Measuring and Reporting Long Term Care Quality: The US Experience

Vincent Mor, Ph.D.
Florence Pirce Grant University Professor
Brown University


Eurohealth
RESEARCH • DEBATE • POLICY • NEWS
Volume 16 Number 2, 2010
Measuring the quality of long-term care
Public reporting of long-term care quality: the US experience

Public reporting of long-term care quality: the US experience

Vincent Mor

Summary: Efforts to improve the quality of long-term care services traditionally focus on regulatory and enforcement systems, however, increasingly provider quality improvement efforts stimulated by public reporting of provider performance has been emphasised in the US in both institutional and community based long-term care. Over the past decade, in the US publicly reporting provider performance has been advanced as a means of introducing competition on the basis of quality into the long-term care sector, providing benchmarks against which providers can compare themselves and be compared. This paper briefly summarises the US experience over the last decade in these efforts and proceeds to discuss and document research regarding the advantages and pitfalls of quality measurement and the effects that public reporting has had. Since provider comparisons in the acute care sector are already underway in many European countries, it is likely that these efforts will be expanded in those countries that have a uniform data system in place which can be used for measurement.

Key words: Quality, long-term care, USA, public reporting, measurement, policy, Medicare, Medicaid

The Nursing Home Resident Assessment Instrument (RAI)

1986 Institute of Medicine Report on Nursing Home Quality Recommended a Uniform RAI to Guide Care Planning

OBRA ‘87 Contained Nursing Home Reform Act Including RAI Requirement

A 300 Item, Multi-Dimensional RAI Tested for 2 Years

Mandated Implementation in 1991

Clinical Planning Basis of the RAI

Assessment Profile in Given Domain
"Triggers" Potential "Risk" Status

Resident Assessment Protocol Reviewed to Determine Presence of Problem or High Risk of Problem

Care Planning and Treatment Directed to the Problem

Assumes Data Quality Contingent upon conduct of Clinical Care Planning Process

RAI History

Version 1.0 Mandated for general use in 1991

Version 2.0 Introduced in 1996

Admission, Short Term and Quarterly Reassessments done on all Residents

Since 1998 all RAI records are computerized and submitted to Centers for Medicare & Medicaid

Version 3.0 introduced in 2010; reaffirms Care Planning Basis of Instrument

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	ROOM NUMBER	
3.	ASSESSMENT REFERENCE DATE	a. *Last day of MDS observation period* Month — Day — Year b. Original (0) or corrected copy of form (enter number of correction)
4a.	DATE OF REENTRY	**Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)** Month — Day — Year
5.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
6.	MEDICAL RECORD NO.	
7.	CURRENT PAYMENT SOURCES FOR N.H. STAY	(*Billing Office to indicate;* ***check all that apply in last 30 days***) Medicaid per diem a. Medicare per diem b. Medicare ancillary part A c. Medicare ancillary part B d. CHAMPUS per diem e. VA per diem f. Self or family pays for full per diem g. Medicaid resident liability or Medicare co-payment h. Private insurance per diem (including co-payment) i. Other per diem j.
8.	REASONS FOR ASSESS	a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment

3.	MEMORY/ RECALL ABILITY	(***Check all*** *that resident was* ***normally able to recall during last 7 days***) Current season a. Location of own room b. Staff names/faces c. That he/she is in a nursing home d. *NONE OF ABOVE* are recalled e.
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(*Made decisions regarding tasks of daily life*) 0. *INDEPENDENT*—decisions consistent/reasonable 1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only 2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required 3. *SEVERELY IMPAIRED*—never/rarely made decisions
5.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS	(*Code for behavior in the* ***last 7 days.)*** ***[Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time].*** 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) **a.** EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) **b.** PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) **c.** EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) **d.** PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) **e.** PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) **f.** MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

MDS 2.0 Rating Resident Function

1. (A) ADL SELF-PERFORMANCE—(*Code for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days* *—Not including setup*)**

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   — Weight-bearing support
   — Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(*Code for* ***MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless* *of resident's self-performance classification*)**

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	**BED MOBILITY**	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	**TRANSFER**	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	**WALK IN ROOM**	How resident walks between locations in his/her room		
d.	**WALK IN CORRIDOR**	How resident walks in corridor on unit		
e.	**LOCOMO-TION**	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency		

MDS 3.0 Requires Resident Interview

Interview for Mental Status.

C0200-C0500: Brief Interview for Mental Status (BIMS)

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Number of words repeated after first attempt

0. None
1. One
2. Two
3. Three

After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code

Ask resident: *"Please tell me what year it is right now."*

A. Able to report correct year

0. Missed by > 5 years or no answer
1. Missed by 2-5 years
2. Missed by 1 year
3. Correct

Enter Code

Ask resident: *"What month are we in right now?"*

B. Able to report correct month

0. Missed by > 1 month or no answer
1. Missed by 6 days to 1 month
2. Accurate within 5 days

Enter Code

Ask resident: *"What day of the week is today?"*

C. Able to report correct day of the week

0. Incorrect or no answer
1. Correct

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*

If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code

A. Able to recall "sock"

0. No - could not recall
1. Yes, after cueing ("something to wear")
2. Yes, no cue required

Enter Code

B. Able to recall "blue"

0. No - could not recall
1. Yes, after cueing ("a color")
2. Yes, no cue required

Enter Code

C. Able to recall "bed"

0. No - could not recall
1. Yes, after cueing ("a piece of furniture")
2. Yes, no cue required

C0500. Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)

Enter 99 if unable to complete one or more questions of the interview

Payment Uses of RAI

Early on in RAI development Medicare/Medicaid expermimented with alternative uses

Case-Mix Reimbursement systems based upon functional and treatment needs designed

Many states used RAI to pay NHs based upon acuity mix of residents; Medicare used RAI for reimbursement beginning 1998

Quality Measurement Uses of RAI

Quality Indicators created using MDS 1.0 as early quality management experiments

Consortia of providers measured quality and shared best practices

Quality Indicators used to “guide” inspections

Movement toward public reporting culminated in 2002 with “Nursing Home Compare”

CMS Quality Measures - Long Term

Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season
Percent of Long-Stay Residents Given Pneumococcal Vaccination
Percent of Residents Whose Need for Help With Daily Activities Has Increased
Percent of Residents Who Have Moderate to Severe Pain
Percent of High-Risk Residents Who Have Pressure Sores
Percent of Low-Risk Residents Who Have Pressure Sores
Percent of Residents Who Were Physically Restrained
Percent of Residents Who are More Depressed or Anxious (Looks back 30 days)
Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder
Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
Percent of Residents Who Spent Most of Their Time in Bed or in a Chair
Percent of Residents Whose Ability to Move in and Around Their Room Got Worse
Percent of Residents with a Urinary Tract Infection (Looks back 30 days)
Percent of Residents Who Lose Too Much Weight (Looks back 30 days)

Psychotropic Drug Use- October/December 2009

State	Anti-Psychotics Overall	Anti-Psychotics LOW Risk	Anti-Anxiety Agents
National	18.6%	15.6%	23.1%
AK	11.2%	4.7%	21.5%
AL	15.9%	14.0%	27.2%
AR	17.9%	15.6%	21.1%
AZ	19.2%	15.8%	21.5%
CA	16.8%	14.0%	20.4%
CO	18.6%	15.1%	18.1%
CT	23.7%	21.2%	22.7%
DC	13.6%	12.4%	13.4%
DE	20.2%	17.8%	23.3%
FL	12.2%	10.1%	27.5%

Conceptual Issues Inherent in Applying Quality Indicators

Requires "shared" interpretation of Quality

Assumes all Providers have same goals

Assumes Measured Quality Domains are Important

Indicators are NOT Quality *per se*, BUT often used as evidence in and of themselves

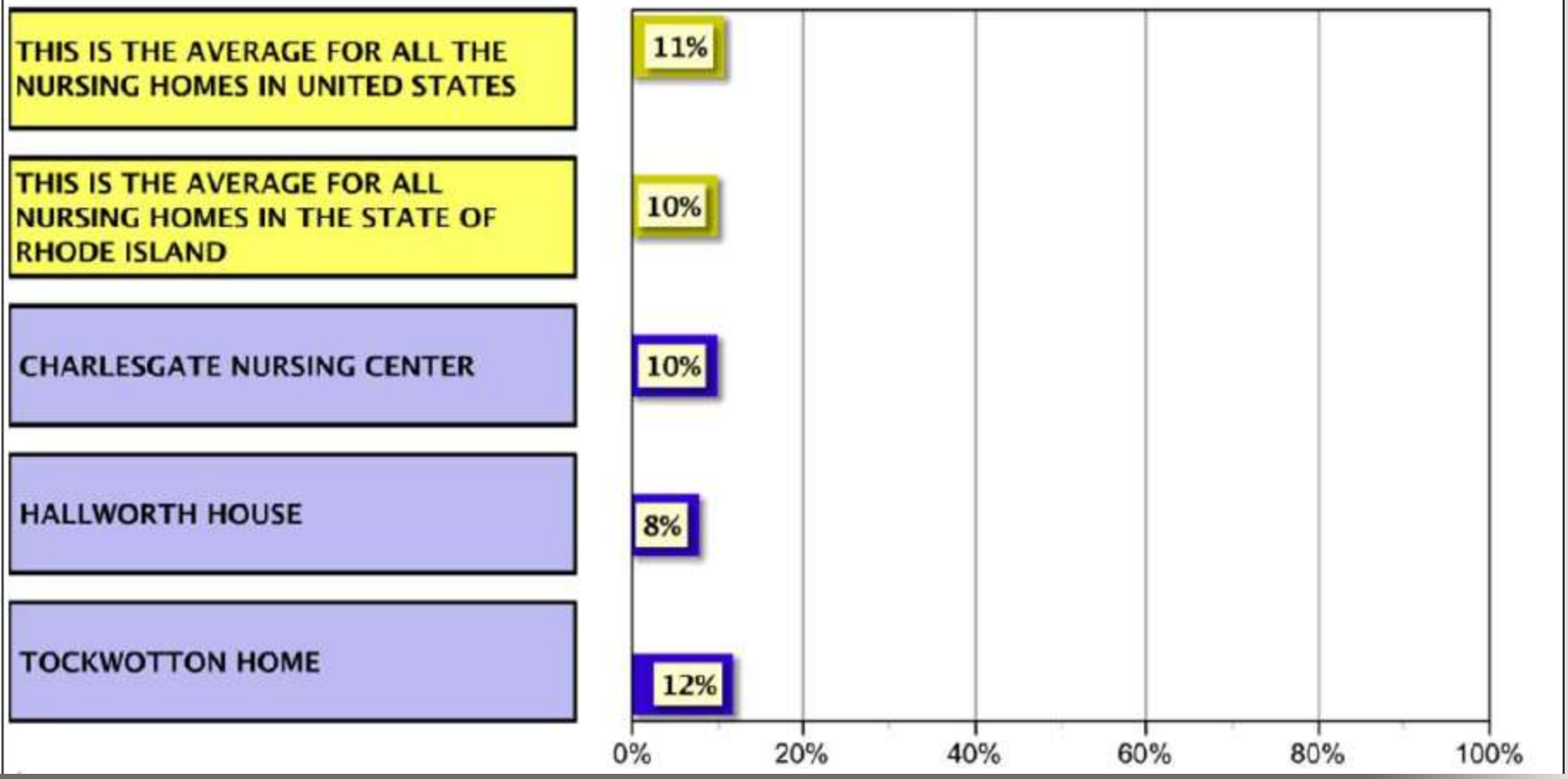
Assumes Providers *Accountable* for most of the variation in the Indicator (e.g. outcomes)

Assumes Providers Know how to Change Practice

Public Reporting of Quality

NURSING HOME COMPARE allows consumers and advocates to identify facilities in their geographic area and to identify which NH's perform best on one or more specific quality measures.

Percent of high-risk long-stay residents who have pressure sores



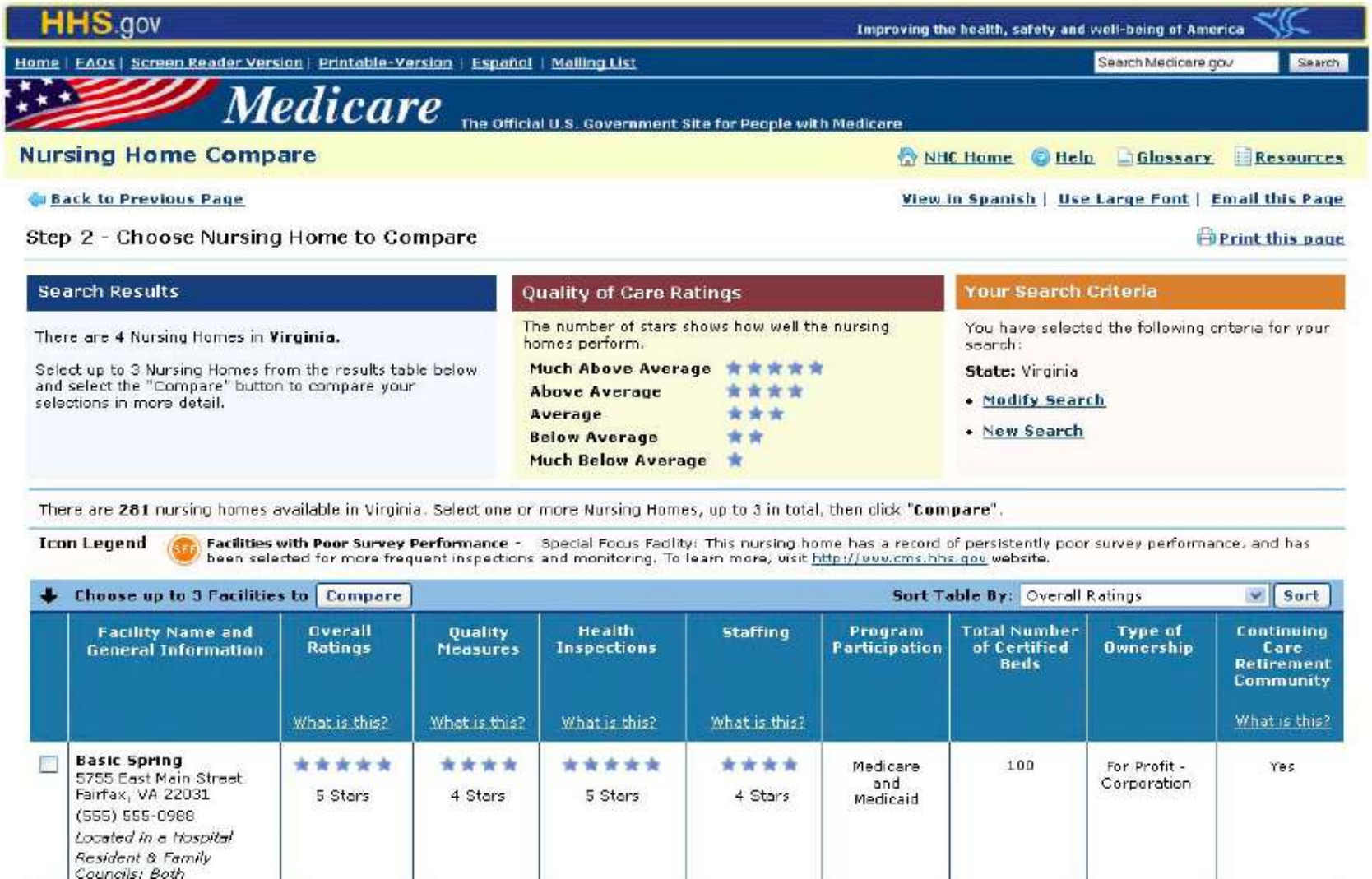
Creating Composites: 5 Star Rating

Five years after public reporting multiple QMs, Advocates concerned that public didn't understand; too complicated wanted simplicity

A 5 Star Rating was created by combining data from inspections, staffing levels & Qis

Inspections and Staffing weighted most highly; some technical adjustments to try to deal with data inadequacies of these data

Reporting Composites: 5 Star Rating



HHS.gov — Improving the health, safety and well-being of America

Home | FAQs | Screen Reader Version | Printable Version | Español | Mailing List — Search Medicare.gov — Search

Medicare — The Official U.S. Government Site for People with Medicare

Nursing Home Compare — NHC Home | Help | Glossary | Resources

Back to Previous Page — View in Spanish | Use Large Font | Email this Page

Step 2 - Choose Nursing Home to Compare — Print this page

Search Results

There are 4 Nursing Homes in **Virginia.**

Select up to 3 Nursing Homes from the results table below and select the "Compare" button to compare your selections in more detail.

Quality of Care Ratings

The number of stars shows how well the nursing homes perform.

Much Above Average	★★★★★
Above Average	★★★★
Average	★★★
Below Average	★★
Much Below Average	★

Your Search Criteria

You have selected the following criteria for your search:

State: Virginia

- Modify Search
- New Search

There are **281** nursing homes available in Virginia. Select one or more Nursing Homes, up to 3 in total, then click "**Compare**".

Icon Legend — **Facilities with Poor Survey Performance** - Special Focus Facility: This nursing home has a record of persistently poor survey performance, and has been selected for more frequent inspections and monitoring. To learn more, visit http://www.cms.hhs.gov website.

Choose up to 3 Facilities to Compare — Sort Table By: Overall Ratings — Sort

	Facility Name and General Information	Overall Ratings (What is this?)	Quality Measures (What is this?)	Health Inspections (What is this?)	Staffing (What is this?)	Program Participation	Total Number of Certified Beds	Type of Ownership	Continuing Care Retirement Community (What is this?)
☐	**Basic Spring** 5755 East Main Street Fairfax, VA 22031 (555) 555-0988 *Located in a Hospital* *Resident & Family Councils: Both*	★★★★★ 5 Stars	★★★★ 4 Stars	★★★★★ 5 Stars	★★★★ 4 Stars	Medicare and Medicaid	100	For Profit - Corporation	Yes

Your Selected Nursing Homes

	HALLWORTH HOUSE 66 BENEFIT STREET PROVIDENCE, RI 02904 (401) 274-4505 **Mapping & Directions**	TOCKWOTTON HOME 75 EAST STREET PROVIDENCE, RI 02903 (401) 272-5280 **Mapping & Directions**	CHARLESGATE NURSING CENTER 100 RANDALL STREET PROVIDENCE, RI 02904 (401) 861-5858 **Mapping & Directions**
Overall Rating	5 out of 5 stars	5 out of 5 stars	2 out of 5 stars
Show Information **Health Inspections**	3 out of 5 stars	5 out of 5 stars	1 out of 5 stars
Show Information **Nursing Home Staffing**	5 out of 5 stars	5 out of 5 stars	1 out of 5 stars
Show Information **Quality Measures**	5 out of 5 stars	2 out of 5 stars	5 out of 5 stars
Show Information **Fire Safety Inspections**	**0** Fire Safety Deficiencies	**0** Fire Safety Deficiencies	**0** Fire Safety Deficiencies

Does Reporting Improve Quality?

Werner & colleagues (2009) found significant improvement in BOTH measured and *unmeasured* quality measures following public reporting – BUT general improvement trend

Mukamel et al (2007) looked carefully at initial response relative to prior quality patterns and also found improvement on most but not all measures

Werner, et al, 2010 also found improvement in post-acute quality scores

Does Reporting Affect Patients' "Choices" of Nursing Home

Werner and colleagues (2011) found small but significant changes in admission patterns and apparent willingness of patients to travel longer distance based upon publicly reported quality

HOWEVER, most admissions are for short stay rehabilitation BUT most quality measures are based upon performance on long stay residents

These studies pre-dated introduction of 5-Star

Can we Integrate the Residents' Voice into Quality Measures?

MDS 3.0 interviews residents; post-acute AND long stay

Asks about Quality of Life; percent of residents answering higher than anticipated; BUT

Long way to go before a quality of life measure can be used and reported;

If clinical quality is hard to define and measure, QoL even more so

Summary

Public Reporting of long term care providers' quality performance is possible;

All measures are flawed, but no more than acute and ambulatory care

Pre-requisite is to have uniform data collected with relevant clinical detail AND should be able to be audited with penalties to minimize bad data

Issues for the Future

Preferable to have common items, measures and metrics across different types of long term care options, technically AND for consumers

Consumers want Composite Scores, but they are less sensitive than domain specific measures

Measures will never be perfect; so, careful how they are applied and interpreted