Quality Measurement Council
Meeting Minutes
February 26, 2020

Council Members Attending in Person
Ann McQueen – AM
Sydney Edlund – SE
Paula Carder – PC
Mauro Hernandez – MH
Fred Steele – FS

DHS Staff Attending in Person
Lynn Beaton - LB
Jan Karlen - JK

Guests Attending in Person
Ruth Gulyas - RG
Linda Kirshbaum - LK

Council Members Attending by Phone
Carolyn Mendez-Luck

Motions History:

QM 1: RETENTION OF DIRECT CARE STAFF:

- **9/9/2018:**
  - Use 12-month (one year) retention period.
  - Adopt formula used by AHCA/NCAL.
  - Delete "vacancy" as term being used and measured.
- **2/21/19:**
  - Finalize Metric 1
  - Clearly define the time-period for tracking as one calendar year vs. stating a 12-month period.

QM 2: COMPLIANCE WITH STAFF TRAINING REQUIREMENTS:

- **2/21/19:**
  - DHS to provide a fillable version of the tracking tool for facilities.
  - The Council will work with DHS to possibly embed into the MOP in later years.
- **5/16/19**
  - Track the percentage of staff completing training.

QM 3: NUMBER OF RESIDENT FALLS:

- **9/9/2018**:
  - Use timeframe of June – November.
  - Track gross numbers.
- **10/17/2018**:
  - Describe "receiving treatment" vs "evaluation" if outside of facility. (Concept: Council believed resident could be sent to hospital without having actual injury. Wanted to distinguish treatment due to harm from being evaluated with no harm.)

- **4/25/2019**
  - Add a column to the "falls" chart that indicates how many residents fell with injury.

- **6/26/2019**
  - FS made a motion to finalize the data points for QM3 as number of residents at the end of each month, total number of falls with injury at the end of each month and total number of residents who fell with injury at the end of the month. The motion was seconded by SK. LB asked if anyone opposed the motion, there was no opposition to the vote.

QM 4: USE OF ANTIPSYCHOTIC MEDICATIONS FOR NON-STANDARD USE:

- **1/23/2019:**
  - For a pre-selected period of time, track:
    - Total number of residents who used a nonstandard, scheduled anti-psychotic, and
    - Total number of residents who used a PRN anti-psychotic.
  - (Council also wanted an explanation of non-standard uses and PRNs and the distinction between the two as part of the background for this metric.)
- **3/20/19**
  - Approve metric with understanding that wordsmithing is needed. (Now completed)
- **4/25/19**
  - The report will present the statewide average (not pooled) and will list whether or not a facility is tracking the rate for non-standard use. The report will <u>not</u> provide the percentage rate for any individual facility.
- **5/16/19**
  - Send FDA list of antipsychotic medications, the generic and trade names only, to facilities each September.

QM 5: RESULTS OF ANNUAL RESIDENT SATISFACTION SURVEY:

- **9/9/2018:**
  - Use original 4 questions.
- **11/28/2018:**
  - Move forward as is.
- **2/26/2020**
  - Add two additional questions to the QMA "How many surveys sent" and "How many surveys received".
  - First year look at completion rate along with exclusion criteria.

GENERAL:

- **12/19/2018:**
  - DHS will send Provider Alerts monthly to remind providers to collect and enter data each month.
  - 1st year – providers to collect and enter data monthly starting in July, report last 3 months.
  - After 2019, providers to track and enter in all months prior to January 31st of the following year.

- **7/17/2019:**
  - MN nominated FS for vice-chair, vote passed unanimously.
  - AM moved that LTCfacilityportal@oregon.gov be established as the URL address for provider data entry. Motion passed unanimously.
- **10-17-19**
  - DHS to enter into an agreement with an existing academic partner to perform consultation, data cleaning and data preparation for report and website.

PARKING LOT ITEMS:

QM 1: RETENTION OF DIRECT CARE STAFF:

- **9/9/2018:**
  - Consider "turnover" at later date.

QM 2: COMPLIANCE WITH STAFF TRAINING REQUIREMENTS:

- **No parking lot items.**

QM 3: NUMBER OF RESIDENT FALLS:

- **11/28/2018:**
  - Next year revisit collecting falls per resident.
  - Possible future rule change recommendation as to who should report the injury.
  - Concerning reporting in the future - how do we standardize measure?
    - Give numbers, not percentages? Give letter grades – does this give a different connotation?

QM 4: USE OF ANTIPSYCHOTIC MEDICATIONS FOR NON-STANDARD USE:

- **10/17/2018:**
  - Discuss again whether to use nonstandard or off-label.
    - Bill uses term "nonstandard" – this gives Council flexibility. National standard is "off label."
    - Should "nonstandard" be considered the same as "off-label?"
- **3/20/19:**
  - Consider using longer list of APs in the future.

QM 5: RESULTS OF ANNUAL SATISFACTION SURVEY:

- **9/9/2018:**
  - Look at adding "activities" in 2020 and notifying facilities of this expected change.
- **10/17/2018:**
  - Allowing narratives and open-ended questions.
- **11/28/2018:**
  - Look at adding "activities" in later years.
  - Third party interviews – possibly consider for memory care specifically.
  - What is cost of surveys for different vendors?

- Work toward a process to ensure fairness for residents with cognitive impairment (adding single question such as, "Why are we here today?")

- **10/17/2019**
  - In March or April 2020, discuss how data is collected by vendors.

- **2/26/2020**
  - Look at what we are unable to evaluate by looking at surveys that are incomplete during the first year.

General Parking Lot Questions

- **3-20-19**
  - What can be done to ensure that data is entered and entered correctly – Should DHS contract with an entity to provide this service?
  - Will there be an opportunity to do "spot checks," come up with a list of questions?
  - Think how providers may be able to respond when their data may look somewhat skewed compared to other facilities. Could there be a comment field? May give it a year or two to see if there is an issue and then determine a strategy on how to deal with it.
- **10-17-19**
  - SE suggested that during 2020, would like for DHS to report on what is problematic for providers to report on. Possibly use information from the monthly provider calls during implementation period.

The meeting minutes for January 23, 2020 were adopted without any amendments or revisions.

Member announcements – None

Next Meeting – Thursday, March 26, 2020.

Quality Measurement Program Updates:

- AM reported that numerous webinars have been conducted. Q & A sessions have also been provided. Not too many participants. The last two sessions there were no participants.
- So far 221 facilities have at least one person registered to enter information into the Quality Metrics Application (QMA).
- Next step will be to send letters to facility administrators and ALF/RCF corporate offices reminding them of the requirement to enter data and providing website resources as to where they can find information. There was a suggestion to obtain a list of facilities that currently does not have anyone registered to enter data and send letters to them. OHCA and LA OR offered to assist with contacting their respective members.

Question and Comments re QMA:

- Since the last meeting only one question came in and it was about the counting of direct care staff who work in more than one licensed setting on a campus and if they should be counted for only one of the facilities or both. The answer given was the direct care staff should be counted for each facility they work in.

Metric 5:

- Review and discussion of the crosswalk on Metric 5 that AM developed which describes the differences between the CORE Q requirements and what Oregon will require for resident satisfaction. The crosswalk will be reviewed during the webinar scheduled for Thursday, February 27, 2020 with the CORE Q vendors.
    - Calculation of score is different. CORE Q provides an overall score, where for Oregon QMA purposes, there will be a score for each question.
    - Exclusion criteria includes residents with a legal guardian, receiving hospice services, and residents living at the ALF/RCF less than two weeks. It is assumed that for people with cognitive impairment they will either not complete the survey or someone will complete it as a proxy for them, either way they will be excluded. The facility will need to indicate to the vendors which residents should be excluded based on the stated criteria.
    - Difference of response rate (total number of surveys received) vs. surveys completed (meaning surveys completed), only the completed surveys will be counted. This will be added to the Oregon standard in the crosswalk. Breakdown could include number who received the survey (after facility provides names of residents who are eligible to receive survey), number of responses and number of surveys completed, AM offered to ask the developers of the QMA to add these questions to the QMA for Metric 5.
    - It was queried as to why responses to any questions on surveys that will be considered not completed can't be counted (for individual responses to the questions). Answer – there would be a different completion rate for each question, and it would likely be complicated explaining the missing information. The response and completion rates are easier to count, evaluate and explain. It could also be overly burdensome to vendors and the facility. Want to keep it as simple as possible this first year and then evaluate for the coming year.
    - LK mentioned that CORE Q has been tested and validated and expressed concern about too many "tweaks" to the tool.
    - CORE Q response rate minimum is 30 percent per facility. For Oregon the minimum rate is 10 responses. All completed surveys from all facilities will be included in regional and statewide averages.
    - AM made the motion to have two additional questions added to Metric 5 in the QMA which include "Number of surveys sent" and "Number of surveys returned". PC seconded, motion passed.
    - Second motion by AM to look at all completed surveys (all four questions answered) along with exclusion criteria the first year and evaluate. PC seconded, motion passed.

- CM asked what the vendors will do with the incomplete surveys where not all the questions have been answered. Answer – the vendor can share the information with the facility, but it will not be included in the report.
- For facilities that have more than one survey conducted each year, they can choose which survey data will be used for the QMA. They cannot use data from more than one survey.
- AM will revise crosswalk in preparation of the vendor webinar.

Timeline for report writing:

- AM shared a GANTT chart for a timeline of writing the report.
- SE recommended that DHS develop the framework that identifies the audience, sets the tone and the goals of the report in the beginning of the report. Suggestion that DHS report back to the Council in March.
- LB questioned about the overlap of the QMA in January 2021 when facilities are finishing inputting data for 2020 and starting to add data for 2021. AM mentioned that the QMA will have the capability to handle data for both years.
- LB also commented on checking in on licensing information that is also required to be included in the report.

Meeting Adjourned. Next meeting scheduled for March 26, 2020.