Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Oregon Residential Care and Assisted Living

Quality Measurement Program Provider Instruction Guide V4

2023 Data Collection

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Oregon's Residential Care and Assisted Living QualityMeasurement Program

Background

In 2017, the Oregon Legislative Assembly passed House Bill 3359 (now ORS 443.447), which:

- Created the Residential Care and Assisted Living Quality Measurement Program.
- Established a governor-appointed Quality Measurement Council staffed by the Oregon Department of Human Services (ODHS).
- Directed the Council, in consultation with ODHS, to develop a uniform quality metrics reporting system to measure and compare the performance of residential care and assisted living facilities across the state.
- Requires that each residential care facility (RCF) and assisted living facility (ALF) annually submit quality metrics data; and
- Requires ODHS to publish an annual report, based on data reported by each RCF/ALF.

The Council is responsible for detailing the operationalization of the measurement program while, as much as possible, limiting the burden on facilities of tracking and reporting data. Current members of the Council are listed below.

2023 Quality Measurement Council

Required Representatives	Appointed Members
Oregon Patient Safety Commission	**Sydney E. Edlund**, MS, Director of Research and Analytics,Oregon Patient Safety Commission
Residential care facilities representative	**Brenda Connelly**, President, The Springs Living
Alzheimer's advocacy organization	**Chris Madden,** Associate Director, Oregon Chapter of the Alzheimer's Association
Practitioner with geriatricexperience	**Dr. Maureen Nash,** MD, MS, FAPA, FACP, MedicalDirector, Providence ElderPlace Oregon
Academic representative with expertise	**Ozcan Tunalilar**, PhD, Assistant Professor, Portland State University
Academic representative with expertise	**Walt Dawson**, D. Phil, Assistant Professor, Oregon Health and Sciences University
Long Term Care Ombudsman	**Fred Steele**, JD, MPH, State Long-Term Care Ombudsman
Direct care worker representative (position added to the QMC by SB703 (2021))	**Daniel Morris,** PhD, Research Manager, SEIU Local 503
Department representative	**Sudha Landman**, MA, Manager of Community Based Care, Oregon Department of Human Services

RCFs and ALFs Responsible for Reporting Quality Metrics Annually

By law, all residential care and assisted living facilities (including those with memory care endorsements) are required to track and report on the following quality metrics:

1. Retention of direct care staff
2. Compliance with staff training requirements
3. Incidence of falls with injury
4. Use of antipsychotic medications for non-standard purposes
5. Results of annual resident satisfaction survey conducted by a third party.

Please note that **ALL Residential Care and Assisted Living Facilities (including those with memory care endorsements) must report quality metrics data.**

Data must be submitted no later than January 31, 2024, at 11:59 pm. via a link that will be provided in a Provider Alert and by email to the administrator email on file. Facilities that do not meet this deadline will be recorded as having not submitted data in the program report to the legislature.

Exception to Reporting
Facilities that opened or closed during 2023 (between 1/1/2023 to 12/31/2023) are not required to submit any metrics data for 2023. New facilities that opened during 2023 will be required to track data beginning in 2024 and will have to submit data by January 31, 2025.

If your facility was open for all of 2023, but changed owner and/or manager, you will still need to report all data for 2023.

The chart below shows important dates to note:

Tracking Year for Facilities	***Provider Deadline for Entering Data***	***Data Reported by DHS to Facilities and Public***
Calendar Year 2023	January 31, 2024	July 1, 2024
Calendar Year 2024	January 31, 2025	July 1, 2025
Calendar Year 2025	January 31, 2026	July 1, 2026

The following chart indicates the frequency and duration of time each of the quality metrics is tracked in 2023:

Metric #	*Metric Name*	*Duration of Time to Measure Each Metric*
1	Retention of Direct Care Staff	Full calendar year
2	Compliance with Staff Training Requirements	Full calendar year
3	Number of Resident Falls with Injury	Six months: June through November
4	Use of Antipsychotic Meds for Non-standard Use	One month: October
5	Results of Annual Satisfaction Survey by 3rd party	Once a year, at any time

Annual Report

The Department will compile the information received from all residential care facilities and assisted living facilities in an annual report to the legislature describing statewide patterns and trends. This report will be available on the Quality Measurement Website for facilities and the public to evaluate and compare facilities.

Questions and Contacts

We encourage you to familiarize yourself with the information in this guide and refer to it whenever you have questions. Please send any additional questions to the Quality Measurement Program via email at: QualityMetrics.Acuity@odhsoha.oregon.gov.

Quality Metric # 1: Retention of Direct Care Staff

Background and Reason for Tracking:
Research indicates that retention of staff results in better care to residents, while high rates of staff turnover are associated with poorer quality of care. Experienced staff are more effective at providing quality care, given their familiarity with residents. As staff become more knowledgeable about residents' preferences, health status and behaviors, these staff are better able to anticipate and meet residents' needs and build caring and trusting relationships with residents. Experienced staff also know and understand the practices, policies, and routines of the facility.

Data to Track for this Measure:

- **The hire date for each direct care staff member**[1] – to determine which direct care staff have been employed by your facility for at least a year as of 12/31/2023.
- **The total number of direct care staff employed by your facility** (regardless of hire date) on 12/31/2023.

Reporting Timeline for this Measure:

- **Tracking:** Facilities track data for this measure from 1/1/2023 through 12/31/2023.
- **Reporting:** Data collected in 2023 shall be reported no later than January 31, 2023.
    - Use this link to access the data collection tool.
    - Consult the 2023 QMP Data Collection Instructions and Screenshots for data entry instructions.

What Facilities Need to Do:

1. On January 1, 2023, record the number and names of all direct care staff regardless of hours worked per week.

2. At the beginning of 2024, count the number of direct care staff continuously employed from 1/1/2023 (or before) through 12/31/2023.

3. At the beginning of 2024, count the number of direct care staff employed by your facility on 12/31/2023.

[1] "Direct care staff," as defined in OAR 411-054-0005(25), are facility employees whose primary responsibility is to provide personal care services to residents. These personal care services may include:
(a) Medication administration.
(b) Resident-focused activities.
(c) Assistance with activities of daily living.
(d) Supervision and support of residents.
(e) Serving meals, but not meal preparation.

Your retention score is calculated as a percentage:

$$\textbf{\textit{Retention}} = \frac{\text{Total number of direct care staff continuously employed from 1/1/2023 (or before) through 12/31/2023.}}{\text{Total number of direct care staff employed on 12/31/2023}}$$

Example:

- A facility has a total of 39 direct care staff employed as of 12/31/2023.
- Twenty-five of those direct care staff were continuously employed at the facility since 1/1/2023 (or before).
- Divide 25 by 39 to calculate the retention rate: 25/39 = .6401
- The facility has a **64% staff retention rate for 2023.**

Hints and Tips:

1. To be considered **direct care staff**, use professional judgment to decide if the staff person meets the definition for direct care staff in rule.
2. Staff are counted as **employed continuously** even if they were on approved leave for any reason during the year. If the staff is on payroll at the end of the year, count them as employed.

Quality Metric #2: Staff Training Requirements

Background and Reason for Tracking:

It is essential to the health and safety of residents to have well trained staff providing resident care. Staff who are well-trained provide residents better care and services and experience greater job satisfaction. Oregon Administrative Rules for residential care and assisted living facilities outline required training and deadlines. Memory care endorsed facilities have additional training requirements. Required training elements with the corresponding rule citations are outlined on pages 12 and 13 of this guide.

This metric measures the percentage of staff employed by the facility on 12/31/2023 who have completed all required trainings within the timelines specified by rule. All facility staff, whether full-time or part-time, direct care or non-direct care (e.g., staff in food services, housekeeping, administration, etc.) are included. Staff compliance with training timelines is determined by their length of employment. Examples are provided below.

Data Facilities Need to Track for this Measure:

1. **The date each staff person was hired.**
2. **Whether the staff is direct care or non-direct care**:
    a. Universal workers[2] are considered direct care staff.
    b. Activities staff are considered non-direct care staff.[3]
3. **The date each staff person completed each element of the required trainings:** There are several elements of required trainings that vary, depending on whether the staff is a new hire, their classification as either direct care or non-direct care staff and whether they work in an endorsed memory care facility.

Data Facilities Report for this Measure:
Direct Care Staff:

1. Total number of direct care staff employed on 12/31/2023?
2. Total number of direct care staff employed for 30 days or less on 12/31/2023?
    2a. Of these, how many staff are on track to complete or have completed required training on time?
3. Total number of direct care staff employed for 31 days to a year on 12/31/2023?
    3a. Of these, how many staff completed their required training on time?

[2] "Universal Workers", "as defined in OAR 411-054-0005(84), are facility employees whose assignments include other tasks (I.e., housekeeping, laundry, or food service) in addition to direct resident services. Universal workers do not include administrators, clerical administrative staff, building maintenance staff or licensed nurses who provided services as specified in OAR 411-054-0034.
[3] Activities staff are considered non-direct care staff for 2023 QMP and training purposes. Previous versions of the 2023 guide instructed otherwise.

4. Total number of direct care staff employed more than a year on 12/31/2023?
   4a. Of these, how many staff completed their required annual in-service training?

Non-Direct Care Staff:

1. Total number of non-direct care staff employed on 12/31/2023?
2. Total number of non-direct care staff employed less than a year on 12/31/2023?
   2a. Of these, how many completed their pre-service training or are on track to complete their preservice training on time?
3. Total number of non-direct care staff employed more than a year on 12/31/2023?
   3a. Of these, how many completed the required annual in-service training? *Note: For these staff, only consider the annual in-service training on infectious disease outbreak and infection control.

Examples:

- A direct caregiver is hired on 12/4/2023 and completed their preservice orientation requirements on 12/6/2023.However, this caregiver has not completed their required 30-day training for direct care staff on 12/31/2023. Did this caregiver complete their preservice training, and will they complete their required 30-day training on time?
    - Yes. This caregiver was hired on 12/4/2023 and completed preservice orientation requirements. Completion of the required 30-day training is due on or before January 3, 2024, and they are on track to complete required training on time.

- A direct caregiver is hired on 10/2/2023 and completed their preservice orientation requirements on 10/6/2023.This caregiver completed their required 30-day training for direct care staff on 11/3/2023. Did this caregiver complete their preservice and required 30-day training on time?
    - No. This direct caregiver completed their preservice orientation before beginning required training within 30-days of hire, however, they did not complete the all required training within 30-days of hire. The caregiver completed the required 30-day training on 11/3/2023, 33 days after date of hire, therefore they did not complete their required training on time.

- A direct caregiver was hired on 12/12/2022 and completed their annual in-service training by 12/9/2023. Did this caregiver complete their required annual in-service training on time?
    - Yes, the caregiver completed their required annual in-service training before their date of hire anniversary.

- As of 12/31/2023, a facility has 95 staff employed, including part-time and full-time

staff. Of the 95 employees, 85 completed all their training within the timeframes required by rule.

Type of staff	# of staff completing required training on time	# of staff total
New direct care staff	25	28
Experienced direct care staff	42	48
New non-direct care staff	4	4
Experienced non-direct care staff	14	15
As of 12/31/2023	85	95
The compliance rate calculation: 85 ÷ 95 = 0.8947 =	89.5%	

Hints and Tips:

- **Experienced staff** are staff who have completed a year of service at the facility and are due for annual in-service training.
    - Only consider annual in-service training for experienced staff.
    - If an experienced staff did not complete training requirements by the required dates in a previous year, this deficiency does not carry forward to the current reporting year.
    - Example: A direct caregiver was hired on 11/13/2022. This caregiver completed their required training within 30 days of hire late, on 12/29/2022. However, this same caregiver did complete their annual in-service training requirements on-time, by 11/12/2023. This caregiver is counted as completing their required trainings on time for 2023 quality measurement reporting. The deficiency from 2022 does not carry forward.
- This metric includes **all** staff hired while QM #1 only includes direct caregivers.
- The administrator of the facility is required to complete preservice training as a **non-direct care staff**.
- Staff who are shared with another facility on the same campus are counted. This means the training documentation for shared staff are maintained at each worksite.

Training Requirements for Assisted Living & Residential Care Facilities *(Without Endorsed Memory Care)*				
Training requirement	***Deadline to complete training***	***New Direct Care Staff (employed less than a year)***	***Experienced Direct Care Staff (a year or longer)****	***Non-Direct Care Staff***
Pre-Service Orientation for ALL Staff - - OAR 411-054-0070 (3)				
Resident rights	Before regular duties	√	-	√
Abuse reporting	Before regular duties	√	-	√
Standard precautions for infection control	Before regular duties	√	-	√
Fire safety and emergency procedures	Before regular duties	√	-	√
Food handling (if employee is to prep food)	Before regular duties	√	-	√
Infectious disease prevention	Before regular duties	√		√
Pre-Service Orientation for All Direct Care Staff - - OAR 411-054-0070 (4)				
Pre-service dementia training	Before providing care	√	-	-
Pre-service orientation to ind. residents	Before providing care	√	-	-
Training Within 30 Days of Hire for Direct Care Staff - - OAR 411-054-0070 (6)				
Service plans	Within 30 days of hire	√	-	-
Activities of Daily Living (ADLs)	Within 30 days of hire	√	-	-
Changes associated with aging	Within 30 days of hire	√	-	-
Change of condition	Within 30 days of hire	√	-	-
Required assessment	Within 30 days of hire	√	-	-
Food safety	Within 30 days of hire	√	-	-
Medication & treatment administration	Within 30 days of hire	√	-	-
Annual In-Service Training for All Staff - - OAR 411-054-0070 (5)				
Training on infectious disease outbreak and infection control	By anniversary of hire date	-	√	√
Annual In-Service Training for Direct Care Staff - - OAR 411-054-0070 (7)				
6 hours training on “other” topics	By anniversary of hire date	-	√	-
6 hours dementia training	By anniversary of hire date	-	√	-

Training Requirements for Endorsed Memory Care Communities Licensed as Assisted Living or Residential Care Facilities				
Training requirement	**Deadline to complete training**	**New Direct CareStaff (employed less than a year)**	**Experienced Direct Care Staff (a year or longer)***	**Non-Direct Care Staff**
ALL STAFF – Pre-Service Orientation - - OAR 411-054-0070 (3)				
Resident rights	Before regular duties	√	-	√
Abuse reporting	Before regular duties	√	-	√
Standard precautions for infection control	Before regular duties	√	-	√
Infectious disease prevention	Before regular duties	√	-	√
Fire safety and emergency procedures	Before regular duties	√	-	√
Food handling (if employee is to prep food)	Before regular duties	√	-	√
ALL STAFF - Pre-Service Dementia Training - - OAR 411-057-0155 (2)(b)				
Education on dementia process	Before providing care	√	-	√
Techniques for responding	Before providing care	√	-	√
Strategies for addressing social needs	Before providing care	√	-	√
Identify and address pain	Before providing care	√	-	√
Provide food and fluid	Before providing care	√		√
Preventing wandering and elopement	Before providing care	√	-	√
Using person-centered approach	Before providing care	√	-	√
Effect of environmental factors	Before providing care	√	-	√
Family support and role of the family	Before providing care	√	-	√
Recognizing behaviors indicating a change in condition	Before providing care	√	-	√
DIRECT CARE STAFF – Pre-Service Training - - OAR 411-057-0155 (2)(c)				
(A) Environmental factors that are important to resident's well-being (e.g., noise, staff interactions, lighting, room temperature, etc.);	Before providing care	√	-	-
(B) Family support and the role the family may have in the care of the resident;	Before providing care	√	-	-
DIRECT CARE STAFF – Pre-Service Training - - OAR 411-057-0155 (3)(a)				
How to provide personal care/orientation to service plan	Before providing care	√	-	-
Use of supportive restraining devices	Within 30 days of hire	√	-	-
DIRECT CARE STAFF - Training Within 30 Days of Hire - - OAR 411-054-0070 (6)				
Service plans	Within 30 days of hire	√	-	-
Activities of Daily Living (ADLs)	Within 30 days of hire	√	-	-
Changes associated with aging	Within 30 days of hire	√	-	-
Change of condition	Within 30 days of hire	√	-	-
Required assessment	Within 30 days of hire	√	-	-
Food safety	Within 30 days of hire	√	-	-
Medication & treatment administration	Within 30 days of hire	√	-	-
DIRECT CARE STAFF - Annual In-Service Training - - OAR 411-057-0155 (3)(c)				
6 hours annual dementia training	Hire date anniversary	-	√	-
10 hours training on "other" topics, may include additional dementia caretraining & infection control topics.	Hire date anniversary	-	√	-
Annual In-Service Training for All Staff - - OAR 411-054-0070 (5)				
Training on infectious disease outbreak and infection control	Hire date anniversary	-	√	√

Quality Metric #3: Resident Falls with Injury

Background and Reason for Tracking
Falls are a primary cause of resident injury and can lead to premature death. It is important to recognize not all falls are preventable, and not all falls are serious enough to cause injury.

It is crucial for staff to learn as much as possible about why falls are occurring and determine what interventions lessen the number and severity of falls.

For the purposes of this metric, a **fall** is defined as:

- **An unintended descent to the floor or other object** (e.g., sink, table, surrounding furniture) **that results in an injury.**
- This includes falls that are witnessed by staff or reported by a resident

An **injury** is defined as any of the following:

- Bruise, abrasion, or wound requiring intervention such as dressing, ice, limb elevation, topical medications, oral pain medications, etc.
- Dislocation, fracture, intracranial injury, laceration requiring sutures/stitches, skin tear/avulsion or significant bruising.
- A fall where the resident complains of pain or discomfort, even if there is no visible injury.

Facilities must track four data points for each month, from June through November 2023:

1. Total number of residents living in the facility on the last day of each month, June through November 2023.
2. Total number of falls with injury that involved residents living in the facility during each month, June through November 2023.
3. Number of residents who fell with injury, during the month.
4. Number of residents who fell with injury more than once during the month.

Example:

At the end of June 2023:

- There were 40 residents living in the facility.
- There were five falls with injury during the month.
- Three residents fell once during the month.
- One resident fell more than once during the month.

Please see the chart below to understand how this metric is calculated.

Total # of **residents** on last day of June 2023	40
Total number of **falls with injury** during June 2023	5
Number of **residents who fell** with injury during June 2023	3
Number of **residents who fell more than once** with injury during June 2023	1

Hints and Tips:

- Use professional judgment to determine whether a fall with injury occurred.
- Examples where judgment is needed to evaluate events as probable falls:
  - A bruise or skin tear are noticed, but a fall was not witnessed by facility staff and the resident is unable to explain.
  - If the resident reports pain, and staff believe the pain is due to a fall, the fall should be counted even if there is no visible indication of the fall.

Quality Metric #4: Antipsychotic Medications Prescribed for Nonstandard Use

Background and Reason for Tracking:
Antipsychotic medications are designed to treat psychosis. Antipsychotics have helped numerous people live more productive lives by treating psychotic symptoms and working to stabilize mood.

Thorough assessment, knowledge about a resident's history and current preferences, adequate staffing and training are crucial elements in providing person-centered care. Medications including antipsychotics, antidepressants, antianxiety medications, and mood stabilizers can be part of a person-centered plan.

There is potential for antipsychotic medications to be used in community-based care to inappropriately sedate or tranquilize residents. Oregon law states residents have the right to be free from, "inappropriate use of psychoactive medications."[4] A psychotropic medication is considered a restraint if it is used for, "the effect of restricting the individual's freedom of movement or behavior," unless it is used, "to treat the individual's medical or psychiatric condition."[5]

Community-based care settings must ensure antipsychotics are only prescribed following a person-centered assessment and with careful consideration of the specific needs of each individual resident. Best practices include ensuring these medications are used in conjunction with ongoing non-pharmacological approaches, such as meaningful activities.

Antipsychotics can be a standard treatment when a resident with dementia has psychosis, physical aggression, or a psychiatric illness. Neuropsychiatric symptoms, also known as behavioral psychological symptoms of dementia, are common and can be distressing; however, they are usually not dangerous and are best addressed through person-centered planning.

There are evidence-based reasons for prescribing antipsychotic medications for nonstandard[6] uses. Data is needed to determine the prevalence of nonstandard antipsychotic use and to encourage facilities to examine the use of these

[4] Oregon Administrative Rule; see OAR 411-054-0027(1)(k)
[5] Oregon Administrative Rule; see OAR 411-054-0005(81)(b)
[6] A **non-standard use** is an antipsychotic prescribed for an evidence-based use other than the uses approved by the FDA.

medications with their residents.

How to Measure:
Facilities must track the use of antipsychotic medications for non-standard uses during October 2023. Facilities will report regularly scheduled[7] and PRN[8] antipsychotic medications for nonstandard uses separately.

Data to Track for this Measure:
Use the 31-day period **October 1 – 31, 2023**.

1. Count the **total number of residents** on the October 31, 2023, facility census. Residents who move out before October 31 are not counted in this metric.
2. Review each MAR and determine which **residents were prescribed an antipsychotic on the list provided in Table A**. (This includes both regularly scheduled and PRN prescriptions).
3. **Exclude any residents who have a diagnosis/reason listed on the Exclusions list provided in Table B.**
4. Determine how many of the remaining residents:
    a. Had a prescribed **scheduled antipsychotic medication for a non-standard use**, during the 31-day period.
    b. Were prescribed a **PRN antipsychotic** medication for a **non-standard use**, during the 31-day period.

Example:

Step 1: Count the residents on the census on 10/31/2023.
- The facility has 52 residents on the 10/31/2023 census.
- Residents who moved out before 10/31/23 are not counted for this metric.

Step 2: Count the residents who have a prescription for an antipsychotic medication.
- 34 of the 52 residents had a prescription for an antipsychotic medication in October 2023.

Step 3: Remove residents with conditions on the Exclusions List (Table B).

[7] A **scheduled medication** is prescribed by a qualified practitioner to be used immediately, for a specific period.
[8] A **PRN (pro re nata) medication**[8] means medications and treatments prescribed by qualified practitioner to be administered as needed.

- Three residents had conditions on the Exclusions List; 31 residents have prescriptions for antipsychotics for a non-standard use.

Step 4: Count the residents with scheduled antipsychotics for a non-standard use.

- 19 of the 31 residents had a prescription for a **scheduled** antipsychotic for a non-standard use in October 2023.

Step 5: Count the residents with PRN antipsychotics for a non-standard use.

- 12 of the 31 residents had a prescription for a **PRN** antipsychotic for a non-standard use in October 2023.

Data Summary

Data Field	Data Reported
The number of residents on the 10/31/23 census	52
The number of residents with a prescription for an antipsychotic medication	34
The number of residents with conditions on the exclusions list	3
Residents with **scheduled antipsychotics** for a nonstandard use	19
Residents with **PRN antipsychotics** for a nonstandard use	12

Using the reported information for this metric, the calculations were:

Calculation 1: **Scheduled** antipsychotic for a non-standard use:

% of residents with a scheduled non-standard use of an antipsychotic drug

$$\frac{\text{\# of residents with scheduled nonstandard antipsychotic}}{\text{Total \# of residents on the 10/31 census}}$$

= 19/52 = .365 = **36.5%** of residents had at least one prescription for a **scheduled antipsychotic** for a non-standard in October 2023

Calculation 2: **PRN** antipsychotic for a non-standard use:

% of residents with PRN use of an antipsychotic drug

$$\frac{\text{\# of residents with } \textit{PRN} \text{ antipsychotic for a non-standard use}}{\text{Total \# of residents on the 10/31 census}}$$

= 12/52 = .231 = **23.1%** of residents had at least one prescription for a **PRN (as needed) antipsychotic** for a non-standard purpose in October 2023

Hints and Tips:

- If a resident has both a scheduled and a PRN antipsychotic prescription, then **both** prescriptions are counted, and the resident would be counted under each category.

Table A: List of Antipsychotic Medications

Source: https://www.singlecare.com

Abilify Maintena	Nuplazid
Abilify MyCite Starter Kit	Olanzapine
Abilify Mycite	Paliperidone Er
Abilify	Perphenazine
Aripiprazole	Perseris
Aristada Initio	Pimozide
Aristada	Prochlorperazine Maleate
Asenapine Maleate	Prochlorperazine
Caplyta	Quetiapine Fumarate Er
Chlorpromazine Hcl	Quetiapine Fumarate
Clozapine	Rexulti
Clozaril	Risperdal Consta
Fanapt Titration Pack	Risperdal
Fanapt	Risperidone
Fluphenazine Hcl	Saphris
Geodon	Secuado
Haldol Decanoate	Seroquel Xr
Haldol	Seroquel
Haloperidol Decanoate	Symbyax
Haloperidol	Thioridazine Hcl
Haloperidol	Thiothixene
Invega Hafyera	Trifluoperazine Hcl
Invega Sustenna	Vraylar
Invega Trinza	Ziprasidone Hcl
Invega	Zyprexa Relprevv
Latuda	Zyprexa Zydis
Loxapine Succinate	

Table B: Exclusions list

Acute agitation Agitation due to schizophrenia or bipolar disorder Acute intermittent porphyria Bipolar disorder Generalized anxiety disorder Intractable hiccups Mania Major depressive disorder Nausea Psychosis (including paranoia, delusions, and hallucinations) Schizoaffective disorder Schizophrenia Serotonin syndrome Suicide prevention Tourette syndrome Vomiting

Source: Epocrates.com[9]

[9] Epocrates.com is a free website and phone app that provides accurate information at the point of care. It is a standard drug information database people can access for free and is updated regularly by clinical experts. *Reviewed by Maureen Nash, MD, 4/8/2023*

Quality Metric #5: Results of an Annual Satisfaction Survey

Background and Reason for Tracking:
Research suggests that high customer satisfaction is directly linked to residents' experiences and quality of care. Conducting a resident survey is an effective way of determining how satisfied residents are with facility care and services.

CoreQ is a set of four measures to assess resident satisfaction. CoreQ questions were developed by a team including Nicholas Castle, Ph.D., with the American Health Care Association/National Center for Assisted Living (AHCA/NCAL), and providers with input from customer satisfaction vendors and residents. Based on a core set of customer satisfaction questions to allow consistent measurement across long-term care settings, CoreQ has been independently tested as valid and reliable.

Data to Track for this Measure:
Facilities will contract with a CoreQ Customer Satisfaction Vendor who will present these CoreQ questions to residents **one time during the year**. The following Likert scale will be used for each response:
☐ Poor (1), ☐ Average (2), ☐ Good (3), ☐ Very Good (4), and ☐ Excellent (5)

1. In recommending this facility to friends and family, how would you rate it overall?
2. Overall, how would you rate the staff?
3. How would you rate the care you receive?
4. Overall, how would you rate the food?

Facilities will also be required to report:

- The number of residents who **received** the survey; don't include residents who were excluded from taking the survey because of dementia, hospice, guardianship or < two weeks at facility
- The number of residents who **returned** the survey: Residents who answered at least one question and returned the survey to the CoreQ vendor which includes residents who completed the survey and returned the survey to the CoreQ vendor
- The number of residents who **completed** the survey: Residents who responded to all questions and returned the survey to the CoreQ vendor

- The name of the CoreQ customer satisfaction vender the facility used
- The method for survey administration, i.e., in writing, by phone, in person, or online.

What facilities need to do: Facilities must hire an approved CoreQ customer satisfaction vendor. Visit www.CoreQ.org and select the "customer satisfaction vendors" tab at the top of the page to find a vendor. This tab displays a list of approved vendors with their contact information.

- Contract with any CoreQ vendor to conduct the annual resident satisfaction survey.
- Choose the vendor that best meets the facility's needs. Vendors have services beyond the minimum four question set required by Oregon's Quality Measurement Program to support a facility's quality improvement program.
- Determine a date in 2023 when the vendor conducts the survey. **Ensure results will be shared with the facility before January 31 of 2024.**
- Report the **count of resident responses by type** (i.e., the **number** of poor, average, good, very good and excellent responses). Percentages are not acceptable.
- Share this *Provider Guide* with your vendor.

Hints and Tips:

- All current residents are initially eligible to answer the CoreQ questions. Residents who meet any of the following criteria are excluded from receiving the CoreQ questionnaire:
    - Dementia impairing their ability to answer the questionnaire defined as having a BIMS score of seven or lower, or MMSE score of 12 or lower. [**Note:** we understand some facilities may not have information on cognitive function available to help with sample selection.]
        - In this case, administer the survey to all residents and assume that those with cognitive impairment will not complete the survey.
    - Have a court appointed guardian
    - On hospice

    - Have been in the facility for less than two weeks

- **Residents must complete the survey on their own.** Neither facility staff nor family may assist residents in completing the survey. The purpose of the survey is to hear directly from residents without the express or implicit input of others.
    - Assistance includes reading the questions to residents. If you know some residents can answer oral questions, but can't answer written questions, plan for this with your third-party vendor.
    - Residents may provide different answers if questioned by staff. Family may unintentionally influence resident answers.
- Tell your residents and their families about the survey in advance. They may be wary of phone surveys or surveys by mail. Advance communication will help avoid confusion and assist residents and their families in understanding the purpose of the survey.
- If fewer than 10 responses are gathered for any facility, data for that facility will not be published at the individual facility level; however, **responses should still be reported**, and they will be published as part of the overall regional and state averages.
- You may refer to the CoreQ User Manual.
- The facility is responsible for paying the customer satisfaction vendor.
- Facilities will enter the data provided by the vendor into the data collection tool; vendors cannot enter data into the data collection tool.
- Surveys may be administered by the customer satisfaction vendor in different ways (i.e., by mail, phone, etc.).
- The survey process should allow for **anonymous answers by residents**. Facilities should not be able to identify how an individual resident reported.
- The method of administration, as well as the cognitive ability to respond to questions, will likely mean some residents will be unable to participate.
- It is okay if residents who are surveyed during the year are no longer

residents at the end of the year. The annual satisfaction survey is a snapshot, and it is expected that some residents who are included in the survey may have left the facility by the end of the year.

- For surveys administered by **phone**:
    - The number of residents who **received** the survey is the number of residents who answered the phone.
    - The number of residents who **returned** the survey is the number of residents who responded to at least one question.
    - You may ask a staff member to take a phone to the resident, but the staff member must not be present or able to hear the resident responses provided to the Customer Satisfaction Vendor.

Lessons Learned in 2022 – Reporting Tips

1. Quality metrics data corresponds to the facility license. If there are multiple licenses on one campus, there will be multiple sets of quality metrics data reported.
   - **Example 1:** A facility has an assisted living license and a separate license for a residential care facility with a memory care endorsement on the same campus. Each licensed facility would enter quality metrics data separately, even though they are on the same campus or under the same roof.
   - **Example 2:** A facility is licensed as an RCF with a MCC endorsement on 20 of the 50 licensed beds. This facility would only enter one set of quality metrics data because there is only one license.
2. Be careful to enter data into the correct cell. For example, for 2022 reporting, there was a high error rate on metric two (staff who completed training on time).
3. The resident satisfaction survey is meant to be **anonymous** for residents. Ensure your process allows residents to complete and return their survey with a reassurance their answers are anonymous, that is, not seen by staff.
4. Resident survey answers are reported by a count of responses, not percentages of responses.
5. Reporting is required even when a change of ownership or management takes place. Facilities that open or close during 2023 are exempted from quality measurement reporting. A change of management or change of ownership does not exempt the facility from reporting.
6. Provider Alerts, Provider Alerts, Provider Alerts! Please ensure you are signed up to receive Provider Alerts. This is the method Quality Measurement Program announcements and other policy statements from Safety, Oversight and Quality will be shared with providers.
7. Keep your Policy Analyst current on your administrator's email address.

Conclusion

The Quality Measurement Program will host a series of regular webinars to train providers on data collection and data entry. Program updates will be announced via Provider Alert. Questions may be addressed to: QualityMerics.Acutiy@odhsoha.oregon.gov.