

# Recommendation Paper on Olmstead Compliance Quality Measure

*For  
The California Department of Public Health*

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## Introduction

California legislation requires the California Department of Public Health (CDPH) and the California Department of Health Care Services (DHCS) to implement a Quality and Accountability Program (QAP) for skilled nursing facilities (SNFs). As part of this statutory requirement, CDPH and DHCS are also required to consider expanding the initial SNF QAP measure set, specifically evaluating the following measure topics:

- ◆ Chemical Restraint Use
- ◆ Olmstead Compliance
- ◆ Direct Care Staffing Retention

CDPH contracted with Health Services Advisory Group, Inc. of California (HSAG) to evaluate the options and provide recommendations for integrating an Olmstead compliance measure into the QAP. DHCS in collaboration with CDPH will examine the recommendations.

## Background

In June 2011, the California Legislature passed AB19, requiring the CDPH and DHCS to implement a SNF QAP to consider the development of a performance measure for monitoring Olmstead compliance.

### ***Supreme Court Decision: Olmstead vs. L.C.***

Title II of the Americans with Disabilities Act (ADA) of 1990, made it a requirement that “state and local governments give people with disabilities an equal opportunity to benefit from all their programs, services, and activities.”<sup>1-1</sup> In 1999, in *Olmstead vs. L.C.*, the Supreme Court ruled that under Title II of the ADA disabled people have “the right to receive care in the most integrated setting appropriate and that their unnecessary institutionalization was discriminatory and violated the ADA.”<sup>1-2</sup> **Olmstead compliance** can be defined as the practice by which States adhere to Title II of the ADA and the Supreme Court ruling in *Olmstead v. L.C.* by ensuring that institutionalized

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<sup>1-1</sup> Kaiser Commission on Medicaid and the Uninsured. *Olmstead v L.C.: The Interaction of the Americans with Disabilities Act and Medicaid*. Washington, DC: The Henry J. Kaiser Family Foundation; June 2004: 1-8. Available at: <http://www.kff.org/medicaid/upload/Olmstead-v-L-C-The-Interaction-of-the-Americans-with-Disabilities-Act-and-Medicaid.pdf> Accessed on: Apr 17, 2012.

<sup>1-2</sup> Ng T, Wong A, Harrington C. *Home and Community-Based Services: Introduction to Olmstead Lawsuits and Olmstead Plans*. UCSF National Center for Personal Assistance Services; April 2012. Available at: <http://www.pascenter.org/olmstead/index.php>. Accessed on: Apr 16, 2012.

Medicare-eligible persons do not experience discrimination and are given the opportunity to be provided care in the least restrictive and most integrated community based care setting.<sup>1-3,1-4,1-5</sup>

### **Post-Olmstead Legislation**

After the Olmstead ruling, Congress passed the Deficit Reduction Act of 2005, which created several home and community based services (HCBS) programs.<sup>1-6</sup> It is generally accepted that HCBS programs “can better maintain the independence and dignity of persons needing long term services and support (LTSS).”<sup>1-7</sup> HCBS are defined as “any care or services provided in a patient’s place of residence or in a non-institutional setting located in the immediate community.”<sup>1-8</sup>

One HCBS program is Money Follows the Person (MFP), which is aimed at funding transitions for persons moving out of nursing homes and into HCBS living environments. **Transition** involves the transfer of individuals from SNFs to a HCBS location and requires the SNF and the local contact agency (LCA) to investigate and resolve resident complaints about movement into the community, supporting residents in their decision-making to leave a SNF, providing residents information and education about their rights and options, and identifying appropriate candidates and making the necessary referrals to LCAs.<sup>1-9</sup>

In 2006, Congress directed the Administration on Aging (AOA) to expand these programs further and placed special emphasis on providing more funding and opportunities for HCBS. In 2010, the Patient Protection and Affordable Care Act (PPACA) “expanded the MFP program and the HCBS State Plan Benefit program.”<sup>1-10</sup>

For States with disabled and elderly citizens residing in and receiving care in SNFs, there is a requirement that the residents’ stay in the SNFs be both ADA and Olmstead compliant. In order to meet this challenge, the Olmstead ruling essentially instructed the States to produce formal plans

<sup>1-3</sup> Ibid.

<sup>1-4</sup> California Health and Human Services Agency. Update on the Implementation of the California Olmstead Plan. Sacramento, CA: California Health and Human Services Agency; May 2005: 1-44. Available at: <http://www.chhs.ca.gov/initiatives/Olmstead/Documents/OLMSTEAD%20PLAN%20IMPLEMENTATION%20Final%20with%20background.pdf>. Accessed on: Apr 17, 2012.

<sup>1-5</sup> Department of Health and Human Services, Center for Medicare & Medicaid Services. Long-Term Care Facility Resident Assessment Instrument User’s Manual, Version 3.0. Published Sep, 2010. Available at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>. Accessed on: Apr 18, 2012.

<sup>1-6</sup> Carlson E, Coffey G. 10-Plus Years After the *Olmstead* Ruling: Progress, Problems, and Opportunity. National, Washington, DC: Senior Citizens Law Center; Sep 2010: 1-34. Available at: <http://www.nsclc.org/wp-content/uploads/2011/07/NSCLC-Olmstead-Report.pdf>. Accessed on: Apr 17, 2012.

<sup>1-7</sup> Ibid.

<sup>1-8</sup> Health Policy Institute of Ohio. Glossary of Health Policy Terms. Published 2012. Available at: <http://www.healthpolicyohio.org/resources/other-resources/glossary.php>. Accessed on May 4, 2012.

<sup>1-9</sup> Milne D. *MDS 3.0 Section Q Pilot Test*. Ascillon Corporation; March 2010. Available at: <http://www.dphhs.mt.gov/sltc/services/nursingfacilities/MDS/PilotTest.pdf>. Accessed on: Apr 18, 2012.

<sup>1-10</sup> Carlson E, Coffey G. 10-Plus Years After the *Olmstead* Ruling: Progress, Problems, and Opportunity. National, Washington, DC: Senior Citizens Law Center; Sep 2010: 1-34. Available at: <http://www.nsclc.org/wp-content/uploads/2011/07/NSCLC-Olmstead-Report.pdf>. Accessed on: Apr 17, 2012Ibid.

for increased community integration, and the Centers for Medicare & Medicaid Services (CMS) issued formal guidance in 2001 “concerning the process and content” of these plans.<sup>1-11</sup>

### ***State of California’s Olmstead Plan***

In 2003, the State of California prepared its Olmstead Plan with the following goals:

“The California Health and Human Services Agency shall develop a comprehensive plan describing the actions which California can take to improve its long term care system so that its residents have available an array of community care options that allow them to avoid unnecessary institutionalization. The plan shall respond to the decision of the United States Supreme Court in *Olmstead v. L.C.*, 526 U.S. 581 (1999) and shall embody the six principles for an “Olmstead Plan” as articulated by the Centers for Medicaid and Medicare Services.... These principles call for: 1) a comprehensive, effectively working plan; 2) a plan development and implementation process that provides for the involvement of consumers and other stakeholders; 3) the development of assessment procedures and practices that prevent or correct current and future unjustified institutionalization of persons with disabilities; 4) an assessment of the current availability of community-integrated services, the identification of gaps in service availability, and the evaluation of changes that could be made to enable consumers to be served in the most integrated setting possible; 5) inclusion in the plan of practices by which consumers are afforded the opportunity to make informed choices among the services available to them; and 6) elements in the plan that provide for oversight of the assessment and placement process, in order to help ensure that services are provided in the most integrated setting appropriate, and to help ensure that the quality of the services meets the needs of the consumers.”<sup>1-12</sup>

The Olmstead Plan tasked the existing Long-Term Care Council (LTC) to guide the work of the State agencies to achieve Olmstead compliance.<sup>1-13</sup> The LTC is tasked with identifying the following data to be used by the Olmstead Plan:

- ◆ Assessment of individuals needing transition to the community.
- ◆ Diversion from unnecessary institutionalization.
- ◆ Transition of residents to community settings.
- ◆ Identifying the community capacity for resident transition to community settings.
- ◆ Identifying available housing and funding for transition to the community.
- ◆ Developing quality assurance methods to track transition to the community.

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<sup>1-11</sup> Ng T, Wong A, Harrington C. *Home and Community-Based Services: Introduction to Olmstead Lawsuits and Olmstead Plans*. UCSF National Center for Personal Assistance Services; April 2012. Available at: <http://www.pascenter.org/olmstead/index.php>. Accessed on: Apr 16, 2012.

<sup>1-12</sup> California Health and Human Services Agency. California Olmstead Plan. Sacramento, CA: California Health and Human Services Agency; 2003: 1-61. Available at: <http://www.chhs.ca.gov/mwg-internal/de5fs23hu73ds/progress?id=NpGZmTi4JY>. Accessed on: Apr 17, 2012.

<sup>1-13</sup> Ibid.

- ◆ Request access to the “Minimum Data Set (MDS) evaluations for the Medi-Cal individuals being placed in nursing facilities,” and use these data to identify residents who are eligible for assessment and transition to the community.<sup>1-14</sup>

In 2005, CMS granted California access to the MDS data and the State began to identify ways to use the data to support Olmstead compliance.<sup>1-15</sup>

The majority of States have created plans to address Olmstead compliance for nursing home residents whose disabilities and medical conditions would allow them to be transitioned to living in the community. However, a review of a number of various States’ plans shows a lack of use of quality measures to determine if Olmstead compliance is adequately addressed at the nursing home facility level.<sup>1-16</sup>

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<sup>1-14</sup> Ibid.

<sup>1-15</sup> California Health and Human Services Agency. Update on the Implementation of the California Olmstead Plan. Sacramento, CA: California Health and Human Services Agency; May 2005: 1-44. Available at: <http://www.chhs.ca.gov/initiatives/Olmstead/Documents/OLMSTEAD%20PLAN%20IMPLEMENTATION%20Final%20with%20background.pdf>. Accessed on: Apr 17, 2012.

<sup>1-16</sup> Ng T, Wong A, Harrington C. *Home and Community-Based Services: Introduction to Olmstead Lawsuits and Olmstead Plans*. UCSF National Center for Personal Assistance Services; April 2012. Available at: <http://www.pascenter.org/olmstead/index.php>. Accessed on: Apr 16, 2012.

## 2. OLMSTEAD COMPLIANCE QUALITY MEASUREMENT

### Overview: No Existing Quality Measures

HSAG conducted an environmental scan of existing Olmstead compliance programs to identify existing performance measures. However, HSAG's research into other States' Olmstead compliance programs and what is provided by CMS did not identify an existing quality measure that could be used by CDPH and DHCS for Olmstead compliance. A previous MDS 2.0-derived resident discharge preference status quality indicator was previously available from CMS; however, this quality indicator is currently not available based on MDS 3.0 data. In other words, there are no existing Olmstead compliance quality measures that CDPH and DHCS can use as part of the QAP.

Therefore, to meet AB19, which requires the CDPH and DHCS to consider incorporating a performance measure for monitoring Olmstead compliance in the QA Program, HSAG recommends that the State consider the possibility of developing an Olmstead compliance measure for the QA Program using data derived from Section Q of the MDS 3.0, which has been revised specifically to address the ADA and Olmstead compliance requirements. Therefore, several items in the MDS 3.0 assessment tool can be used as the basis for a performance metric for monitoring Olmstead compliance in nursing homes. In addition, published studies and research on nursing home transition of residents to community have demonstrated the utility of MDS-derived data to support this topic.

### Quality Measure Development: Existing Literature

HSAG conducted a literature review of previous investigation and projects using MDS related to Olmstead compliance. These efforts have focused on the Desire to Return to the Community for other populations as well as some previous analysis on nursing home residents.<sup>2-1</sup>

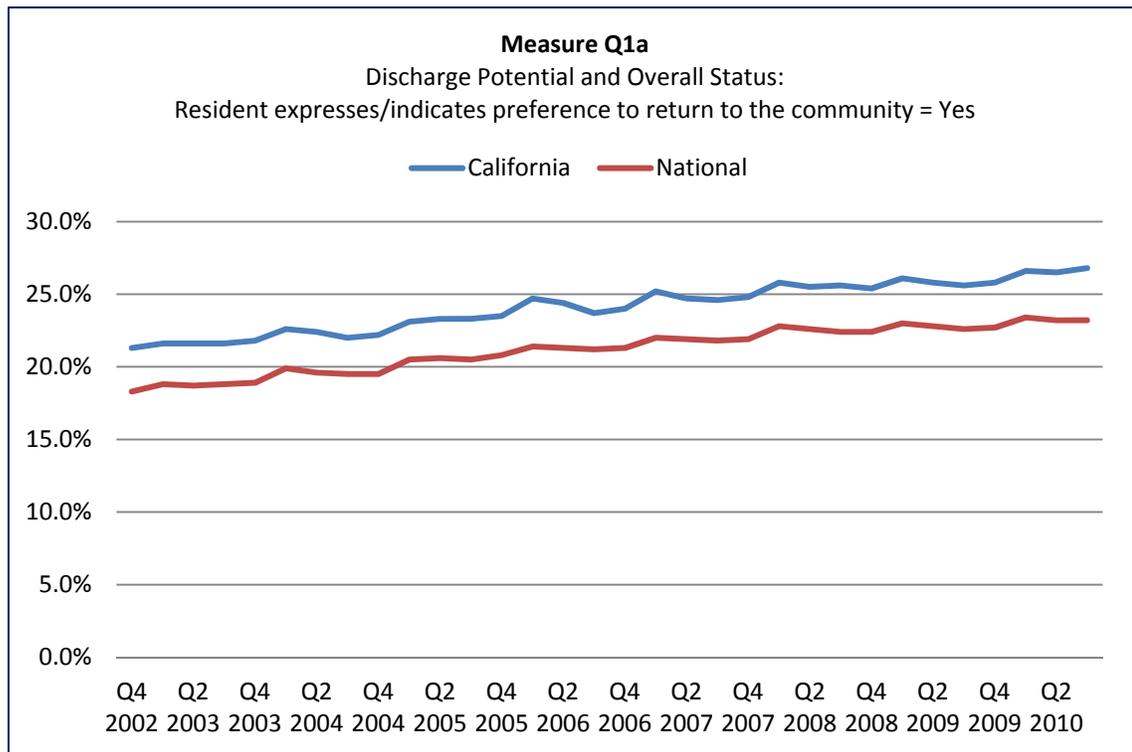
#### *Review of MDS 2.0 Data for Section Q*

A review of MDS 2.0 Quality Measure/Indicator Reports for the question "Q1a: Discharge Potential and Overall Status: Resident expresses/indicates preference to return to community = Yes" shows that in California, SNF residents' interest in being discharged to the community increased from 21.3 percent in Quarter 4, 2002 to 26.8 percent in Quarter 3, 2010, and that the average rate of California residents who expressed or indicated preference in being discharged to the community are higher than the overall national average as displayed in Figure 2-1.

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<sup>2-1</sup> PASRR Technical Assistance Center. Introduction to PASRR. Available at:  
<http://www.pasrrassist.org/resources/introduction-pasrr>

**Figure 2-1—Comparison of California and National Preference to Discharge to Community Rates<sup>2-2</sup>**



### **Use of MDS 2.0 Section Q Data in Nursing Home Transition Programs**

The Rutgers Center for State Health Policy, under CMS grants, published two reports documenting ways States and other organizations have used MDS data in their nursing home transition projects. In their first report “Using the Minimum Data Set (MDS) to facilitate Nursing Home Transition,” the researchers identified programs in Vermont, Wyoming, New Jersey, and Louisiana that used Section Q data to identify residents who expressed a preference to return to the community.<sup>2-3</sup> In these nursing facility transition projects, States and organizations used Section Q in the MDS to identify nursing home residents who might prefer to live in the community rather than a nursing home. These were small scale programs that did not lead to any major transition projects, but they did demonstrate the validity of using the MDS section Q data to identify SNF residents who desired to transition to community living.

In the second report by the Rutgers Center for State Health Policy, findings show that the MDS Section Q questions were effective in identifying a resident’s discharge preferences, and changes to MDS Section Q content and process could improve the data used for counseling residents about

<sup>2-2</sup> Department of Health and Human Services, Center for Medicare & Medicaid Services. MDS Q1a Report. Published Apr 4, 2012. Available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MDSPubQIandResRep/qIareport.html>. Accessed on: Apr 18, 2012.

<sup>2-3</sup> Reinhard S, Hendrickson L, Bemis A. *Issue Brief: Using the Minimum Data Set (MDS) to Facilitate Nursing Home Transition*. Rutgers Center for State Health Policy; February 2005. Available at: <http://www.hcbs.org/files/66/3279/MDSReportFeb05.pdf>. Accessed on: Apr 18, 2012.

their options for returning to the community.<sup>2-4</sup> The survey of the grantees found agencies in Alabama, Wyoming, New Hampshire, Pennsylvania, Georgia, Maryland, and Nevada were using the Section Q1a data to identify residents who sought to return to the community.<sup>2-5</sup> All of these agencies found limitations in using the Section Q data and believed data access could be improved, and the Section Q questions could also be improved to make them more useful. The researchers made several suggestions for improving the Section Q questions and data collection to include: giving Section Q more visibility, making section Q completion mandatory, adding more detailed questions to Section Q, and making the questions more person-centered to improve transition planning.<sup>2-6</sup>

### **Minnesota: Nursing Home Transitions Study**

A series of studies on nursing home transitions was conducted to understand the factors affecting community discharges and to inform the design of Minnesota's Return to Community Program based on MDS data.

One study examined the relationship of resident-level and facility-level factors to preference for community discharge.<sup>2-7</sup> A related study examined the relationship of market-level and facility-level factors on facility's discharge to community rates.<sup>2-8</sup> In both studies, the researchers found that nursing home residents are more likely to be discharged if they enter facilities where a higher proportion of residents express a preference or have support for a community discharge. Admissions who were unmarried, older, receiving Medicaid per diem, cognitively impaired, diagnosis of Alzheimer's or other dementia, activities of daily living (ADL) dependent, incontinent, and with a psychiatric disorder, diabetes, cancer, or an end-stage disease diagnosis were less likely to be discharged to the community. Other facility-level factors that influence the likelihood of discharge to the community include Medicare-oriented facilities, higher nurse staffing, and higher occupancy.

Both studies used measures of discharge status from the MDS. Measures of community discharge preference and support were taken from MDS item Q1a – "Resident expresses/indicates preference to return to the community" (yes/no) and Q1b – "Resident has a support person who is positive toward discharge" (yes/no) measured at admission to the nursing home. Additional study variables that were derived from the MDS included age, gender, marital status, length of stay, and living alone before admission as well as diagnoses and problem conditions such as Alzheimer's or dementia, psychiatric disorder (schizophrenia or anxiety disorder), depression, diabetes, hip fracture, cancer, end-stage disease, and bowel or bladder continence.

Finally, these studies have shown that the MDS can be a valuable tool in targeting residents for a transition program.

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<sup>2-4</sup> Reinhard S, Hendrickson L. *Discussion Paper: Money Follows the Person: State's Progress in Using the Minimum Data Set (MDS) to Facilitate Nursing Home Transition*. Rutgers Center for State Health Policy; June 2006. Available at: <http://www.hcbs.org/files/95/4742/MDSIIWEB.pdf>. Accessed on: Apr 18, 2012.

<sup>2-5</sup> Ibid.

<sup>2-6</sup> Ibid.

<sup>2-7</sup> Milne D. *MDS 3.0 Section Q Pilot Test*. Ascillon Corporation; March 2010. Available at:

<http://www.dphhs.mt.gov/sltc/services/nursingfacilities/MDS/PilotTest.pdf>. Accessed on: Apr 18, 2012.

<sup>2-8</sup> Ibid.

## ***MEDPAC: Community Discharge and Potentially Avoidable Rehospitalization Report***

Since 2000, the Medicare Payment Advisory Commission (MEDPAC) has been reporting on nursing home quality measures that are specific to short-stay patients in SNFs, including rehospitalization and community discharge rates using the national DataPRO SNF Stay File. This file is constructed using Medicare SNF and inpatient hospital claims, MDS assessments, and facility staffing data from the Online Survey Certification and Reporting (OSCAR) system. A resident-level risk adjustment model was developed which includes comorbidity indices, functional status (Barthel's Score and Cognitive Performance Score), selected disease indicators, do not resuscitate indicators, marital status, and a set of five binary indicator variables for rehabilitation RUG (ultra high, very high, high, medium, and low vs. other categories). Facility expected rates were calculated based on the risk adjustment models and the admitting characteristics of SNF residents at each facility. Facility adjusted rates were also calculated using the method described in the National Nursing Home Quality Measures User's Manual.

## ***California Department of Public Health's Licensing and Certification Program Report to the Legislature***

In 2009, the CDPH Licensing and Certification program issued a legislative report that focused on the extent to which residents who had expressed a preference to return to the community were able to return to the community.<sup>2-9</sup> The report used MDS 2.0 data to report the percentage of residents who expressed desire to return to the community were discharged to home or a lesser level of care within a year of admission. A sample of residents who answered affirmatively to MDS 2.0 Section Q1a. Discharge Potential and Overall Status were identified. This item was used in conjunction with Section A3a. Assessment Reference Date to identify the residents' first indication of preferring community life, and Section R3a. Assessment/Discharge Information to identify the discharge status of the residents in the sample. The main result of this analysis show that over 60 percent of residents who were admitted to a California skilled nursing facility during calendar years 2005 and 2006 and who had a preference for home or community living were discharged to home or a lesser level of care by 2008.

## **Review of Options and Existing Data**

Often, the largest barrier to developing a quality measure is having data. Data is often unavailable and even if available it can be biased, invalid, or otherwise unusable because it was designed for another purpose and is not applicable. This is not true of Olmstead compliance as there are specific MDS 3.0 related data points. Further, published reports on previous experiences by States and other organizations in using the MDS assessment tool in nursing home transition projects and research studies show the usefulness of MDS data in evaluating discharge or transition planning efforts.

The latest version of MDS 3.0 data contains data specifically designed to address this subject. Given that several items in the MDS 3.0 assessment instrument address aspects of care related to

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<sup>2-9</sup> Ibid.

Olmstead compliance; it may be possible to develop performance measures that can evaluate nursing home Olmstead compliance.

The 2010 “MDS 3.0 Section Q Pilot Test” stated that the Section Q questions were “part of broader systemic efforts by CMS to support an individual’s right to choose the services and settings in which they receive those services” and meet the requirements of the ADA and the Olmstead decision.<sup>2-10</sup> Further, the revisions were designed to replace less useful questions found in the MDS 2.0 and assist States in their efforts to support individuals who desire to transition to HCBS.<sup>2-11</sup> The MDS 3.0 data can form the basis for developing a quality measure.

In March 2010, prior to the release of the revised MDS 3.0 Section Q questions, CMS funded a study titled “MDS 3.0 Section Q Pilot Test,” which examined how effective the revised Section Q questions were at identifying residents who sought referral and transition to the community.<sup>2-12</sup> Prior to the development of the new Section Q questions in 2008, CMS convened a 12 State work group “to provide input on the development and implementation of policies, procedures and tools used in transitioning individuals from institutional to community living situations including changes to Section Q of the MDS 3.0.”<sup>2-13</sup> California, Connecticut, and Texas conducted pilot testing in 2008, and New Jersey and Michigan conducted pilot testing in 2010.<sup>2-14</sup> Two key findings of the study included:

- ◆ The new Section Q items were somewhat helpful for identifying good candidates for transition.
- ◆ Roles and responsibilities of the designated LCA must be clearly identified so that the LCA can contact referred individuals in a timely manner, provide information about transition programs, and collaborate with the nursing facilities to implement the transition to the community.<sup>2-15</sup>

The researchers identified that the pending changes to Section Q were a response to requests from State agencies and consumer advocates to improve the transition referral process and meet the requirements to comply with the ADA and the Olmstead decision.<sup>2-16</sup>

The finalized Section Q in the MDS assessment instrument includes several items that are consistent with the Olmstead decision (see Appendix A). These items under Section Q support residents’ rights to choose where they receive their long-term care services by enabling nursing homes to assess residents’ preferences and needs for LTC options and supports, identifying candidates and strengthening the referral and transition of individuals to community living.

Item Q0500 Return to Community requires nursing homes to contact residents directly about their interest in speaking to someone regarding returning to live in the community during each admission, quarterly and annual assessments. Residents or family or significant other may opt out

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<sup>2-10</sup> Ibid.

<sup>2-11</sup> Ibid.

<sup>2-12</sup> Ibid.

<sup>2-13</sup> Ibid.

<sup>2-14</sup> Ibid.

<sup>2-15</sup> Ibid.

<sup>2-16</sup> Ibid.

of being asked this question on all assessments. Nursing facilities are expected to follow up and refer the resident to a LCA in a “reasonable” time, preferably within 10 days.<sup>2-17</sup> Section Q also asks if there’s a discharge plan in place (Q0400) and if a referral has been made to the LCA (Q0600).

### **MDS 3.0 Data Elements**

Existing MDS 3.0 data elements have been developed specifically to address Olmstead compliance. These elements, listed below, can be used to address this issue, but have had limited use given how recent the 3.0 version has been implemented. Given the specific nature of these data elements a quality measure can be developed and no proxy or substitutive measure is needed.

Although there are no specific section Q reports published by CMS, the State does have access to the raw MDS 3.0 data that can be used. This data can be used to identify residents requesting transition to HCBS in accordance with the Olmstead decision and requirements of the subsequent laws arising from the Olmstead decision.

The following MDS 3.0 items are potential sources for extracting data that the State can use in monitoring nursing homes’ compliance with Olmstead:

- ♦ **A2100:** Discharge Status. This question asks if the patient has been discharged and if the answer is yes, “Code 01, community (private home/apt., board/care, assisted living, group home)” applies.<sup>2-18</sup> This item is designed to track patient demographic and outcome information and also requires the nursing home to review the residents’ medical records for a discharge plan, and documentation of discharge location.
- ♦ **Q0400:** Discharge Plan. This section contains item 0400A which asks, “Is active discharge planning already occurring for the resident to return to the community?”<sup>2-19</sup> The rationale for this question is twofold. First, they are designed to improve the residents’ quality of life by returning them to home or a non-institutional setting, and for long-term residents it is important to determine if they are interested “in talking with LCA experts about returning to the community.”<sup>2-20</sup> Second, they are designed to initiate planning for care: “Some nursing home residents may be able to return to the community if they are provided with appropriate assistance and referral community resources;” further, this question was designed to aid in meeting the Olmstead compliance requirements that “residents needing long-term care services have a right to receive services in the least restrictive and most integrated setting.”<sup>2-21</sup> The nursing home needs to develop a care plan and detailed

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<sup>2-17</sup> Department of Health and Human Services, Center for Medicare & Medicaid Services. Long-Term Care Facility Resident Assessment Instrument User’s Manual, Version 3.0. Published April 2012. Available at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>. Accessed on: Apr 18, 2012.

<sup>2-18</sup> Ibid.

<sup>2-19</sup> Ibid.

<sup>2-20</sup> Ibid.

<sup>2-21</sup> Ibid.

discharge instructions that include planning for sub-acute residents including the elderly, disabled, and intellectually challenged.<sup>2-22</sup>

- ◆ **Q0500: Return to Community.** Item Q0500A asks “Has the resident been asked about returning to the community?”<sup>2-23</sup> The goal of this item is to facilitate action from the nursing home to initiate and collaborate with the LCA to support the resident’s expressed interest in being transitioned to community living.
- ◆ **Q0600: Referral.** Item Q0600 asks “Has a referral been made to the Local Contact Agency?”<sup>2-24</sup> The question supports the notion that some nursing home residents may be able to return to the community if they are provided appropriate community resources to facilitate care in a non-institutional setting.

## Potential Quality Measure Concepts

The MDS 3.0 data could be used to address quality measurement for Olmstead compliance and offers several different measurement concepts that can be used as the basis for the development of a quality measure.

There is considerable debate regarding whether a quality measure should evaluate processes or outcomes of care. Process of care measures of quality assesses the degree to which providers perform healthcare processes demonstrated to achieve the desired aims or outcomes. Outcomes of care measures of quality are focused on achievement of a particular state of health.

There are advantages and disadvantages to both types of measures.<sup>2-25</sup> Process measures are useful to providers because they can provide feedback for quality improvement initiatives. They provide information that is actionable (i.e., what is being done well and what needs improvement). When process measures are developed well and accurately reflect the care that health care providers are delivering, providers feel accountable for them.<sup>2-26</sup> However, while providers may care about process measures, patients and non-clinicians generally place more value on outcome measures. They believe that it is the provider’s responsibility to perform the appropriate processes and to avoid those that are harmful.<sup>2-27</sup> The primary reason to deliver health care services is to maximize improvement and minimize decline in patient health status. Thus, measurement of changes in health status or outcomes should be central components of quality improvement or performance improvement systems within healthcare provider systems.<sup>2-28</sup> Nevertheless, outcome measures may often require risk adjustment as well as a larger sample size. Most outcome measures cannot be used to give feedback to providers about how to improve what they are doing; oftentimes, poor

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<sup>2-22</sup> Ibid.

<sup>2-23</sup> Ibid.

<sup>2-24</sup> Ibid.

<sup>2-25</sup> Rubin, H. R., Pronovost, P., & Diette, G. B. (2001). The Advantages and Disadvantages of Process-based Measures of Health Care Quality. *International Journal for Quality in Health Care*, 13(6), 469 –474.

<sup>2-26</sup> Ibid

<sup>2-27</sup> Ibid

<sup>2-28</sup> Bryant, L. L., Floersch, N., Richard, A. A. & Schlenker, R. E. (2004). Measuring Healthcare Outcomes to Improve Quality of Care Across Post-Acute Care Provider Settings. *Journal of Nursing Care Quality*, 19(4), 368-376.

outcome are not always a result of a particular faulty process and maybe affected by other factors not within the providers' control.<sup>2-29</sup>

There are two potential measure concepts that can be explored for measure development:

- ◆ Process measure: Discharge Planning to Return to Community
- ◆ Outcome measure: Appropriate Discharge to Community

Further analysis is needed to analyze potential quality measures that can be developed using MDS 3.0. Creating an Olmstead compliance measure from the existing MDS items requires access to specific data elements, which may not be routinely accessed by the State. These data elements will require cleaning and aggregation of data for each facility.

Further, additional resources are needed in developing an Olmstead compliance measure. Meticulous evaluation of the potential Olmstead compliance measure with regards to its attributes meeting the CA QAP Measure Selection Criteria is critical. In a prior white paper developed by HSAG for the SNF QAP, HSAG identified proposed measure selection criteria. These measure selection criteria include:

- ◆ Importance
- ◆ Scientific Acceptability
- ◆ Feasibility
- ◆ Usability
- ◆ Comparison to Related and Competing Measures

Before any further steps are undertaken to develop the Olmstead compliance measure, the State will have to evaluate the costs associated with these tasks. Further, measure development is a multi-step process involving extensive literature review, expert engagement, measure testing and empirical analyses, and precise specifications. The overall process of measure development can take approximately 20 months to complete.<sup>2-30</sup>

### **Potential MDS 3.0 Data Elements for Quality Measure Concepts**

This section describes potential MDS 3.0 data elements that can be used to support the proposed measure concepts for Olmstead compliance. However, additional analysis and testing should be conducted to ensure appropriateness of data elements for an Olmstead compliance measure.

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<sup>2-29</sup> Rubin, H. R., Pronovost, P., & Diette, G. B. (2001). The Advantages and Disadvantages of Process-based Measures of Health Care Quality. *International Journal for Quality in Health Care*, 13(6), 469 –474.

<sup>2-30</sup> Agency for Healthcare Research and Quality. U.S. Department of Health and Human Services. Quality Indicator Measure Development, Implementation, Maintenance and Retirement. Published January 2011. Available at <http://www.qualityindicators.ahrq.gov/Downloads/Resources/Publications/2011/QI%20Measure%20Development%20Implementation%20Maintenance%20Retirement%20Summary%2005-03-11.pdf>. Accessed on May 21, 2012.

## Potential Process Measure: Discharge Planning to Return to Community

There is evidence to support the effectiveness of discharge planning on transitioning nursing home residents to the community.<sup>2-31</sup> Further, effective discharge planning programs have been shown to improve patient outcomes in older adults transitioning from one setting to another.<sup>2-32</sup> As such, a process measure concept can be developed to assess the facility's discharge planning process when a resident expresses the desire to return to the community. This potential measure could start with evaluating the resident's desire to return to community and if this is the case, also assess the process of developing a transition plan and ultimately transitioning the resident to HCBS, if possible. A nursing facility resident's desire to return to the community does not always mean it is possible that the resident is capable of returning to the community. The following data elements may be used to support this measure concept:

- ◆ Q0500 Return to Community

Ask the resident (or family or significant other if resident is unable to respond) "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"

0. No

1. Yes

9. Unknown or uncertain

- ◆ Q0400 Discharge Plan

Is active discharge planning already occurring for the resident to return to the community?

0. No

1. Yes

- ◆ Q0600 Referral

Has a referral been made to the Local Contact Agency?

0. No – referral not needed

1. No – referral is or may be needed

2. Yes – referral made

There are issues to consider when considering a process-based measure for Olmstead compliance. First, in order for the process measure to be valid, there must be a strong relationship between the process of care and outcome. In evaluating the quality of a process of care, the linkage of practice to outcomes must either have been demonstrated scientifically or must be widely accepted by peers.<sup>2-33</sup> Therefore, additional analysis is required to evaluate the strength of the scientific

<sup>2-31</sup> Meador, R., Chen, E., Schultz, L., Norton, A., Henderson, C. & Pillemer, K. (2011). Going home: Identifying and overcoming barriers to nursing home discharge. *Care Management Journal*, 12(1).

<sup>2-32</sup> Richards, S. & Coast, J. (2003). Interventions to improve access to health and social care after discharge from hospital: A systematic review. *Journal of Health Services Research and Policy*, 8, 171-179.

<sup>2-33</sup> Rubin, H.R., Pronovost, P., & Diette, G. B. (2001). From a process of care to a measure: The development and testing of

evidence to support the validity of these processes of care related to transitioning residents to the community. In evaluating the strength of the evidence, the quantity, quality, and consistency of the body of evidence that the measured process leads to desired outcomes should be taken into consideration. If scientific evidence establishing these links is absent, or if guidelines are lacking, measure developers often use consensus among experts to establish the validity of process-based quality measures.<sup>2-34</sup> Identified experts explicitly address the certainty or confidence that benefits patients from the specific process to greatly outweigh potential harms. This is done by using a specified process that is transparent and open to peer review (e.g., modified Delphi, formal consensus process, RAND Appropriateness Method).<sup>2-35</sup>

Second, it is possible that the process of care measure concepts identified do not capture the “ideal” care needed for Olmstead compliance. This may be limited by the availability of information collected in the MDS. In addition, it is possible that the process of care measure concept identified may not be the most important aspect of care related to Olmstead compliance. If process measures are not comprehensive and do not capture all important aspects of the process that affect outcomes, they may be misleading to users.<sup>2-36</sup> Finally, the appropriateness of using this process of care measure concept in the QA Program need further examination. Overall, more detailed analyses using the MDS data and other available and feasible data sources will have to be done to evaluate the validity and reliability of this potential measure concept.

### **Potential Outcome Measure: Appropriate Discharge to the Community**

One of the key aspects of Olmstead compliance is the placement of residents in the least restrictive environment. This outcome of care measure concept captures a particular goal of Olmstead (i.e., community discharge). The MDS offers one data element to support this measure concept:

- ◆ A2100 Discharge Status
  - 01. Community
  - 02. Another nursing home or swing bed
  - 03. Acute hospital
  - 04. Psychiatric hospital
  - 05. Inpatient rehabilitation facility
  - 06. ID/DD facility
  - 07. Hospice
  - 08. Deceased
  - 09. Long Term Care Hospital (LTCH)
  - 99. Other

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a quality indicator. *International Journal for Quality in Health Care*, 13(6), 489–496

<sup>2-34</sup> Ibid

<sup>2-35</sup> National Quality Forum. (2011). Guidance for Evaluating the Evidence Related to the Focus of Quality Measurement and Importance to Measure and Report. [www.qualityforum.org](http://www.qualityforum.org)

<sup>2-36</sup> Rubin, H. R., Pronovost, P., & Diette, G. B. (2001). The advantages and disadvantages of process-based measures of health care quality. *International Journal for Quality in Health Care*, 13(6), 469–474.

There are issues to consider when developing an outcomes-based measure concept for Olmstead compliance. Specifically, technical issues pertaining to risk adjustment is the most critical issue to consider. Because health outcomes depend not only on the care patients receive but also on their risk factors, outcome-based measures must account for differences in the mix of patients' risk factors across providers. Otherwise, these measures are likely to be biased, typically underestimating the quality of those treating the sickest patients.<sup>2-37</sup> In addition, insufficient risk adjustment may create perverse incentives to avoid admission of the sickest patients, limiting access to nursing home care for those who need it the most.<sup>2-38</sup>

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<sup>2-37</sup> Mukamel, D., Glance, L. G., Li, Y., Weimer, D. L., Spector, W. D., Zinn, J. S. & Mosqueda, L. (2008). Does Risk Adjustment of the CMS Quality Measures for Nursing Homes Matter? *Medical Care*, 46(5), 532-541.

<sup>2-38</sup> Ibid.

### 3. CONCLUSIONS AND RECOMMENDATIONS

#### Current Performance Year (7/1/2012-6/30/2013)

There are no existing quality measures that address nursing homes' Olmstead compliance. As previously discussed, CMS currently does not have a measure in the Nursing Home Quality Reporting program nor in the MDS 3.0 Quality Indicator/Quality Measure report that the State can use to monitor nursing homes' compliance with Olmstead. Although an MDS 2.0-derived resident discharge preference status quality indicator was previously available from CMS, this quality indicator is currently not available based on MDS 3.0 data. Further analysis and measure development would be needed.

#### Future Performance Years

At this time, given there is no existing measure to add, HSAG recommends further analysis and measure development of an Olmstead compliance measure for subsequent years. If the State elects to develop a measure for Olmstead compliance for the QAP, HSAG recommends that the State develop two Olmstead compliance measures using items from MDS 3.0. Although CMS has not developed a specific quality measure to track Olmstead compliance, it has revised Section Q of the MDS 3.0 to specifically address the ADA and Olmstead compliance requirements to provide the elderly and disabled with community based services that place these individuals in programs that provide the most integrated settings for appropriate community based care. Therefore, several items in the MDS 3.0 assessment tool can be used as the basis for a performance metric for monitoring Olmstead compliance in nursing homes.

Two potential measure concepts were presented: Discharge Planning to Return to Community (process) and Appropriate Discharge to Community (outcome). In addition, potential MDS 3.0 data elements that might serve to support the measure concepts were discussed. However, there are several issues that the State will need to consider when pursuing measure development. Measure development is a multi-step process comprised of extensive literature reviews, expert engagement, testing and empirical analyses, and precise specifications. It can take the State up to two years to develop an Olmstead compliance measure. These tasks will require additional resources that must be available prior to moving forward with measure development. Additionally, advantages and disadvantages between process-based and outcomes-based measures need to be weighed, and the appropriateness of the proposed quality measure concepts should be investigated further. Finally, HSAG recommends that any Olmstead compliance measure developed by the State must meet the measure selection criteria for the SNF QAP.

Resident	Identifier	Date
<b>Section Q Participation in Assessment and Goal Setting</b>		
<b>Q0100. Participation in Assessment</b>		
Enter Code <input type="checkbox"/>	<b>A. Resident participated in assessment</b> 0. No 1. Yes	
Enter Code <input type="checkbox"/>	<b>B. Family or significant other participated in assessment</b> 0. No 1. Yes 9. No family or significant other available	
Enter Code <input type="checkbox"/>	<b>C. Guardian or legally authorized representative participated in assessment</b> 0. No 1. Yes 9. No guardian or legally authorized representative available	
<b>Q0300. Resident's Overall Expectation</b> Complete only if A0310E = 1		
Enter Code <input type="checkbox"/>	<b>A. Select one for resident's overall goal established during assessment process</b> 1. Expects to be discharged to the community 2. Expects to remain in this facility 3. Expects to be discharged to another facility/institution 9. Unknown or uncertain	
Enter Code <input type="checkbox"/>	<b>B. Indicate information source for Q0300A</b> 1. Resident 2. If not resident, then family or significant other 3. If not resident, family, or significant other, then guardian or legally authorized representative 9. Unknown or uncertain	
<b>Q0400. Discharge Plan</b>		
Enter Code <input type="checkbox"/>	<b>A. Is active discharge planning already occurring for the resident to return to the community?</b> 0. No 1. Yes → Skip to Q0600, Referral	
<b>Q0490. Resident's Preference to Avoid Being Asked Question Q0500B</b> Complete only if A0310A = 02, 06, or 99		
Enter Code <input type="checkbox"/>	<b>Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?</b> 0. No 1. Yes → Skip to Q0600, Referral 8. Information not available	
<b>Q0500. Return to Community</b>		
Enter Code <input type="checkbox"/>	<b>B. Ask the resident (or family or significant other if resident is unable to respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"</b> 0. No 1. Yes 9. Unknown or uncertain	
<b>Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again</b>		
Enter Code <input type="checkbox"/>	<b>A. Does the resident (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)</b> 0. No - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. Yes 8. Information not available	
Enter Code <input type="checkbox"/>	<b>B. Indicate information source for Q0550A</b> 1. Resident 2. If not resident, then family or significant other 3. If not resident, family or significant other, then guardian or legally authorized representative 8. No information source available	
<b>Q0600. Referral</b>		
Enter Code <input type="checkbox"/>	<b>Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)</b> 0. No - referral not needed 1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20) 2. Yes - referral made	

