Quality Metrics Council
Meeting Minutes
April 25, 2019

Council Members – Present in Person
Paula Carder - PC
Sara Kofman - SK
Mauro Hernandez - MH
Fred Steele - FS
Ann McQueen - AM

Council Members not Present
Carolyn Mendez-Luck - CM

Staff Present
Lynn Beaton - LB
Ann Birch - AB
Rebecca Mapes - RM
Jan Karlen - JK

Guests Attending
Maureen Nash, MD - MN
Linda Kirshbaum – LK
Ruth Gulyas – RG
Lindsay Schwartz – LS

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 will 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.

QM 3: NUMBER OF RESIDENT FALLS:

- **9/9/2018**:
  - Decided to 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.

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.
- **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.

QM 5: RESULTS OF ANNUAL RESIDENT SATISFACTION SURVEY:

- **9/9/2018:**
  - Use original 4 questions.
- **11/28/2018:**
  - Move forward as is.

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.

<u>PARKING LOT ITEMS</u>:

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.

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:**
  - **Parking Lot:** Look at adding "activities" in later years.
  - **Parking Lot:** Third party interviews – possibly consider for memory care specifically.
  - **Parking Lot:** What is cost of surveys for different vendors?
  - **Parking Lot:** Work toward a process to ensure fairness for residents with cognitive impairment

    (adding single question such as, "Why are we here today?")

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", maybe come up with a list of questions to ask.
  - 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.

Meeting called to order and introductions were made.

Minutes from March 20, 2019 were reviewed. Minutes accepted with minor corrections. Take off motions that are no longer current.

BM announced that the May 16th and June 27th meetings will both be on Thursdays.

Report is a way of organizing the work and a way of summarizing the work.

Quality Metric #1 - Staff Retention
Page 4 – only change was 12 months, due to CM's previous comments it is now "calendar year".

Quality Metric #2 – Staff Training

- Need to add training requirements for memory care communities to the metric report.
- Training Tracker – reiterated that DHS will provide the development of a training tracker, will not be part of the portal and DHS will likely not be able to provide technical assistance to facilities on how to use the tool. Will provide training for facilities on how to use the tool.
- AB learned from the tech folks that putting all three categories of people one tracker it will be difficult. For example, new staff requirements for pre-service vs. current staff for in-service training as well as direct care workers vs. other staff. Another concern is that the formulas wouldn't be as stable. In addition, people may move in and out of positions. The start date will be the hire date on the form.
- Need to add language regarding the pre-service training that was required to be completed by December 31, 2018 but being surveyed to until July 1, 2019.
- Discussion included that the fillable would have five worksheets or tabs, that include worksheets for:
    1. New direct care staff through year 1 of employment.
    2. Current direct care workers.
    3. Other staff not providing direct care, i.e. maintenance, dietary and administrative.
    4. Memory care training.
    5. Summary sheet that provides percentage values.
- There will be instructions towards the bottom of each page.
- Suggestion to do a YouTube video to show providers how to complete the Training Tracker.
- Plan a training for the policy analysts, surveyors and corrective action coordinators.
- Conditional formatting depending on how long the employee has been there.

Quality Metric #3 - Falls with Injury

- "Fall with injury" is defined as either a minor or major injury and examples are provided in the description for each type to provide clarification.
- Page 8 – third bullet added to address the concern that even though a resident is sent to the hospital and is fully evaluated and not receiving any treatment for the fall should not be counted as a "fall with injury" for purposes of this metric.
- MN raised concerns about people who fall frequently vs. those who fall much less. In addition, those who are at end of life process and tend to fall more frequently and people with certain conditions such as Parkinson's disease are more prone to falling. Furthermore, sometimes the fall doesn't cause the injury, it may be caused by something like a compression fracture that causes the person to fall. Response – the Council has discussed the issue of people who fall frequently and there was a decision to

work on that issue in subsequent years. There has also been discussion regarding falls resulting from conditions such as compression fractures, however there has not been a decision on how to address it.

- There is value in tracking falls, because some providers are not tracking falls, so at least this measure would encourage them in looking at how falls may have occurred and take steps to prevent them.
- The chart on bottom of page 8, identifies the month, number of residents at end of each month, total number of falls with injury at end of each month and percentage of falls with injury per facility.
- PC mentioned there is a new falls risk assessment tool designed for long-term services and supports (refers to people living at home) that looks at whether the person is bedbound, or ambulatory etc. This may be used at a later date.
- SE mentioned that she thought another column would be added that would indicate how many residents fell with injury. It was mentioned that it was not reflected in the minutes.
- It was noted that falls are going happen no matter what, some people will fall more frequently than others and there should be some context around that. The description of this metric will be revised to reflect that. LS and MN will provide additional information for the revision of this metric.
  Motion: SE made the motion to add a column that indicate how many residents fell with injury to the chart at bottom of page 8. AM seconded.
- MH inquired about calculating this metric. Will now have to add in the number of residents who fell with injury, so will need to provide clear directions to providers on how to calculate this.

Quality Metric #4 - Use of Antipsychotic Medications for Nonstandard Uses

- LB mentioned that she worked on incorporating the revisions that were suggested during the March meeting, and it was somewhat challenging.
- Page 9 – last sentence in the second paragraph is inaccurate. The AP rate overall is not four times higher than in nursing facilities (NFs). There has been an initiative to reduce the use of off-label use of APs for people with dementia in NFs. It was decided to delete this sentence.
- Review of third paragraph:
  - Revise first sentence.
  - Delete third sentence.
  - Revise last sentence to read “The first step is to measure…”
- MN expressed concern about the national Partnership to Improve Dementia Care and how it purports and sustains discrimination to people with mental illness. People who live with mental illness or who receive these medications are not accepted in LTC settings. It is part of the campaign against people who live with mental illness living in LTC settings. And there is nothing in the document about how AP’s have helped people live productive lives. There are more dangerous drugs, for example blood thinners.

- LK mentioned this measure was written as nonstandard use vs. off-label use because we didn't want to go down the nursing home road. This council can craft the measure to improve resident's lives. There is room for improvement.
- MN appreciates that the measure lists the FDA approved list of conditions AP use, suggested removing resistant depression and replace with major depressive disorder or leave as depression. In addition, delete "irritability", but leave autistic disorder.
- Add OAR language about the right to be free from chemical and physical restraints, and not to be used for the convenience of staff.
- Concern that because the report will identify facilities and their rate of AP usage and number of falls, they may not be willing to accept residents who take AP's or who have a history of falls.
- Suggest that first sentence mentions the appropriate conditions for which APs are used then state what they may not be appropriate for. Ensure there is language that discusses being person-centered.
- There will be an extensive re-write of the description to represent that there are useful uses for APs.
- FS expressed concern that by reporting on this metric it may exacerbate the issue around move-outs. Perhaps a recommendation that the report reflects the aggregate number and the number of each facility. The goal as to why this metric is being tracked is that we encourage the <u>appropriate</u> use of APs not the discontinuation of APs if used appropriately.
- Discussion – the goal is for facilities to track the nonstandard use of APs. If that is the case, then the number on the report can be a statewide aggregate and each facility's percentage rate does not have to be reported. However, each facility will be able to compare their rate against the overall statewide rate.

Motion: PC made the motion that report will state the <u>statewide average</u> (not pooled) and whether the facility is tracking the rate for non-standard use. The percentage rate for the individual facility will not be reported. The motion was passed unanimously.

- LB asked if we are tracking for both the nonstandard use (routine) and nonstandard PRN use. Would we combine these two numbers?
- Need to provide facilities with resources on how to use the information and the professional standards. There are already requirements around why the resident is receiving the medications. Perhaps provide tools the future.
- Pooled vs. average – should be average as long as the total number residents is reported. Look at AHRQ SOPS program for patient safety.

Quality Metric #5: Resident Annual Satisfaction Survey

- Metric description is okay, just change title to Resident Annual Satisfaction Survey.
- Website for consultants with COREQ capacity has been added.
- LK asked if we will be contacting Nick Castle to see if he's prepared. MH will check with him.

Next Steps:

- Metrics have been determined, but there will be revisions to the descriptions. Will get those out to the group.
- Need to start drafting guidance on how to enter information into the portal.
- Start drafting webinars and Provider Alerts and invite Council members to help with the webinars. There are drafts of Provider Alerts and webinars, but not ready for prime time yet.