoring program for in your District Office?	Yes	No	Don't Know		
8	Describe any additional initial training you received.	Free Text				
9	What can L&C do to improve new employee training for analyst?	Free Text				

Gap Analysis Surveys

CDPH L&C Field Operations – Support Staff

	Ongoing Training					
#	Questions	Possible Responses				
10	How do you receive information on updates and changes that impact your work? (check all that apply)	Formal Training Programs (classroom, webinar, online)	Reading the AFLs, S&C Letters, DOM Updates	Emails from Headquarters	District Office Meetings	Word of Mouth
11	Who is your primary source for receiving training on changes and updates, changes and new issues?	A designated mentor	Another person in my District Office	Someone at headquarters or another District Office	Word of Mouth	I don't generally receive training on updates and changes
12	How useful do you find the training webinars ?	Very useful	Somewhat useful	Not very useful	Not useful at all	N/A (don't or haven't participated)
13	How could training on updates and changes be improved?	Free text				
14	What other suggestions do you have related to improving ongoing training for analysts?	Free text				
	IT Systems					
#	Questions	Possible Responses				
15	The speed of the ASPEN system is a major barrier to completing my work.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
16	Overall, I am satisfied with how easy it is to use the ASPEN system.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
17	What other hardware or software would be helpful in completing your work?	Free text				
18	What changes could L&C make to IT systems that would significantly improve the effectiveness and efficiency of your work?	Free text				

Gap Analysis Surveys

CDPH L&C Field Operations – Support Staff

Work Environment

#	Questions	Possible Responses				
19	We have adequate Analytical Staff to accomplish the required workload at my District Office.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
20	We have the equipment and supplies needed to complete our work effectively and efficiently.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
21	If you answered "Disagree" or "Strongly Disagree" to Question #20, please specify what equipment or supplies are needed.	Free text				
22	I am treated with respect as a valued member of the team.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
23	Please describe additional issues, challenges, and barriers that impact your ability to complete your work in an effective and efficient manner.	Free text				

Gap Analysis Surveys

CDPH L&C District Office Support Staff Supervisors

	Initial Orientation (First Year)					
#	Questions	Possible Responses				
1	Who provided your initial orientation to the Supervisor position/role?	My Manager	My Peers	No on – I was on my own	Other (please specify)	
2	How well did your orientation to the Supervisor role prepare you for the job?	Very well	Somewhat well	Not very well	Not well at all	No training received
3	Before or after the New Supervisor Training (Cal HR course), who provided additional mentoring or training on personnel processes and issues?	My Manager	My Peers	No on – I was on my own	Other (please specify)	
4	How could initial orientation for new Supervisors be improved?	Free Text				
	Work Environment					
#	Questions	Possible Responses				
5	How do you receive information on updates and changes to survey processes	Reading the AFLs	Reading the S&C Letters	Reading updates to the DOM	DA/DM Meetings	Word of Mouth
6	Who is your primary source for receiving training on changes, updates and new issues?	My Manager	My Peers	No on – I was on my own	Other (please specify)	
7	How useful do you find the training webinars	Very useful	Somewhat useful	Not very useful	Not useful at all	N/A (don't or haven't participated)
8	How could training for Supervisors on updates and changes be improved	Free Test				

Gap Analysis Surveys

CDPH L&C District Office Support Staff Supervisors

	Leadership Development & Management Skills						
#	Questions	Possible Responses					
9	What Leadership Development training and/or mentoring programs have you participated in since becoming a Supervisor?	Programs offered at my District Office	Programs offered by Headquarters	State (calHR) programs	Outside Programs (sponsored by CDPH)	None	
10	What Management Skills training (such as Decision Making, Delegation, Planning & Goal Setting, Building Effective Teams) have you participated in since becoming a Supervisor?	Programs offered at my District Office	Programs offered by Headquarters	State (calHR) programs	Outside Programs (sponsored by CDPH)	None	
11	What other suggestions do you have related to improving training for Supervisors?	Free Text					
	IT Systems						
#	Questions	Possible Responses					
12	The speed of the ASPEN system is a major barrier to completing my work.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	
13	Overall, I am satisfied with how easy it is to use the ASPEN system.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	

APPENDIX F: Region IX FY13 State Performance Review Draft Results

RO-IX FY 2013 End-of-Year State Performance Review *DRAFT* Results

Scheduled	(As of 4/30/2013 Revision Admin Info: 13-02.02)	Arizona	California	Hawaii	Nevada			
01/05/2014	Reports to be run for measures F1, F2, F3, F4, Q7	01/06/2014	01/06/2014	01/06/2014	01/06/2014			
02/07/2014	Date RO sends DRAFT Reports to SA for review		02/05/2014					
02/21/2014	Date SA sends comments/POC for DRAFT Rpt. to RO							
	Date of Acceptable POC from SA							
03/11/2014	Date Final Report sent to CO and SA							
Measure	**Dimension**		**CA**					
	FREQUENCY DIMENSION		t QIS implem					
F1	**Off Hour Surveys:** (Previously PS 1A)		**Met**					
	Threshold (10%) Score:		19.8%					
F2	**Frequency of NH Surveys:** (1B)		**Met**					
	# of Active Nursing Homes		1,218					
	# Surveyed		1,218					
	(Max # of months between surveys:)		15.4					
	# Exceeding 15.9 Months		0					
	Threshold (100%) % NH Surveyed		100.0%					
	Statewide Avg Interval (Months; threshold: ≤ 12.9 mos.)		12					
F3.1	**Frequency of Non-Nursing Home Surveys:** (1C)		**Met**					
	# of Active HHAs		491					
	# Surveyed		491					
	(Max. # of Months between Surveys:)		na					
	# Exceeding 36.9 Months		0					
	Threshold (100%) % HHAs Surveyed		100.0%					
	# of Active ICF/MRs		1,152					
	# Surveyed		1,152					
	# of ICF/MRs Exceeding 15.9 Months		0					
	Statewide Avg Interval (Months; threshold: ≤ 12.9 mos.)		10.9					
	Threshold (100%) % ICF/MRs Recert. before TLA End Date/Extens		100.0%					
	# Initial 1% Deemed Hospital(s) Sample (1)		9					
	# Deemed Hospitals Sample (2)		na					
	# of Surveys Conducted		9					
F3.2	**Frequency of Non-Nursing Home Surveys - Tier 2**		**Met**					
	# of Active Hospices		120					
	# of Hospices Surveyed		15					
	Threshold ([T2: ≥5%]) % Hospice:		12.5%					
	# of Active OPTs		104					
	# of OPTs Surveyed		10					
	Threshold ([T2: ≥5%]) % OPTs:		9.6%					
	# of Active CORFs		9					
	# of CORFs Surveyed		4					
	Threshold ([T2: ≥5%]) % CORFs:		44.4%					
	# of Active RHCs		276					
	# of RHCs Surveyed		19					
	Threshold ([T2:≥5%]) % RHCs:		6.9%					
	# of Active ASCs		401					
	# of ASCs Surveyed		113					
	Threshold ([T2: ≥25%]) % ASCs:		28.1%					
	# of Active ESRDs		545					
	# of ESRDs Surveyed from Targeted Sample		60					
	Threshold ([T2:≥10%]) % Targeted Sample ESRDs:		11.0%					
	# of Active Hospitals- STAC		16					
	# of Hospitals Surveyed- STAC		4					
	Threshold (T2: ≥5%) % Surveyed-STAC		25.0%					
	Max # of Years between Surveys non-accredited Hospital		4.9					
	# Exceeding Max 5 yr. Interval (All Non-accredited hospitals)		0					

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RO-IX FY 2013 End-of-Year State Performance Review *DRAFT* Results

Measure	Dimension	AZ*	CA	HI*	NV	Met	Met	NA
	FREQUENCY DIMENSION	* underwent QIS implementation						
F3.3	**Frequency of Non-Nursing Home Surveys - Tier3 (# Exceeding Max Interval)**		Not Met					
	Max # of Years between Surveys (Hospice)		22.9					
	Threshold ([T3: 0 #> 7 yrs]) # Hospice:		39					
	Max # of Years between Surveys (OPT)		23.8					
	Threshold ([T3: 0 # >7yrs]) # OPTs:		31					
	Max # of Years between Surveys (CORF)		na					
	Threshold ([T3: 0 # >7yrs]) # CORFs:		0					
	Max # of Years between Surveys (RHC)		21.4					
	Threshold ([T3: 0 # >7yrs]) # RHCs:		164					
	Max # of Years between Surveys (ASC)		15.3					
	Threshold ([T3: 0 # >6yrs]) # ASCs:		4					
	Max # of Years between Surveys # ESRD		28.5					
	Threshold ([T3: 0 # >4.5yrs]) Sample ESRDs:		195					
	Max # of Years between Surveys NAH		4.9					
	Threshold ([T3: 0 # >4yrs]) #Non-Deemed Hospitals:		3					
F4	**Frequency of Data Entry:** (7A)		↑ Met					
	Nursing Home (# of Surveys Entered)		1,209					
	Threshold (70 Cal days) Nursing Home (Mean # of Days)		42.8					
	% of NH Surveys-Data Entry Exceeds 70 Days		3.7%					
	Non-Deemed Hospitals (# of Surveys Entered)		11					
	Threshold (70 Cal days) Non-Deemed Hospitals (Mean # of Days)		64.5					
	% of Non-Deemed Hospital Surveys-Data Entry Exceeds 70 Days		45.5%					
F5	**Frequency of Data Entry of Complaint Surveys for Non-Deemed Hospitals and Nursing Homes**		Not Met					
	Nursing Homes - % uploaded on time (Threshold ≥ 85%)		60.8%					
	Total # of Nursing Home Complaints uploaded		10486					
	# of nursing home complaints uploaded complaints on time		6376					
	Non-Deemed Hospitals-% uploaded on time(Threshold≥85%)		6.3%					
	Total # of Non-deemed Hospital Complaints uploaded		205					
	# of non-deemed hospital complaints uploaded on time		12					
	QUALITY DIMENSION							
Q1	**Documentation of deficiencies** (Previously PS 2)		Not Met					
	Requirement 1 Score **(Threshold: ≥85%)**		100.0%					
	Requirement 2 Score **(Threshold: ≥85%)**		100.0%					
	Requirement 3 Score **(Threshold: ≥85%)**		98.0%					
	Requirement 4 Score **(Threshold: ≥85%)**		100.0%					
	Requirement 5 Score **(Threshold: ≥85%)**		100.0%					
	Requirement 6 Score **(Threshold: ≥85%)**		98.0%					
	Requirement 7 Score **(Threshold: ≥85%)**		99.0%					
	Threshold 1 - NH Score:		Met					
	Requirement 1 Score **(Threshold: ≥85%)**		94.0%					
	Requirement 2 Score **(Threshold: ≥85%)**		97.0%					
	Requirement 3 Score **(Threshold: ≥85%)**		92.0%					
	Requirement 4 Score **(Threshold: ≥85%)**		100.0%					
	Requirement 5 Score **(Threshold: ≥85%)**		99.0%					
	Requirement 8 Score **(Threshold: ≥85%)**		83.0%					
	Threshold 2 - Non-NH Score:		Not Met					
Q2	**Survey in accordance w/ Federal Standards** (3A)		Met					
	Average Rating #1 **(Threshold ≥ 3.0)**		4.04					
	Average Rating #2 **(Threshold ≥ 3.0)**		4.35					
	Average Rating #3 **(Threshold ≥ 3.0)**		3.64					
	Average Rating #4 **(Threshold ≥ 3.0)**		4.16					
	Average Rating #5 **(Threshold ≥ 3.0)**		4.00					

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RO-IX FY 2013 End-of-Year State Performance Review *DRAFT* Results

Measure	Dimension	AZ*	CA	HI*	NV	Met	Met	NA
	FREQUENCY DIMENSION	* underwent QIS implementation						
	Average Rating #6 (Threshold ≥ 3.0)		3.96					
Q3	**Documentation of non-compliance** (3B)		**Met**					
	Threshold (unjust. disparity rate is ≤ 20%) Report 2 Score:		2.30%					
Q4	**Accuracy of identification of Deficiencies during Nursing Home Comparative Surveys** (3C,3D)		**Not Met**					
	Agreement Rate (Threshold ≥ 80%)		23.5%					
Q5*	**Accuracy of Immediate Jeopardy** (3D) (Now Q4 Score3)							
Q6	**Prioritizing complaints and incidents** (5A)		**Not Met**					
	# of intakes reviewed		40					
	# of intakes prioritized accurately		29					
	Threshold (90%) NH Score:		72.5%					
	# of intakes reviewed		12					
	# of intakes prioritized accurately		11					
	Threshold (90%) Non-NH Score:		91.6%					
Q7	**Timeliness of complaint/incident investigations** (5B)		⬆ **Met**					
	Criteria 1: (≥95%) : IJ Complaints/Incidents - Non-Deemed Providers		Met					
	Criteria 1 cumulative score:		98.2%					
	Nursing Home (NH) % Investigated Score:		98.7%					
	NH #w/in 2 days:		329.0					
	NH Total Reviewed:		333					
	ESRD % Investigated Score:		0.0%					
	ESRD #w/in 2 days:		0					
	ESRD Total Reviewed:		1					
	non-deemed HHA % Investigated Score:		na					
	non-deemed HHA #w/in 2 days:							
	non-deemed HHA Total Reviewed:		0					
	non-deemed ASC % Investigated Score:		na					
	non-deemed ASC #w/in 2 days:							
	non-deemed ASC Total Reviewed:		0					
	non-deemed hospitals % Investigated Score:		91.6%					
	non-deemed hospitals #w/in 2 days:		11					
	non-deemed hospitals Total Reviewed:		12					
	Criteria 2: (≥95%) : IJ-Deemed Providers		Met					
	Criteria 2 cumulative score:		100.0%					
	Deemed-Hospital % Investigated Score:		100.0%					
	Deemed-Hospital # within 2 days:		10					
	Deemed-Hospital Total Reviewed:		10					
	deemed ASC % Investigated Score:		100					
	deemed ASC #w/in 2 days:		2.0					
	deemed ASC Total Reviewed:		2					
	deemed HHA % Investigated Score:		na					
	deemed HHA #w/in 2 days:							
	deemed HHA Total Reviewed:		0					
	Criteria 3: (≥95%) : Non-IJ High-Nursing Homes		Met					
	Nursing Home (NH) % Investigated Score:		97.2%					
	NH # within 10 working days:		6803					
	NH Total Reviewed:		6994					
	Criteria 4: (≥95%) : Non-IJ - Deemed Providers		Met					
	Deemed-Hospital % Investigated:		95.4%					
	Deemed-Hospital # within 45 Days:		42					
	Deemed-Hospital Total Reviewed:		44					
Q8	**Quality of EMTALA Investigations** (5C)		⬆ **Met**					
	Overal Measure Percentage (Threshold: ≥ 90%)		99.8%					

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RO-IX FY 2013 End-of-Year State Performance Review *DRAFT* Results

Measure	Dimension	AZ*	CA	HI*	NV	Met	Met	NA
	FREQUENCY DIMENSION		QIS implem					
	Requirement 1 Score (**Threshold: ≥95%**)		100.0%					
	Requirement 2 Score (**Threshold: ≥95%**)		90.0%					
	Requirement 3 Score (**Threshold: ≥80%**)		100.0%					
	Requirement 4 Score (**Threshold: ≥80%**)		0.0%					
	Requirement 5 Score (**Threshold: ≥80%**)		100.0%					
Q9	**Quality of Complaint/Incident Investigation** (6D)		Not Met					
	Requirement 1 Score (**Threshold: ≥85%**)		73.0%					
	Requirement 2 Score (**Threshold: ≥85%**)		80.0%					
	Requirement 3 Score (**Threshold: ≥85%**)		73.0%					
	Requirement 4 Score (**Threshold: ≥85%**)		94.0%					
	Requirement 5 Score (**Threshold: ≥85%**)		100.0%					
Q10	**Accuracy of data entry** (7B) Removed as of FY2007							
	ENFORCEMENT & REMEDY DIMENSION							
E1	**Timeliness of Immediate Jeopardy** (Prev. PS 4A)		**Met**					
	# of Accepted Cases		2					
	# of Casses Reviewed		2					
	Percentage (**Threshold: ≥95%**)		100.0%					
	# extenuating circumstances							
E2	**Timeliness of DPNA** (4B)		⬆ **Met**					
	# of Accepted Cases		115					
	# of Casses Reviewed		124					
	Percentage (**Threshold: ≥80%**)		92.7%					
E3	**Adherence to termination process** (4C)		Not Met					
	# of Accepted Cases		3					
	# of Casses Reviewed		11					
	Percentage (**Threshold: ≥80%**)		27.0%					
	# extenuating circumstances							
E4	**Special Focus Facilities (new as of FY2007)**		**Met**					
	# of Selected Facilities		12					
	# of Standard Surveys for SFFs		25					
	Threshold 1 Score		100.0%					
	Threshold 2 Score							
	RO-IX Totals (Measures scored)							
	Percent of Standard Scores							
	Met							
	Not Met							
	N.A.							
	Developmental Measures							
⬆	Performance INCREASE from previous year							
⬇	Performance DECREASE from previous year							
Plan:	1. Provide training for survey teams (Training)							
	2. Directed Quality Improvement Plan (DQIP)							
	3. Technical assistance on scheduling & procedural policies							
	4. Require the state to undertake improvements specified in		tion (POC)					
	5. Provide CMS directed scheduling (Dir-Sch)							
Sanctions:	1. Place state on compliance for failure to follow the Medica		IX Comp)					
	2. Meet with the Governor and other responsible State Offici		als)					
	3. Reduce Federal Financial participation for survey and cer		uce FFP)					
	4. Initiate action to terminate agreement…either in whole or		te)					
	Measure not evaluated in FY2013 Mid-Year review							
	Temporary Results or Pending Results							
	*Results not changed, but there is a valid Extenuating C		oted					
	DEVELOPMENTAL - Not Assigned a Score							

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APPENDIX G: Benchmark Performance Summary Reports

CMS BENCHMARK REPORT 1S QUARTER 2014				
CMS benchmark report 1s Quarter 2014	**Report Date**			
	01/13/14	**03/31/14**	**06/30/14**	**09/30/14**
BENCHMARK 1: MANAGEMENT STRUCTURE AND PERSONNEL STABILIZATION				
Continue Detailed short term and long-term timeline for hiring and report on progress to achieve a full complement of staff. Vacancy Rate: (Previously 10.9% in Sept.2013) Hire 30 new staff on a quarterly basis	Updated Ongoing 8.11% DO: 75 LA: 8			
Continue detailed short term and long term plan to address career management and leadership development and mentoring	Ongoing			
Managers continue career development and leadership	Ongoing			
Substantial progress made in Reclassification study	Ongoing			
BENCHMARK 2: TRAINING				
Assign and train required number of MAT Instructors	**Ongoing**			
Complete detailed schedule to accommodate new hires attending California Surveyor Academy and CMS Basic Training	**Ongoing**			
Complete assessment of basic and specialty training needs (with detailed schedule)	**Ongoing**			
Stabilize the training supervisor position	**Completed**			
Substantial progress and continuity in the above areas	**Ongoing**			
Continue detailed schedule to continue accomplishments (previously submitted work plan)	**Updated** **Ongoing**			
BENCHMARK 3: Tiered Workload % Required to be completed per Report Date	**25%**	**50%**	**75%**	**100%**
		% COMPLETED		

CMS BENCHMARK REPORT 1S QUARTER 2014

CMS benchmark report 1s Quarter 2014	Report Date			
	01/13/14	03/31/14	06/30/14	09/30/14
TIER 1				
SNF (1228 scheduled)	**Met -50% (615)**			
ICF/IID (1170 scheduled)	**Met 51% (593)**			
HHA (145 scheduled)	**Not Met 24 % (34)**			
Validation Surveys (Deemed facilities * As assigned by CMS during the year to be completed within 60 days by SA				
HHA Validations (5%) - 2 assigned	**Met- (1)**			
Deemed GACH (1%) - 3 assigned	**Met (1)**			
CAH (5%) -none assigned	**None Assigned**			
Validation Deemed Hospice- 1 assigned	**Met (1)**			
Validation Deemed ASC (5-10%) - 2 assigned	**Met (2)**			
Patient Safety Initiative	**PENDING**			
TIER 2				
Targeted ASC (25%) - (110 scheduled) REQUIRED: 101	**Not Met 18% (18)**			
Targeted CAHs (5%) - (3 scheduled) REQUIRED: 1	**Not Met 0%**			
BENCHMARK 3: Tiered Workload % Required to be completed per Report Date	**25%**	**50%**	**75%**	**100%**
	% COMPLETED			

CMS BENCHMARK REPORT 1S QUARTER 2014				
CMS benchmark report 1s Quarter 2014	**Report Date**			
	01/13/14	**03/31/14**	**06/30/14**	**09/30/14**
CONTINUED				
Targeted CORF (5%) - (1 scheduled) REQUIRED: 1	**Not Met- 0%**			
Targeted ESRD (10%) - (60 scheduled) REQUIRED: 56	**Not Met 9% (5)**			
Targeted HHA (5%) - NOT REQUIRED				
Targeted Hospice (5%) -(46 scheduled) REQUIRED: 13	**Met 54% (7)**			
Targeted Non-Deemed GACH (5%) - (3 scheduled) REQUIRED: 3	**Met-33% (1)**			
Targeted OPT (5%) - (29 scheduled) REQUIRED: 6	**Met-50 % (3)**			
Targeted RHC (5%) - (25 scheduled) REQUIRED: 14	**Not Met-21% (3)**			
Targeted Sample Transplant Centers (5-25%) * 7 To be completed by HMS contractor- 2 completed	**MET- 29% (2)**			
Targeted Portable X-Ray Suppliers (5%) ___ Assign	**In progress**			
Implement, monitor and evaluate statewide tracking system regarding completion of Tiered Workload	**Updated Ongoing**			
Implement detailed plan to continue to track and evaluate accomplishments into 2013 (Previously submitted work plan)	**Updated Ongoing**			

CMS BENCHMARK REPORT 1S QUARTER 2014				
CMS benchmark report 1s Quarter 2014	**Report Date**			
	01/13/14	**03/31/14**	**06/30/14**	**09/30/14**
BENCHMARK 4: Complaints				
LTC				
Maintain policies and procedures for investigations of complaints and provide complaint investigation training	**Updated Ongoing**			
Forward "G" and/or above deficiencies timely to Regional Office for enforcement sanctions	**Met**			
95% of all non-deemed hospitals (including non-deemed CAHs) and nursing homes will be investigated and closed (uploaded) within 60 days of the investigation.	**Not Met**			
Nursing homes *(Includes complaint/ERI investigations from 10/1/12 thru 12/31/13)	**83.26%**			
Non-deemed hospitals (includes non-deemed CAHs) *(Includes complaint/ERI investigations from 10/1/12 thru 12/31/13)	**47.55%**			
NON-LTC				
Condition-level non-compliance "Statement of Deficiencies" forwarded to the Regional Office within 10-days	**Met 100%**			
Standard level findings forwarded to the Regional Office within 30-days	**Met 100%**			
EMTALA Survey Investigation reports forwarded to Regional office within mandated timeframes	**Met 100%**			
TOTAL INDIVIDUAL BENCHMARKS "MET"	**31 out of 38**			

CMS BENCHMARK REPORT 2013				
CMS benchmark report 2013	**Report Date**			
	12/31/12	**03/26/13**	**06/30/13**	**09/30/13**
BENCHMARK 1: Management Structure and Personnel Stabilization				
Continue Detailed short term and long term timeline for hiring and report on progress to achieve a full complement of staff. Vacancy Rate: (Previously 29% in 2011)	**Updated Ongoing**	**Updated Ongoing- 7.64% (3/15/13)**	**Updated Ongoing- 8.63% (6/15/13)**	**Updated Ongoing 10.29% (9/15/13)**
Continue detailed short term and long term plan to address career management and leadership development and mentoring	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**
Managers continue career development and leadership	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**
Substantial progress made in Reclassification study	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**
BENCHMARK 2: Training				
Assign and train required number of MAT Instructors	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**
Complete detailed schedule to accommodate new hires attending California Surveyor Academy and CMS Basic Training	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**
Complete assessment of basic and specialty training needs (with detailed schedule)	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**
Stabilize the training supervisor position	**Completed**	**Completed**	**Completed**	**Completed**
Substantial progress and continuity in the above areas	**Ongoing**	**Ongoing**	**Ongoing**	**Ongoing**
Continue detailed schedule to continue accomplishments (previously submitted work plan)	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**
BENCHMARK 3: Tiered Workload % Required to be completed per Report Date	**25%**	**50**	**75**	**9/30: 100%**
			% COMPLETED	

CMS BENCHMARK REPORT 2013

CMS benchmark report 2013	Report Date			
	12/31/12	03/26/13	06/30/13	09/30/13
TIER 1				
SNF	**MET 26.9%**	**MET 45.7%**	**NOT MET 72.7%**	**MET-100% (1224)**
ICF/IID	**MET 27.8%**	**MET 48.1%**	**MET 77.7%**	**MET-100% (1167)**
HHA	**NOT MET 5.7%**	**NOT MET 45.5%**	**MET 82.5%**	**MET-100% (505)**
Validation Surveys (Deemed facilities)* As assigned by CMS during the year to be completed within 60 days by SA				
HHA (5%)	**MET**	**MET**	**MET**	**MET (7)**
Deemed GACH (1%)	**MET**	**MET**	**MET**	**MET (9)**
CAH (5%)	**N/A**	**N/A**	**MET**	**MET (1)**
Hospice	**MET**	**MET**	**MET**	**MET(3)**
ASC (5-10%)	**MET**	**MET**	**MET**	**MET(15)**
Patient Safety Initiative - 8 Assigned	**NOT MET**	**MET**	**NOT MET**	**MET (8)**
TIER 2				
Targeted ASC (25%) - 101 required	**NOT MET 19%**	**MET 48.5%**	**MET 99.9%**	**MET (114)**
Targeted CAHs (5%) - 1 required	**NOT MET 0%**	**MET 200%**	**MET 400%**	**MET (4)**
BENCHMARK 3: Tiered Workload % Required to be completed per Report Date	**25%**	**50%**	**75%**	**100%**
			% COMPLETED	

CMS BENCHMARK REPORT 2013				
CMS benchmark report 2013	**Report Date**			
	12/31/12	**03/26/13**	**06/30/13**	**09/30/13**
TIER 2 CONTINUED				
Targeted CORF (5%) - 1 required	**MET 100%**	**MET 200%**	**MET 400%**	**MET (4)**
Targeted ESRD (10%) - 57 required	**NOT MET 16.6%**	**MET 50%**	**MET 83.9%**	**MET (59)**
Targeted HHA (5%) - 15 required	**NOT MET 11.7%**	**MET 64.7%**	**MET 100%**	**MET (15)**
Targeted Hospice (5%) 6 required	**NOT MET 0%**	**MET 57.1%**	**MET 171.43%**	**MET(15)**
Targeted Non-Deemed GACHJ (5%) - 2 required	**NOT MET 0%**	**MET 50%**	**MET 150%**	**MET (5)**
Targeted OPT (5%) - 6 required	**MET 42.8%**	**MET 83.3%**	**MET 216.67%**	**MET(17)**
Targeted RHC (5%) - 14 required	**NOT MET 5.5%**	**NOT MET 26.3%**	**MET 120%**	**MET(19)**
Targeted Sample Transplant Centers (5-25%) - 1 required	**NOT MET 0%**	**NOT MET 0%**	**MET 100%**	**MET(1) 7 by HMS**
Targeted Portable X-Ray Suppliers (5%)	**In Progress**	**100%**	**MET 100%**	**MET 100%**
Implement, monitor and evaluate statewide tracking system regarding completion of Tiered Workload	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**
Implement detailed plan to continue to track and evaluate accomplishments into 2013 (Previously submitted work plan)	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**

CMS BENCHMARK REPORT 2013				
CMS benchmark report 2013	**Report Date**			
	12/31/12	**03/26/13**	**06/30/13**	**09/30/13**
BENCHMARK 4: Complaints				
LTC				
Maintain policies and procedures for investigations of complaints and provide complaint investigation training	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**
Forward "G" and/or above deficiencies timely to Regional Office for enforcement sanctions	**MET**	**MET**	**MET**	**MET**
75% of SNF Complaints will be investigated and closed within 60 days of the investigation	**MET 96.4%**	**NOT MET 63.46%**	**Benchmark Modified**	**Benchmark Modified**
95% of all non-deemed hospitals (including non-deemed CAHs) and nursing homes will be investigated and closed (uploaded) within 60 days of the investigation.	**N/A**	**N/A**	**NOT MET 50.05%**	**NOT MET 64%**
Continue to track timely closure of SNF complaints (Previously submitted Work Plan)	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**	**Updated Ongoing**
NON-LTC				
Condition-level non-compliance "Statement of Deficiencies" forwarded to the Regional Office within 10-days	**NOT MET 85%**	**MET 100%**	**NOT MET 93%**	**MET 100%**
Standard level findings forwarded to the Regional Office within 30-days	**NOT MET 82.3%**	**MET 100%**	**MET 100%**	**MET 100%**
EMTALA Survey Investigation reports forwarded to Regional office within mandated timeframes	**MET 100%**	**MET 100%**	**MET 100%**	**MET 100%**

APPENDIX H: Summary of Licensing and Certification Requirements

Frequency of Licensing and Certification Survey by Provider Type
(updated February 3, 2013)

Summary of Licensing & Certification Survey Requirements

Family/Agency Type	Licensing Authority	Licensing Survey Frequency	Certification Survey Frequency
Skilled Nursing Facility (SNF)	H&S 1250 & 1253	Every 2 years. Annually if facility issued a B, A, or AA citation until citation free. H&S 1279 and 1422.	12- month average, not to exceed 15.9 months between surveys. 42 CFR 488.308
Intermediate Care Facility (ICF)	H&S 1250 & 1253	Every 2 years. Annually if facility issued a B, A, or AA citation until citation free. H&S 1279 and 1422.	12 month average, not to exceed 15.9 months between surveys. 42 CFR 488.308
Intermediate Care Facility/ Developmentally Disabled (ICF/DD)	H&S 1250 & 1253	Every 2 years. Annually if facility issued a B, A, or AA citation until citation free. H&S 1279 and 1422.	12 months average, not to exceed15.9 months 42 CFR 456.606
ICF/DD – Nursing (ICF/DD-N)	H&S 1250 & 1253	Every 2 years. Annually if facility issued a B, A, or AA citation until citation free. H&S 1279 and 1422.	12 months average, not to exceed15.9 months 42 CFR 456.606
ICF.DD- Habilitative (ICF/DD-H)	H&S 1250 & 1253	Every 2 years. Annually if facility issued a B, A, or AA citation until citation free. H&S 1279 and 1422.	12 months average, not to exceed15.9 months 42 CFR 456.606
General Acute Care Hospitals (GACH)	H&S 1250 & 1253	Every 3 years. H&S 1279	No certification survey of hospitals deemed by an Accreditation Organization. Every 3 years for non- deemed hospitals. Social Security Act 1864 (a)
Acute Psychiatric Hospital (APH)	H&S 1250 & 1253	Once every 3 years. H&S 1279	No certification surveys for deemed APH. Once every 4 years for non- deemed providers. Social Security Act 1864 (a)
Home Health Agencies (HHA)	H&S 1726	Not required if certified, otherwise annually H&S 1733	Survey frequency cannot exceed 36.9 months from last survey. Social Security Act 1891 (c)(2)(A)
Adult Day Health Care (ADHC)	H&S 1575	Once every 2 years. H&S 1576.2	Once every 1 or 2 years depending on expiration date of TLA. W&I 14573(a)
Ambulatory Surgery Center (ASC)	Not a licensure category.	N/A: Not a licensure category.	Once every 4 years. Social Security Act 1864(a)

Summary of Licensing & Certification Survey Requirements

Family/Agency Type	Licensing Authority	Licensing Survey Frequency	Certification Survey Frequency
End Stage Renal Dialysis (ESRD)	Not a licensure category.	N/A: Not a licensure category.	Once every 3.5 years. Social Security Act 1864(a)
Hospice	H&S 1747	No specific timeframe, but prohibits "redundant" licensing and certification surveys. H&S 1752	Once every 6.5 years. Social Security Act 1864(a)
Primary Care Clinics (PCC)	H&S 1201 & 1204	Once every 3 years, unless accredited. H&S 1228	Not applicable
Dialysis Clinics	H&S 1201 & 1204	Once every 3 years. H&S 1228	Not a certification category. Dialysis Clinics may be certified as an ESRD
Alternate Birthing Center (ABC)	H&S 1201 & 1204	Once every 3 years. H&S 1278	Not a certification category
Chemical Dependency Recovery Hospital	H&S 1250 & 1253	Once every 2 years. H&S 1279	Not a certification category
Correctional Treatment Centers (CTC)	H&S 1250 & 1253	Once every 2 years. H&S 1279	Not a certification category
Pediatric Day Health Respite Care (PDHRC)	H&S 1760.4	Once every 2 years. H&S 1422(b)(1)	Not a certification category
Referral Agency	H&S 1400	No statutory requirement. Practice has been to survey every 2 years.	Not a certification category
Comprehensive Outpatient Rehabilitation Facilities (CORF)	Not a licensure category.	N/A: Not a licensing category.	Once every 7 years Social Security Act 1864(a)
Outpatient Physical and Speech Therapy	Not a licensure category.	N/A: Not a licensing category	Once every 7 years Social Security Act 1864(a)
Portable X-Ray	Not a licensure category.	N/A: Not a licensing category	Once every 7 years Social Security Act 1864(a)
Critical Access Hospitals (CAH)	H&S 1250 & 1253	Licensed as General Acute Care Hospitals (GACH). Once every 3 years. H&S 1279	Once every 3 years. Social Security Act 1864(a)

APPENDIX I: Facility Types by District Office

Facility Count by Facility Type and District Office
Main Facilities with Open Status, Active License and No Facility Closure Date
Report Date: March 13, 2014

Facility Type	Total	District Office																	
		Bakersfield	Chico	East Bay	Fresno	Los Angeles	Orange County	Riverside	Sacramento	San Bernardino	San Diego North	San Diego South	San Francisco	San Jose	Santa Rosa/Redwood Coast	State Facility Unit North	State Facility Unit South	Unspecified	Ventura
ABC	6	.	1	.	.	.	1	.	1	1	.	1	.	.	1	.	.	.	.
ADHC	271	.	.	.	.	.	201	.	.	.	.	.	.	70	.	.	.	.	.
APH	127	4	1	6	2	40	14	4	5	5	8	5	10	7	5	4	3	.	4
ASC/SURGC	31	3	.	1	5	.	3	1	3	4	3	.	2	3	1	.	.	.	2
CDC	19	1	.	1	.	7	3	.	.	.	.	.	2	.	1	.	3	.	1
CDRH	8	.	.	2	.	4	.	1	.	.	1	.	.	.	.	.	.	.	.
CLHF	71	.	1	4	2	38	4	2	3	1	7	.	1	2	1	.	.	.	5
COMTYC	1,130	60	55	85	48	313	54	28	74	25	44	68	57	70	87	.	.	.	62
CTC	21	.	.	.	.	.	.	.	.	.	.	.	.	.	.	12	9	.	.
ESRD	1	.	.	.	.	1	.	.	.	.	.	.	.	.	.	.	.	.	.
ESRD/CDC	484	15	11	35	29	146	34	27	43	27	32	.	20	21	24	.	.	.	20
FREEC	54	2	2	7	2	7	2	.	2	.	2	2	16	1	3	.	.	.	6
GACH	431	15	28	28	23	95	39	19	31	26	13	14	22	21	30	3	4	.	20
HHA	1,569	21	31	92	35	787	83	70	57	109	78	.	46	46	36	.	.	1	77
HOFA	6	.	2	.	3	.	.	.	.	.	1	.	.	.	.	.	.	.	.
HOSPICE	717	13	10	21	16	386	46	25	29	66	26	.	18	14	14	1	.	.	32
ICF	17	.	.	1	.	3	2	.	.	1	.	1	.	2	.	5	2	.	.
ICFDD	16	.	.	.	.	6	1	.	.	.	.	1	.	.	.	1	5	.	2
ICFDDH	760	28	17	44	32	192	84	57	36	74	.	81	24	11	46	.	.	.	34
ICFDDN	419	40	17	22	45	84	35	23	31	34	.	20	15	22	15	.	.	.	16
OPT/SP	21	.	.	.	.	.	.	5	.	.	12	3	.	.	1	.	.	.	.
PDHRCF	16	1	4	.	1	1	.	.	3	1	2	.	.	3	.	.	.	.	.
PPSPSCH	15	.	1	.	.	.	10	.	.	.	3	1	.	.	.	.	.	.	.
PPSREHB	15	.	2	.	.	1	3	.	.	1	5	2	.	.	1	.	.	.	.
PSYCHC	22	.	.	5	1	8	.	1	.	.	.	1	2	1	3	.	.	.	.
REFRLAG	3	.	.	.	.	3	.	.	.	.	.	.	.	.	.	.	.	.	.
REHABC	13	1	.	2	.	5	.	2	.	.	1	.	.	.	.	.	.	.	2
RHC/COMTYC	41	1	3	.	35	1	.	.	.	1	.	.	.	.	.	.	.	.	.
SNF	1,265	35	46	105	72	396	75	52	94	55	50	41	63	61	64	4	7	.	45
SURGC	5	1	.	.	1	1	1	1	.	.	.	.	.	.	.	.	.	.	.
Total	7,574	241	232	461	352	2,525	695	318	412	431	288	241	298	355	333	30	33	1	328

(*) Certified Only Facilities Status are not Included in this Table
(**) Only Main Facilities are Included in this Table

Source: Research and Evaluation Section
Data Source: ELMS Database
Extraction Date: 03/03/2014
Report Date: 03/13/2014 HvB

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APPENDIX J: Field Operations Branch Chief Assignments

Field Operations Branch Chief Responsibilities Effective January 21, 2014

	Region I	Region II	Region III	Region IV	Region V	Region VI	Region VII	Region VIII
Branch Chief	Ley Arquisola	Eric Morikawa	Virginia Yamashiro	Michael Egstad	Cassie Dunham		Jackie Lincer Orange Sacramento	Ernie Pooleon Suzette Leverett-Clark
District Offices	Riverside, Sacramento, San Diego No. & So., San Bernardino	East Bay, San Jose LSC	San Francisco, Los Angeles	Chico, Santa Rosa, State Facilities Unit	Bakersfield, Ventura, Fresno		Orange	Los Angeles County
Units		Emergency Preparedness	SEQIS	FOBU	Centralized Applications Unit		Consultants[1]	
Specialties								
ICF IID					X			
Clinics			X					
End Stage Renal Disease			X					
Transplant Programs							X	
General Acute Care Hospitals							X	
Home Health Agencies					X			
Hospice				X				
Adult Day Health Care Centers	X							
OSHPD		X		X				
Administrative Penalties	X							
Adverse Events	X							

	Region I	Region II	Region III	Region IV	Region V	Region VI	Region VII	Region VIII
Medical Information Breaches		X	X					
ASC							X	
SNFs	X	X	X[2]	X	X		X	X
Special Focus Facilities								X
Portable X-Ray Suppliers							X	

[1] Will handle the Joint Commission and other consultant-related projects.

[2] Lead on SNFs meetings.

APPENDIX K: Roles and Responsibilities, Field Operations Branch Chief

Policy

- Participate in management team discussions, review operational policies and procedures and analyze their effectiveness
- Review, evaluate, and implement revisions to program policies and procedures
- Interpret and implement State and Federal policies, rules, laws and regulations
- Update policies and procedures as needed (i.e. AFLS and DOMs)
- Provide information, policies, procedures and recommendations on behalf of the Licensing and Certification program
- Consult with CMS regarding issues related to the State Operations Manual
- Compose emails to L&C staff communicating information regarding CMS policy and process changes
- Propose solutions to problems identified by L&C, staff, providers and licensees
- Respond to external stakeholders regarding provider issues related to policy
- Provide guidance to staff, professional organizations, licensees and the public health with regard to the State and federal laws and regulations governing the functions of L&C
- Prepare Week Ahead Report and Cabinet Daily Activity Report
- Respond to legislation, public and media requests
- Respond to correspondence
- Consult with the Policy and Enforcement Unit and Legal Governmental Affairs on operational and implementation of new statutes and regulations
- Respond to Legislative Governmental Affairs requests
- Research, prepare and submit requests for legal opinion to the Office of Legal Services on a variety of licensing, enforcement, and administrative services activities, as necessary
- Streamline processes (development and implementation)
    - Adverse Events Report
    - Guidelines
    - Innovative Changes
    - Immediate Jeopardy Administrative Penalties and Citations
- Serve as Subject Matter Experts (provide expertise, or sharing information, to assist others in improving their knowledge, skills, abilities, or process)
- Develop Job Aids/Work checklists
    - Surveyors and field administrative staff
- Coordinate training for district office analysts and headquarters analysts in the areas of L&C processes and guidelines

Enforcement

- Ensure consistent application of laws, regulations, statutes, and department policies and procedures

- Consult, coordinate and work closely with CMS on compliance issues
- Review citations and administrative penalties
- Review and approval of Stipulated and Settlement Agreements legal documents
- Negotiate settlement agreement of citations and monetary penalties
- Review and endorse actions for license revocation or suspension
- Review and respond to complain investigations (research and resolve issues)
- Telephone calls with providers, complainants, and Office of Legal Services
- Assistance provided to district managers developing letters to providers, complainants, and consumers
- Respond to correspondence sent from district offices from providers, consumers, and complainants for DPD and CCUs

Management

- Responsible for the day to day oversight of the District Offices
- Provide technical and supervisory direction to the district offices
- Communication to district offices
- Respond to district office issues (i.e. space and equipment)
- Policy and procedures, District Office Memoranda, All Facility Letters
- Workload monitoring
    - Maintain and evaluate workload statistics
    - Redirection of resources as needed
    - Develop corrective measures
    - Develop tracking tools to monitor L&C workload performance benchmarks, State Performance Standards, and results
    - Conduct weekly District Office meetings
    - Review weekly Branch Chief and District Office meeting worksheets and management reports
    - Monitor progress on CMS benchmarks and State Performance Standards
    - Provide monthly/quarterly CMS benchmarks and State Performance Standards status updates
    - Review and update CMS benchmarks work plans (Management Structure and Personnel Stabilization, training and tiered workload) and State Performance Standards on a quarterly basis
    - Review CMS Survey & Certification and Administrative Information Memoranda for changes that impact L&C and provide a summary for the district offices
    - Assist with the development of federal grant
    - Assist with standard average hours for licensing
    - Monitor completion of Mission and Priority Workload, assist in redirecting district office staff to assist another district office or utilize CMS contractor services to complete mandated workload
    - Collaborate with other units in the CDPH and outside agencies to expand knowledge and networking

Meetings

- Meetings with STAR, Research, and Forecast on data issues and reports
- Meetings and correspondence from field dealing with district office space issues, resolving disputes over space issues
- Serve as lead on facilitating meetings, including the development and coordination of agenda for the monthly and quarterly DA/DM, California Association of Health Services at Home, California Primary Care Association, Long-Term Care Providers, and Adult Day Health Center
- Attend and actively participate in meetings, training, seminars, and other forums
- Represent L&C in meetings, negotiations, hearings and other forums
- Prepare presentations for CMS and external stakeholders
- Prepare and conduct presentations for industry and program staff

Human Resources/Personnel Issues

- Hiring and recruitment
- Effectively applying preventive and corrective employee supervisory techniques (e.g., Progressive Supervision/Discipline Process, informing affected employees regularly and in a timely manner of areas needing improvement, documenting appropriately, consulting with appropriate staff for advice and assistance, etc.)
- Review/evaluate individual and collective
- Promote staff development by continuously monitoring staff performance, providing routine feedback to staff, and ensure the completion of all staff performance evaluations
- Regularly assessing staff job performance and providing feedback to promote improvement
- Ensure staff attend mandatory training
- Team building (employee recognition and staff meetings)

Specialties

- Lead on special projects/assignments
    - HFEN job specification revision
    - HFEM II/I and HFES I examination raters
    - Accreditation Readiness Team
    - SB 1228 SHSNF Pilot Program
    - Affordable Care Act
    - Transparency (long-term care post survey evaluation)
    - Health Facilities Consumer Information System (HFCIS)
    - Developing a revised GACH abbreviated licensing tool and combined survey process

APPENDIX L: GLOSSARY

AE	Adverse Events
AFLs	All Facility Letters
AGPAs	Associate Governmental Program Analysts
BLTCC	Basic Long Term Care Course
CAN	Certified Nurse Assistants
CAU	Central Applications Unit
CCR	California Code of Regulations
CDPH	California Department of Public Health
CHCQ	Center for Health Care Quality
CHT	Certified Hemodialysis Technicians
CIR	Center for Investigative Reporting
CMS	Centers for Medicare and Medicaid Services
DA	District Administrator
DM	District Manager
DOM	District Office Memorandum
DSS	Department of Social Services
EMTALA	Emergency Medical Treatment and Labor Act
ERIs	Entity-Reported Incidents
FSS	Federal System Support
FY	Fiscal Year
GACH	General Acute Care Hospitals
HAI	Healthcare-Associated Infections
HFEN	Health Facility Evaluator Nurse
HFID	Health Facilities Inspection Division
HHA	Home Health Aides
HSC	Health & Safety Code
ICFs	Intermediate Care Facilities
IJ	Immediate Jeopardy
IS	Investigation Section
ITSD	Information Technology Support Division
IVR	Integrated Voice Response
L&C	Licensing and Certification
LAC	Los Angeles County
LSC	Life Safety Code
MAT	Magnet Area Training
MERP	Medication Error Reduction Plan
MPD	Mission and Priority Document

NHA	Nursing Home Administrators
NHPPD	Nursing Hours Per Patient Day
NSA	New Surveyor Academy
OIG	Office of the Inspector General
OJT	On the Job Training
P&P	Policy & Procedure
PCB	Professional Certification Branch
PI	Performance Improvement
PLU	Personnel Liaison Unit
PY's	Personnel Year
QA	Quality Assurance
QASP	Quality and Accountability Supplemental Payment
SEQUIS	Staff Education & Quality Improvement Section
SET	Surveyor Employment and Training
SFY	State Fiscal Year
SME	Subject Matter Expert
SMQT	Surveyor Minimum Qualification Test
SNF	Skilled Nursing Home
SOM	State Operations Manual
SOW	Statement of Work
SPSS	State Performance Standards System
STAR	Staffing Audits and Research Branch
STS	Surveyor Timekeeping System
TEAM	Time Entry and Activity Management
VDI	Virtual Desktop Interface