Quality Measurement Council
July 17, 2019
Meeting Minutes

Council Members – Present in Person
Sydney Edlund – SE
Ann McQueen – AM
Fred Steele – FS
Maureen Nash – MN
Carolyn Mendez-Luck – CM

Council Members – On Phone
Mauro Hernandez – MH
Paula Carder – PC

Council Members - Not Attending
Sara Kofman

Staff Present
Lynn Beaton
Ann Birch
Jan Karlen
Rebecca Mapes

Guests Attending
Sara Woodcock-SW
Michelle Cate - MC
Linda Kirschbaum – LK
LeRoy Patton – LP (on phone)

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 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.

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.

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?")

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.

RM announced the next meetings:

- Thursday, August 15, 2019
- Thursday, September 19, 2019

Introductions were made – see members, staff and public attending.

Online portal:
LB introduced SW, who is managing development of the online portal (MOP) for QMC data collection. SW said the Council had decided on all the necessary data elements for reporting except Metric # 3; she said she wanted to be involved with the development of calculating Metric # 3, so information technology developers could address any anticipated data issues. SW said providers would need specific, clear instructions so they would know what information to track for calculating metrics.

HB 3359 requires tracking five quality metric measurements and providing a web-based acuity tool to ensure adequate facility staff. SW presented information on recommended website design specifics:

- There is a currently a Quality Measurement website at (https://www.oregon.gov/DHS/PROVIDERS-PARTNERS/LICENSING/CBC/Pages/Quality-Metrics.aspx). The plan is to develop this page to include links to download information like the quality measurements data report (also a HB3359 requirement.)
- The webpage would include a single sign-in portal for providers from which facilities could choose either to go to the acuity tool or to the quality metrics data entry portal.
- The plan is to link to another page where additional information would describe the metrics data in more detail.
- An advantage to this proposed website layout is there would be a single log-in site which providers could bookmark and then easily access to enter required data.
- The acuity tool would be just for providers, allowing them to enter information about individual resident needs and determine appropriate staffing levels based on resident acuity. The information would only be accessible to individual facilities.
- A potential concern for providers could be the database information might be co-mingled; however that is not possible as each data base is a separate entity.
- SW recommended that providers bookmark the site or access data sets through the web.
- Discussion about the possible URL name for the online portal.
    - AM moved that LTCfacilityportal@oregon.gov be established as the URL address for provider data entry. Motion passed unanimously.
- SE raised concern that the acuity tool can be accessed by persons other than the facility utilizing the acuity tool for their specific needs. Response – There will be a great deal of training.
- LK suggested PSU and OSU surveys could be considered as information which could be posted on Quality Measurement website.

Quality Metric #3 – Resident Falls with Injuries
LB mentioned that that as of the last meeting a motion was made and passed, to finalize the data points as follows:

- Number of residents at end of each month;
- Total number of falls with injury at the end of each month
- Total number of residents who fell with injury at the end of each month.
- Last Council meeting the primary consensus was to track this metric for a full calendar year.

Key issues raised:

- SW – need clear instructions for calculating Metric #3.
- MN – it's important to include the number of falls and the number of people who fell because it provides more specific information. Easiest for facilities to capture fall information with serious fall outcome such as fractures or death because the injury is more concrete. Injuries such as bruises or scratches are more complicated to measure. MN said CMS counts: no injury, mild injury and serious injuries. It was pointed out a facility with older residents would have more serious injuries and a facility with younger people will have less serious injuries. might be difficult for a medication tech or a direct care work to discern whether an injury would be considered a minor or serious injury. MN proposed tracking only serious injuries that result in fractures or death because they are easier to define than minor injuries.
- SE indicated providers should be counting only falls with injury (as prescribed in HB3359) and providers would not be differentiating between minor or serious injuries
- AM asked whether the Council wanted providers to look at falls in general and develop better fall protocol, or did they recommend providers look at falls with the most serious implications (e.g., fractures and death)?
- MN said when Tuality Hospital instituted a fall program, where they encouraged people to get up and encouraged them to walk, the patients still fell, but the falls were much less serious. Falling isn't the problem, but serious falls are the problem, falling "well" is the solution.
- SE referred to previous discussion regarding concern facilities might under-report falls with injury because fall injuries might not be immediately apparent, staff might not be able to determine an injury resulted from a fall, or staff might have difficulty determining the seriousness of an abrasion etc. SE said it would be best to make this broad reporting requirement to get away from a complex definition of falls with injury.
- LB asked whether the Council wants to consider asking for two data points, one for minor falls and another for major falls, allowing the public and providers to interpret the resulting data.
- CM said the Council should try to be consistent with national data sets adding nursing facilities report fall on MDS.
- MN mentioned CMS for the PACE program looks at fractures, hospitalizations and death. If facilities are required to measure both minor and major, there is a concern that non-licensed staff would not be able to discern between minor and major falls.
- MH said just reporting the number of falls, falls with injury, and residents with falls is not helpful data, if the data does not represent the number of residents with falls. MH was asked if it would be difficult for facilities to differentiate between minor or serious injuries? MH said he thought the definitions are straight forward.
- PC mentioned the numbers in the PSU report have been consistent over the years and they have been trying to determine what is useful for providers to know vs. what is useful for consumers, recognizing useful information for consumers and providers might not be the same information.
- SW said during the June Council meeting it was decided to measure fall data for 12 months and the Council was currently discussing three possible reporting options for this metric:
    - Reporting only falls with injury without making the distinction of minor or serious.
    - Reporting only falls with major injury; or
    - Reporting on falls with both minor or major injury.

- LK mentioned the Council has the ability to adjust the metric in the future. For example, they could decide to count major injury falls for the first year and make minor injury falls an optional reporting piece to incentivize providers.
    - Since Incident reports would be the source of falls information, would providers be able to distinguish between the two types of injuries? Maybe incident report forms need to be revised to assist providers with more easily identify minor and major injuries? It might take time to recognize consistency in reporting, but training should help.
- MH said with time and revised tools to ensure they are correctly reporting information providers should get there. He said caregivers generally write an incident report and administrators and/or RNs review the report.
- SW suggested providers could report on the major and the minor fall injuries, along with the number of residents who fell and the total number of residents. The Council could decide to roll both the minor and major injuries into one number for reporting data.
- MH asked if from a user standpoint, is it easier to ask for a total number of falls with injury, and how many of those were major falls?
- CM – important to ensure the resulting data is meaningful for the audience. She said published information could be built around the data and it would be good comparison data with other states similar data.
- **Decision made:** build the portal with the four data points.
- **Decision made:** re-convene remaining members of original subcommittee for this topic (SE and PC) and add MN. Subcommittee agreed to meet before next meeting to discuss how the numbers will be presented in portal.

Council's Role in the Quality Measurement Program:
SE provided a presentation on the duties and the goals of the QMC. She said she wanted to review information which had been presented at the first QMC meeting. (Please refer to PowerPoint provided as handout during meeting.)

- Question – since the dates for data collection and report writing have been extended for one year, what about the January 1, 2022 date for when the Council may update the rule pertaining to quality metrics reporting requirements. (Staff have now reviewed SB 815 (the bill used to revise the data collection and report writing dates) and determined the January 2022 deadline has not changed.
- What is the tenure for Council membership? – Tenure is three years and is mentioned in the Charter dated August 8, 2018. Current tenure will be up in 2021, but the intent was for staggered membership.
- DHS is responsible for developing and making a published report available.
    - The Council will have input regarding the published report and council members should be aware of how DHS will make the report available to the public.
- Does the Council have a role in the online training modules? No, the training modules are determined by the two most often cited deficiencies each year. Development of the training modules for this year is almost completed, and the current training module topics are change of condition and staff training.

<u>Questions from public</u>:

- LP asked how often will the Measurement Council standard (metrics) will be reviewed during the year and who will be looking at them? LP also asked who will be checking {the data} before the report is written? LB responded there will be reporting process test run with a select group of facilities. However, there will not be a spot check or requirement next year when all facilities are required to report. If a facility reports numbers that seem very unusual, the facility will be contacted to see if we can help them to get the correct data. Otherwise, facilities will be auditing their data themselves.
- FS mentioned that there are other groups that should be updated on the Council's purpose and activities, for example, the Governor's Commission on Senior Services (GCSS).
- LP expressed concern about spending a lot of money on standards that are not met. He believes there should be a standard measurement system before the state spends money to develop a data tracking system.LB responded that the Council agrees there are concerns about the accuracy of data that will be provided, however the Council anticipates most providers will be honest with the data they provide, there may be an opportunity in future years for an auditing tool to be built into the system.
- LP asked why we can't do auditing as they input the data? LB responded that the system is being built so data will be entered by the facilities by either each month or at the end of the year and there is not enough DHS staff to audit all facility data.

Acceptance of meeting minutes:
MN made a motion to accept the minutes from the June 26, 2019 meeting. Minutes were adopted as written.

Revised Timeline:

- LB said the timeline has been amended to reflect extended deadlines. LB reviewed the columns with the tasks that are to be completed by the QMC, DHS and providers each month. The timeline can be more expansive, however a separate workplan was developed that provides more detail. She requested Council's input regarding what they think is doable and possible.
- LB said most of the quality metrics to be measured are complete, except for falls (QM 3). The next steps are the technical tasks, such as step-by-step provider instructions available at the data portal. Council members were asked if they would review portal data entry instructions. There will be a standalone set of set of instructions explaining the reasons for gathering the metrics data. This information will be posted on the primary web page for the quality metrics along with introductory information.
- LB said the goal is to keep data very clean, but if a provider has a question as to why it is needed, then they can access the instructions and go back in to the data portal and input the data.
- On the timeline, AM requested to change "Completed Initial Quality Metrics Report" to "Completed Initial Quality Metrics Manual".
- LB said a small group of providers have volunteered to be part of a test group and will test the data entry process to assist with data entry questions and issues. Initial provider training and instruction will be edited based on the test group feedback and finalized information would be distributed to providers.

- CM suggested asking providers who will "sandbox test" the metric report process to provide feedback on the level of difficulty of inputting each metric as well as a list of questions or topics for feedback.
- SE reminded the committee it could take four to six months for the metrics portal development.
- SE asked if the portal will be completed by 1/1/2020 and LB said it may not all be done, therefore some of the metrics may have to be entered into the portal from paper records.
- SE said some people can get caught up on details and she suggested there should be a point of no return regarding the portal development.
- CM suggested having a second beta test after the portal is available for providers.
- SE asked about expectations for providers in terms of what information they need to review before logging onto the portal.
- LK asked about what information will be available for providers regarding data entry. She said the guide we've been reviewing each month at committee meetings is high level, but she was assuming there will be much more detail information provided regarding the data collection process, etc.
- LK said if email addresses were created at the organizational level for the purpose entering data, and the addresses could be maintained at the organizational level she thought this would be helpful.
- LP asked if each facility could have an audit coordinator to be responsible for entering the data for continuity. LB said it was a good idea, but it could not be a requirement because it isn't in the law. LK said that OHCA is recommending to their members that each facility have one staff person enter the metrics information.

Closing statements:

- AM said she was happy LP joined the call as he is representing the (GCSS). She also mentioned that in her new role she will be interacting more often with boards and commissions and offered to provide information on the Council with them and encourage others to participate in the quality metrics process.
- RM reviewed the terms of Council membership as found in the Charter:
  Each member shall serve a term of three years, with the ability to extend/add an additional three year term. During the first six years of this council, three positions will serve a six-year term. This will ensure at least three experienced members are on the council following the appointment of new members. The Chair and Vice-Chair shall complete a term of one year after which elections shall take place and members will vote to either re-elect or select a new Chair and Vice-Chair of the Council. The chair has the right to resign his/her position by giving the group a minimum of 28 days' notice.
- The question was brought up about electing a new chair and vice chair, however a new chair was just voted in. MN nominated FS for vice-chair, vote passed unanimously.
- CM commented that at some time we will have to discuss selecting new Council members.