Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Oregon Residential Care and Assisted Living

Quality Measurement Program Provider Instruction Guide V1

2024 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.

2024 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))	**Devin Edwards**, MPP, Research Coordinator, SEIU
Department representative	**Sudha Landman**, MA, Manager of Community Based Care, Oregon Department of Human Services

RCFs and ALFs Must Report 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 nonstandard 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, 2025, at 11:59 pm. via a link that will be provided in a Provider Alert. The Quality Measurement Program is non-regulatory and facility data will not be used for regulatory enforcement. However, a failure to report is a violation of OAR 411-054-0320(5) and may result in an enforcement action. 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 2024 (between 1/1/2024 to 12/31/2024) are not required to submit any metrics data for 2024. New facilities that opened during 2024 will be required to track data beginning in 2025 and will have to submit data by January 31, 2026.

If your facility was open for all of 2024, but changed owner and/or manager, you will still need to report all data for 2024.

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 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 2024:

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 12/31/2024.
- **The total number of direct care staff employed by your facility** on 12/31/2024.

Reporting Timeline for this measure:

- **Tracking:** Facilities track data for this measure from 1/1/2024 through 12/31/2024.
- **Reporting:** Data collected in 2024 shall be reported during January 2025.

What Facilities Need to Do:

1. On January 1, 2024, record the number and names of all direct care staff regardless of hours worked per week.
2. At the beginning of 2025, count the number of direct care staff continuously employed from 1/1/2024 (or before) through 12/31/2024.
3. At the beginning of 2025, count the number of direct care staff employed by your facility on 12/31/2024.

Your retention score is calculated as a percentage:

$$\textit{Retention} = \frac{\text{Total number of direct care staff continuously employed from 1/1/2024 (or before) through 12/31/2024.}}{\text{Total number of direct care staff employed on 12/31/2024}}$$

[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.

Example:

- A facility has a total of 39 direct care staff employed as of 12/31/2024.
- Twenty-five of those direct care staff were continuously employed at the facility since 1/1/2024 (or before).
- Divide 25 by 39 to calculate the retention rate: 25/39 = .6401
- The facility has a **64% staff retention rate for 2024.**

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 through 15 of this guide.

This metric measures the percentage of staff employed by the facility at any time during 2024 who have completed all required trainings within the timelines specified by rule, given their length of employment. 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:

For each staff person employed by the facility during 2024:

1. **The date hired**
2. **The date they left employment, as applicable**
3. **Whether direct care or non-direct care**:
    a. Universal workers[2] are considered direct care staff
    b. Activities staff are considered non-direct care staff
4. **The date each element of the required trainings was completed**

There are several elements of required trainings that vary, depending on whether the staff is in their first year of employment or employed longer than a year, 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 at any time during 2024?
2. Of these, how many completed their training on time, given their length of employment?

[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.

Non-Direct Care Staff:

1. Total number of non-direct care staff employed at any time during 2024?
2. Of these, how many completed their training on time, given their length of employment?

What Facilities Need to do:

Count the number of staff employed by the facility at any time during 2024. At the same time, count the total number of these staff who completed all required training modules for the past year by the required dates according to that employee's job type and length of employment.

Examples:

- **Example 1:** A direct caregiver is hired on 12/4/2024 and completed their preservice orientation requirements on 12/6/2024. However, this caregiver has not completed their required 30-day training for direct care staff on 12/31/2024. Did this caregiver complete their preservice training as required, and will they complete their required 30-day training on time?
    - Yes and yes. This caregiver was hired on 12/4/2024 and completed preservice orientation requirements. Completion of the required 30-day training is due on or before January 3, 2025, and they are on track to complete required training on time, even though they did not complete the training by the end of the 2024.

- **Example 2:** A direct caregiver is hired on 10/2/2024 and completed their preservice orientation requirements on 10/6/2024. This caregiver completed their required 30-day training for direct care staff on 11/3/2024. Did this caregiver complete their preservice and required 30-day training on time?
    - No. Although the direct caregiver completed their preservice orientation before beginning required training within 30-days of hire, they did not complete all required training within 30-days of hire. Instead, the caregiver completed the required 30-day training on 11/3/2024, 33 days after date of hire; therefore, they did not complete their required training on time.

- **Example 3:** A direct caregiver was hired on 12/12/2023 and completed their annual in-service training by 12/9/2024. 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.

- **Example 4:** During 2024, a facility had 95 staff employed at some point during the year.

This included part-time and full-time staff, and staff who left employment during 2024. Of the 95 employees, 85 completed all their training within the timeframes required by rule, given their length of employment.

Type of staff	# of staff completing required training on time	# of staff total
Direct care staff employed less than a year	25	28
Direct care staff employed longer than a year	42	48
Non-direct care staff employed less than a year	4	4
Non-direct care staff employed longer than a year	14	15
As of 12/31/2023	85	95
The compliance rate calculation: 85 ÷ 95 = 0.8947 = 90%		

Hints and Tips:

- If a staff did not complete training requirements by the required dates in a previous reporting year, this deficiency does not carry forward to the current reporting year. Only consider trainings due during 2024.
    - Example: A direct caregiver was hired on 11/13/2023. This caregiver completed their required training within 30 days of hire late, on 12/29/2023. However, this same caregiver did complete their annual in-service training requirements on-time, by 11/12/2024. This caregiver is counted as completing their required trainings on time for 2024 quality measurement reporting. The deficiency from 2023 does not carry forward.
- This metric includes **all** staff hired (direct care and non-direct care staff) while QM #1 only includes direct care staff.
- The administrator of the facility is required to complete preservice training as a **non-direct care staff**.
- Staff who are shared with another licensed facility on the same campus are counted separately at each licensed facility where they worked. The training documentation for shared staff are maintained at each worksite.

Training Requirements for Staff of Assisted Living & Residential Care Facilities (Without Endorsed Memory Care) Pre-Service Orientation for Requirements for ALL Staff – OAR 411-054-0070 (3) New Direct Care Staff (employed less than a year) *and* New Non-Direct Care Staff (employed less than a year)	
Training requirement	**Deadline to complete training**
Resident rights	Before regular duties
*LGBTQIA2S+	Before regular duties
**Home and Community Based Services	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 and reporting	Within 30 days of hire
General food safety, serving and sanitation	Within 30 days of hire
Medication & treatment administration	Within 30 days of hire

Annual and Biennial Inservice Training for All Staff Employed a Year or Longer of Assisted Living & Residential Care Facilities (Without Endorsed Memory Care) OAR 411-054-0070 (5)	
Training on infectious disease outbreak and infection control	By anniversary of hire date
*LGBTQIA2S+	By anniversary of hire date, every other year
**Home and community-based services	Hire date anniversary
Annual Inservice Training for Direct Care Staff – OAR 411-054-0070 (7)	
6 hours training on other topics (The three topics above, infectious disease, HCBS and LGBTQ+ are included in these six hours).	By anniversary of hire date
6 hours dementia training	By anniversary of hire date

* All staff must complete the initial department approved LGBTQIA2S+ training no later than December 31, 2024. Beginning in 2025 this requirement changes: LGBTQIA2S+ training is a pre-service orientation requirement for all staff.

**For 2024, all staff must have completed a department approved Home and Community-Based Services training by March 31, 2024. As of April 1, 2024, this requirement changes: HCBS training must be completed prior to beginning job responsibilities.

Training Requirements for *Endorsed Memory Care Communities* Licensed as Assisted Living or Residential Care Facilities ALL STAFF – Pre-Service Orientation – OAR 411-054-0070 (3) Direct and non-direct care staff employed less than a year and	
Training requirement	**Deadline to complete training**
Resident rights	Before regular duties
Abuse reporting	Before regular duties
*LGBTQIA2S+	Before regular duties
**Home and community-based services	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 to behaviors	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

Training Requirements for *Endorsed Memory Care Communities* Licensed as Assisted Living or Residential Care Facilities Direct care staff employed less than a year	
Training requirement	**Deadline to complete training**
(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
(C) Recognizing behaviors indicating change of condition	Before providing care
DIRECT CARE STAFF – Pre-Service Training – OAR 411-057-0155 (3)(a)	
How to provide personal care, including orientation to resident, service plan	Before independently providing care
Use of supportive devices with restraining qualities	Within 30 days of hire

* All staff must complete the initial department approved LGBTQIA2S+ training no later than December 31, 2024. Beginning in 2025 this requirement changes: LGBTQIA2S+ training is a pre-service orientation requirement for all staff.

**For 2024, all staff must have completed a department approved Home and Community-Based Services training by March 31, 2024. As of April 1, 2024, this requirement changes: HCBS training must be completed prior to beginning job responsibilities.

Training Requirements for *Endorsed Memory Care Communities* Licensed as Assisted Living or Residential Care Facilities Direct care staff employed less than a year	
Training Within 30 Days of Hire for Direct Care Staff – OAR 411-054-0070 (6)	
Training requirement	**Deadline to complete training**
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 and reporting	Within 30 days of hire
Food safety	Within 30 days of hire
Medication & treatment administration	Within 30 days of hire
Direct Care Staff – Annual Inservice 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 care training & infection control topics.	Hire date anniversary

Annual and Biennial Inservice Training for All Staff Employed a Year or Longer of Assisted Living & Residential Care Facilities (With Endorsed Memory Care) OAR 411-054-0070 (5)	
Training on infectious disease outbreak and infection control	By anniversary of hire date
*LGBTQIA2S+	By anniversary of hire date, every other year
**Home and community-based services	Hire date anniversary
Annual Inservice Training for Direct Care Staff OAR 411-057-0003 (c)	
10 hours training on other topics (The three topics above, infectious disease, HCBS and LGBTQ+ are included in these six hours).	By anniversary of hire date
6 hours dementia training	By anniversary of hire date

* All staff must complete the initial department approved LGBTQIA2S+ training no later than December 31, 2024. Beginning in 2025 this requirement changes: LGBTQIA2S+ training is a pre-service orientation requirement for all staff.

**For 2024, all staff must have completed a department approved Home and Community-Based Services training by March 31, 2024. As of April 1, 2024, this requirement changes: HCBS training must be completed prior to beginning job responsibilities.

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 2024:

1. Total number of residents living in the facility on the last day of each month, June through November 2024?
2. Total number of falls with injury that involved residents living in the facility during each month, June through November 2024?
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 2024:

- 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 2024	40
Total number of **falls with injury** during June 2024	5
Number of **residents who fell** with injury during June 2024	3
Number of **residents who fell more than once** with injury during June 2024	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:

Metric four is a measure of the how often residents are prescribed antipsychotic medications for nonstandard uses. We measure how often these medications are prescribed as regularly scheduled, and how often these medications are prescribed on an as needed basis.

Antipsychotic medications are designed to treat psychosis, some mental illnesses and vomiting. 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, and adequate staffing and training are crucial elements in providing person-centered care. Medications including antipsychotics, antidepressants, antianxiety medications, and mood stabilizers can be an appropriate part of a person-centered plan for those who need them.

When the legislature created the Residential Quality Measurement Program in 2017, there were concerns that antipsychotic medications were being misused in some community-based care facilities to inappropriately sedate or tranquilize residents. This is usually referred to as a chemical restraint. Oregon law states that residents have the right to be free from inappropriate use of psychotropic medications.[3] A psychotropic medication is not considered a restraint if it is used to treat a medical or psychiatric condition. When a psychotropic medication is used for "the effect of restricting the individual's freedom of movement or behavior" it is a restraint.

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

[3] Oregon Administrative Rule; see OAR 411-054-0027(1)(k)

Medications like antipsychotics can be used in standard or nonstandard ways. A standard use of a medication refers to using a medication to treat a symptom or disease for which there is evidence. Doctors often prescribe medications for their standard uses because there is evidence to support their effectiveness and safety for those specific conditions.

By contrast, a nonstandard use of a medication is every other use. Nonstandard uses are not FDA approved and are not evidence based. Metric four is a measure of nonstandard uses of antipsychotics. Examples of nonstandard use include giving an antipsychotic to try to address wandering, cause sedation, or to attempt fall prevention.

In standard use, antipsychotics are crucial for managing symptoms such as hallucinations, delusions, and mood associated with neuropsychiatric disorders. They help stabilize brain chemicals to alleviate these symptoms and improve overall quality of life.

This measure is not defining standard or nonstandard as all correct or incorrect. In Oregon assisted living and residential care facilities, residents choose their own health care providers like doctors or nurse practitioners. Individual decisions between a patient and their healthcare provider are complex. Assisted living and residential care facilities do not prescribe medications or employ the staff who do. Health care providers measure their patient's needs and decide what medications should be prescribed to their patients.

What assisted living and residential care facilities do is monitor and report. Assisted living and residential care facilities do not change, reduce, or increase medications. Then, the health care provider sends or modifies the prescriptions to the assisted or residential care facility based on the monitoring and reporting done by the facility. Finally, the facility has non-licensed, trained staff called medication aides who administer the medications to residents.

The goal of collecting metric four data is to identify the use of antipsychotic medications so that an informed policy conversation can be had. There is a perception that there is a high rate of nonstandard use, but is that accurate?

Here's what we can do at a facility level:

- Make sure you have a reason that every medication is prescribed from the provider. This is what allows you to service plan for the resident.
- Assure that the person-centered service plan contains behavioral

interventions and/or environmental modifications, in addition to psychotropic medications, when they are prescribed.
- Closely monitor the status of residents and report any changes from their usual status to the resident's health care provider.
- When an antipsychotic is prescribed, ask the provider:
    - What are the side effects?
    - How will we know it's working?
    - If there is a new as needed or PRN medication, is there a reason? If not, contact the prescriber.

Data collection on nonstandard uses of antipsychotic medications in assisted living facilities serves as a critical tool for identifying any potential misuse. We can create targeted interventions and quality improvement initiatives to ensure the safe and effective use of antipsychotics in these settings, ultimately enhancing the overall quality of care for residents.

How to Measure:
Facilities must track the use of antipsychotic medications for nonstandard uses during October 2024. Facilities will report regularly scheduled[4] and PRN[5] antipsychotic medications for nonstandard uses separately.

Data to Track for this Measure:
Use the 31-day period October 1 – 31, 2024.

1. Count the total number of residents on the October 31, 2024 facility census.
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. Use Table B to identify residents with diagnoses that show standard use. Residents taking antipsychotics for a standard use are not reported.
4. Determine how many of the remaining residents:
    a. Had a prescribed, **scheduled antipsychotic** medication for a **nonstandard** use, during the 31-day period.
    b. Were prescribed a **PRN antipsychotic** medication for a **nonstandard** use, during the 31-day period.

[4] A **scheduled medication** is prescribed by a qualified practitioner to be used immediately, for a specific period.
[5] A **PRN (pro re nata) medication[5]** means medications and treatments prescribed by qualified practitioner to be administered as needed.

Example:

Step 1: Count the residents on the census on 10/31/2024.
- The facility has 52 residents on the 10/31/2024 census.

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 2024.

Step 3: Remove residents with conditions on the Exclusions List (Table B).
- Three residents had conditions on the Exclusions List. 31 residents have prescriptions for antipsychotics for a nonstandard use.

Step 4: Count the residents with scheduled antipsychotics for a nonstandard use.
- 19 of the 31 residents had a prescription for a **scheduled** antipsychotic for a nonstandard use in October 2024.

Step 5: Count the residents with PRN antipsychotics for a nonstandard use.
- 12 of the 31 residents had a prescription for a **PRN** antipsychotic for a nonstandard use in October 2024.

Data Summary

Data Field	**Data Reported**
The number of residents on the 10/31/24 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

For those who want to know how this metric is calculated, read below:

Calculation 1: **Scheduled** antipsychotic for a nonstandard 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 nonstandard

in October 2024

Calculation 2: **PRN** antipsychotic for a nonstandard use:

% of residents with PRN use of an antipsychotic drug

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

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

Tip: 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, scheduled and as needed.

Table A presents both the name brand and generic name of antipsychotic medications alphabetically. **Source:** https://www.singlecare.com

Table A: List of Antipsychotic Medications

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

Table B: Exclusions list[6]

Excluded Diagnosis	Variations of the Excluded Diagnosis
Acute Agitation	Terminal agitation, end-of-life agitation, severe agitation, treatment of agitation associated with dementia (or due to Alzheimer's), behavioral and psychological symptoms of dementia (BPSD), severe agitation or aggression, dementia with agitation, dementia with aggression, hitting/pushing/grabbing type behaviors.
Agitation due to schizophrenia or bipolar disorder	
Acute intermittent porphyria	
Bipolar disorder	Manic depression, Bipolar depression, mixed bipolar affective disorder, bipolar mood disorder, manic-depressive disorder, acute mania, manic and mixed episodes associated with Bipolar, Bipolar I Disorder, Traumatic brain injury (TBI) with agitation
Generalized anxiety disorder	GAD, anxiety, anxiety d/o, anxiety/agitation
Intractable hiccups	

[6] The medication record for each resident that the facility administers medications to must include the name of medications, reason for use, dosage, route and date and time given. OAR 411-054-0055(2)(b)(B)

Table B: Exclusions list, continued

Excluded Diagnosis	Variations
Mania	
Major depressive disorder	Depression, psychotic depression, depression (mild, mod/severe), recurrent major depressive disorder, recurrent depression, treatment of refractory depression, depression with psychosis, depression with psychotic features, MDD, Adjunctive treatment for depression, chronic depression, Bipolar II depression
Nausea	N/V
Psychosis (including paranoia, delusions, and hallucinations)	Psychotic disorder, unspecified psychosis not due to a substance or known psychological condition, depression with psychosis, paranoia and hearing voices, Parkinson's Disease psychosis, Psychosis with expressions/or indicators of distress, delirium, dementia with psychosis, chronic psychotic illness
Schizoaffective disorder	
Schizophrenia	
Serotonin syndrome	
Suicide preventions	suicidal ideation, hx of suicidal thoughts
Tourette syndrome	
Vomiting	N/V, emesis

Source: Epocrates.com[7]

[7] 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 https://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 2025.**
- 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 CoreQ Customer Satisfaction 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.

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. The resident satisfaction survey (metric five) 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.
3. Resident survey answers are reported by a count of responses, not percentages of responses.
4. Reporting is required even when a change of ownership or management takes place. Facilities that open or close during 2024 are exempted from quality measurement reporting. A change of management or change of ownership does not exempt the facility from reporting.
5. 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.
6. 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.