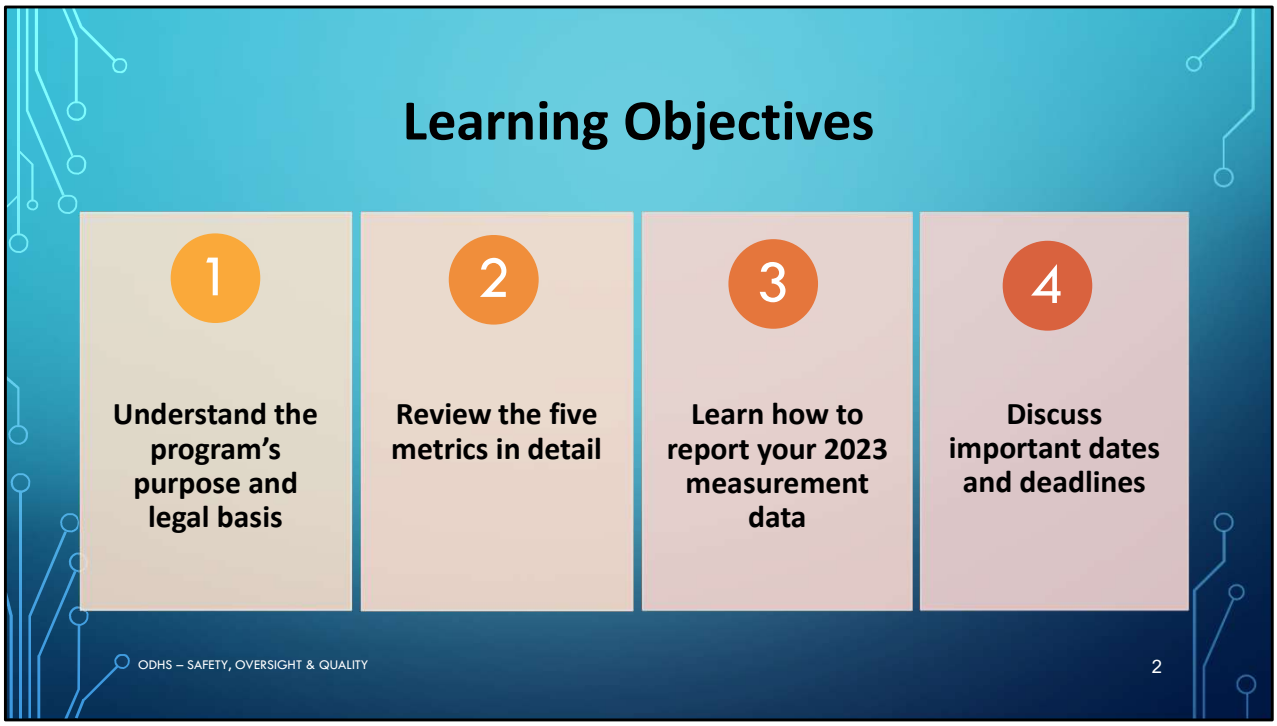
Hello thank you for viewing this webinar on Quality Measurement Program Reporting for 2023. This presentation explains the reporting requirements for assisted living and residential care facilities for the Quality Measurement Program. Let's review our learning objectives:



The Learning objectives for this presentation are:

1. Understand the Quality Measurement Program's purpose and legal basis
2. Review the five metrics in detail
3. Learn how to report your 2023 measurement data
4. Discuss important dates and deadlines

Where Did the Quality Measurement Program Come From?

- The legislature created the program in 2017
- The Governor appoints a council to oversee the process
- ODHS reports the information by July 1

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The Quality Measurement Program (QMP) was created in 2017. The process began with convening the Quality Measurement Council (QMC) created by the legislature and defining the metrics provided by the legislature.

The council is comprised of 9 members: A representative from the Oregon Patient Safety Commission, a representative for assisted living and residential care facilities, a representative from the Alzheimer's Association, a medical practitioner with experience in geriatrics, two academics who perform research in geriatrics, the State Long-Term Care Ombudsman and a representative for direct care workers. The intention of comprising a multidisciplinary council is to add the experience of all these different views to the project of measuring and

improving the quality of care.

In 2020, the Quality Measurement Program was ready to collect data. However, due to strain COVID-19 placed on facilities, the Council decided to collect only yes/no answers for 2020 and 2021. You can view the reports on the QMP website.

2022 was the third QMP reporting year, but the first year numerical data was collected. Upcoming slides show that 2023 data collection expands the timeframes and level of detail for some metrics..

Next, we'll review the goals for the Quality Measurement Program.

Our big goal is to work toward the **highest quality possible quality care** for residents. We can break that down into three component goals.

The first goal is **measuring quality**. A quality measure is a tool for making decisions that make it more likely to experience a good result and less likely to experience an adverse result that was not foreseen or was not understood.

Measurement is the first step in quality improvement. Measurement provides a benchmark to compare our performance with other providers. For example, in 2022, facilities reported how many direct caregivers they retained. The higher the retention rate, the higher the quality of care. We can compare the performance of each facility year to year. We can also select peer facilities to compare performance.

The second goal is **sharing the data so consumers can compare** one facility to another. If you are a consumer considering a few assisted living facilities in your area, you can compare their quality metrics to see how they performed in comparison to each other.

The third goal **is identifying areas for quality improvement**. Quality data should be used by leaders in residential care services. You can use this data to compare the performance of your facility year-to-year and to compare to other facilities. Then, the data can be used to

identify trends and areas for improvement. For example, you may observe a higher turnover at your facility, as compared to other facilities. This may lead you to conversations with your internal teams, with the supports at Oregon Department of Human Services (ODHS), with the professional associations that represent facilities, and with other facilities to share ideas for quality improvement around staff retention.

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So, why measure quality? We measure quality to help us improve. Measuring an issue allows us to better manage it.

Quality matters because our resident's health and happiness depends on high quality services. Quality also impacts the bottom line of our business. High quality services results in lower turn over of residents and staff. Having a reputation for quality keeps makes marketing easier and helps keep our buildings full. High quality services means fewer complaints and problems to address.

Quality is defined by the National Academy of Medicine as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

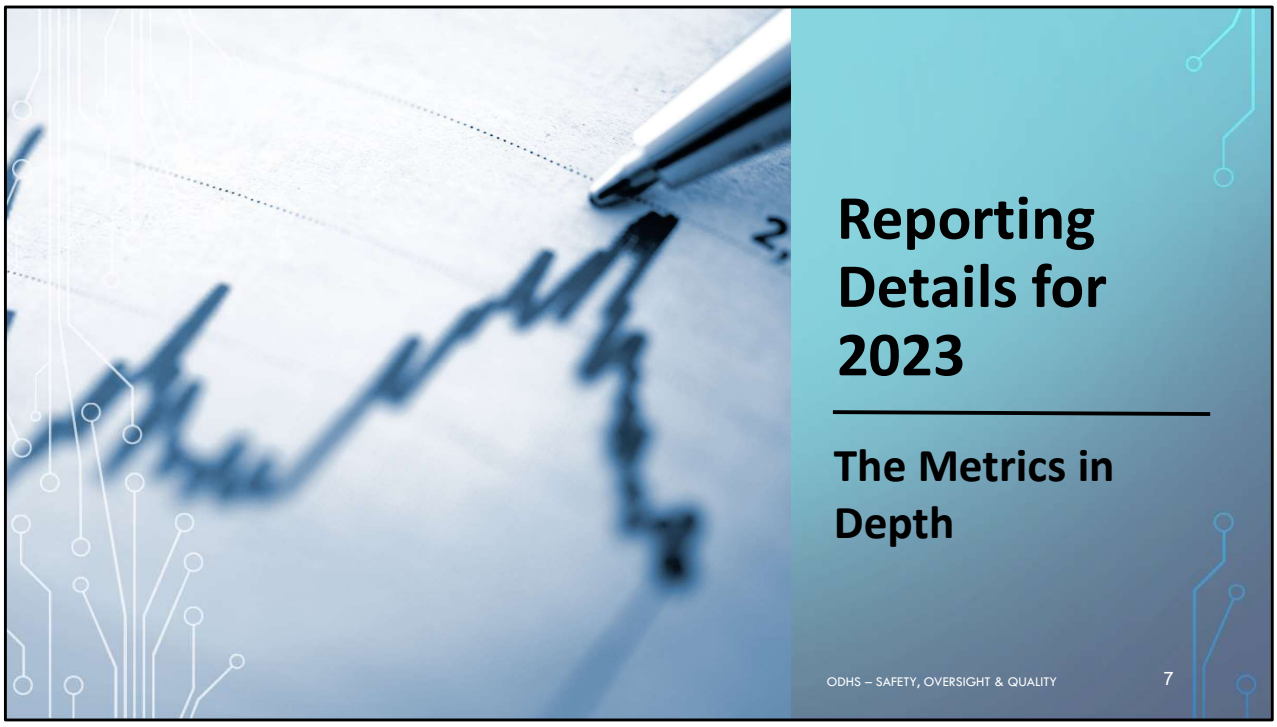
Quality improvement is the framework used to systematically improve care. Quality improvement seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for (patients) residents, healthcare systems, and organizations. **Structure** includes things like technology, culture, leadership, and physical capital; **process** includes knowledge capital (e.g., standard operating procedures) or human capital (e.g., education and training). (Source: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-*

Improvement-).

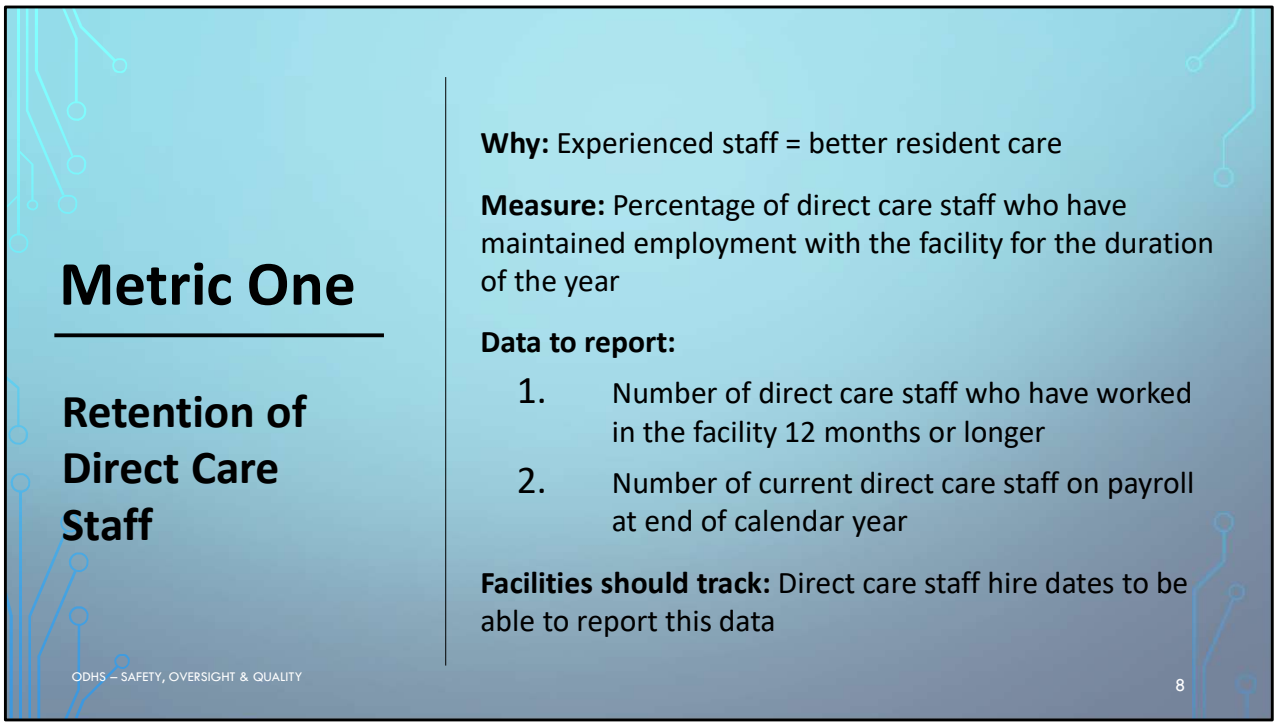
OAR 411-054-0025(9) requires facilities to develop and conduct an ongoing quality improvement program that evaluates services, resident outcomes and resident satisfaction. (Source: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-Improvement*-). The quality metrics Oregon uses speak to the elements in the quality improvement rule. Use the quality metrics to determine how your facility is performing year to year and with similar facilities.

This slide provides an overview of each of our five metrics, the timeframe for measurement, and calls out changes for 2023:

1. Metric one is the same as 2022; this metric measures the percentage of direct care staff retained over the course of 2023.
2. Metric two measures compliance with staff training for all staff employed on 12/31/2023. In 2022, the measurement was limited to staff hired in the last quarter.
3. Metric three measures the number of resident falls with injury. The 2023 time frame is reporting data for six months, June through November. In 2022, measurement was in October only.
4. Metric four is a measure of the number of residents who receive antipsychotics for a non-standard use. 2023 is the first year numerical data will be collected. Facilities will report data for October 2023.
5. Metric five is the annual resident satisfaction survey. There are no changes from measurement in 2022. The survey must be conducted at some time during 2023 with the data available to report in January 2024.



Now for our detailed conversation about each of the metrics.

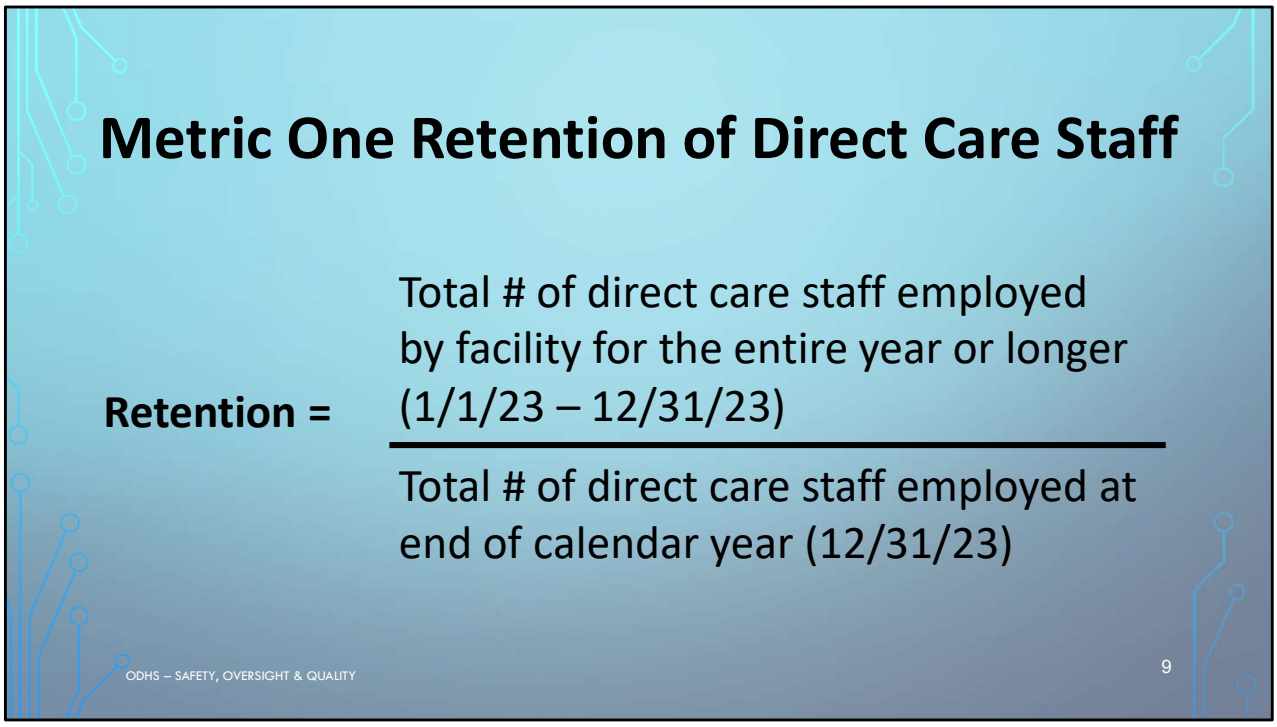


Metric one is the retention of direct care staff.

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.

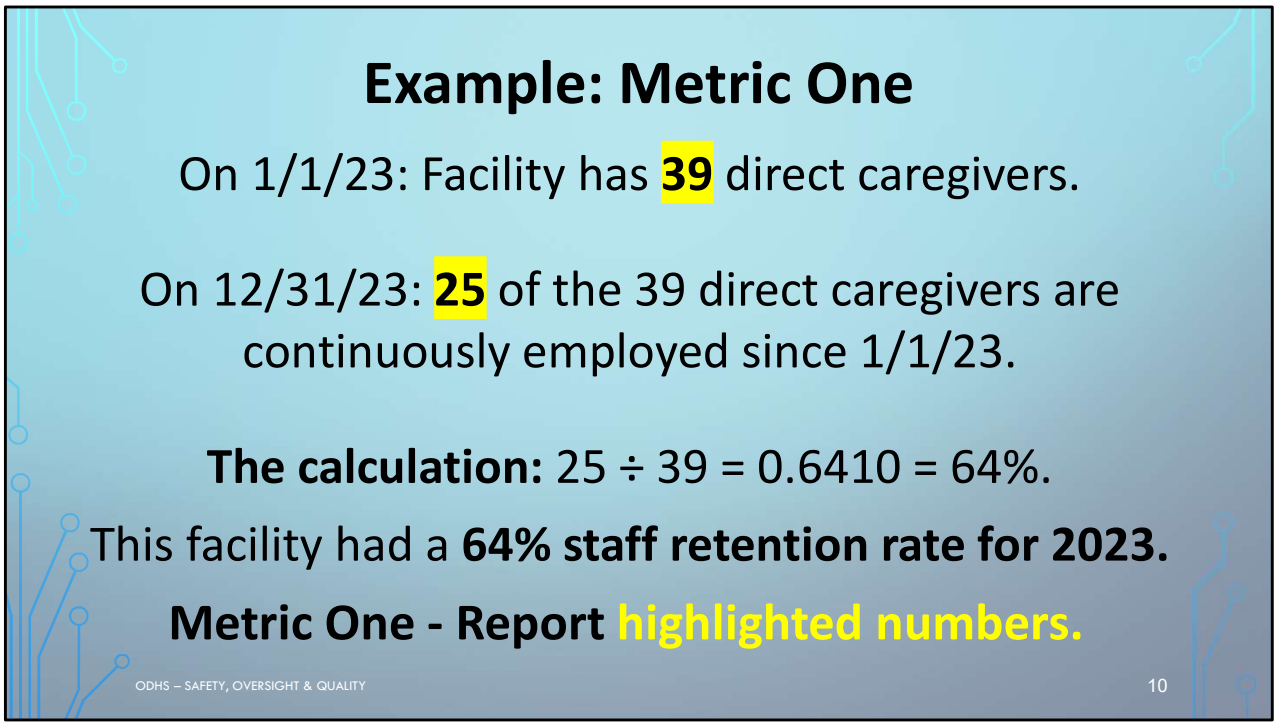
Members of the QMC and staff at ODHS are acutely aware of the challenges providers face in hiring and retaining new staff. This is a nice opportunity to remind you of our guiding principle: Measuring an issue allows us to better manage it. Because there is no penalty or regulatory use of any QMP data, help us all improve by reporting your retention (and all data!) as fully and accurately as possible. It will help us get a sense of the size of the staffing challenge we share.

The slide details the data to report and what information facilities should track to report.



While this measure is incredibly important, the data and calculation is very straight forward. The percentage of staff retained over the course of the year is calculated by dividing the total number of direct care staff employed by the facility for the entire year or longer divided by the total number of direct care staff employed at the end of the year.

When you enter your data in for 2023, the data collection tool will not calculate the percentage for you. Instead, you will enter two numbers: the total number of direct care staff employed from January 2023 through December 2023 and the total number of direct care staff employed at the end of the year. It's important that you enter the data into the correct cells and perform the calculation yourself. If you are getting a retention percentage over 100%, it means you've entered data into the wrong cells. Next, we'll practice this in an example.



Read the slide to apply the calculation to an example.

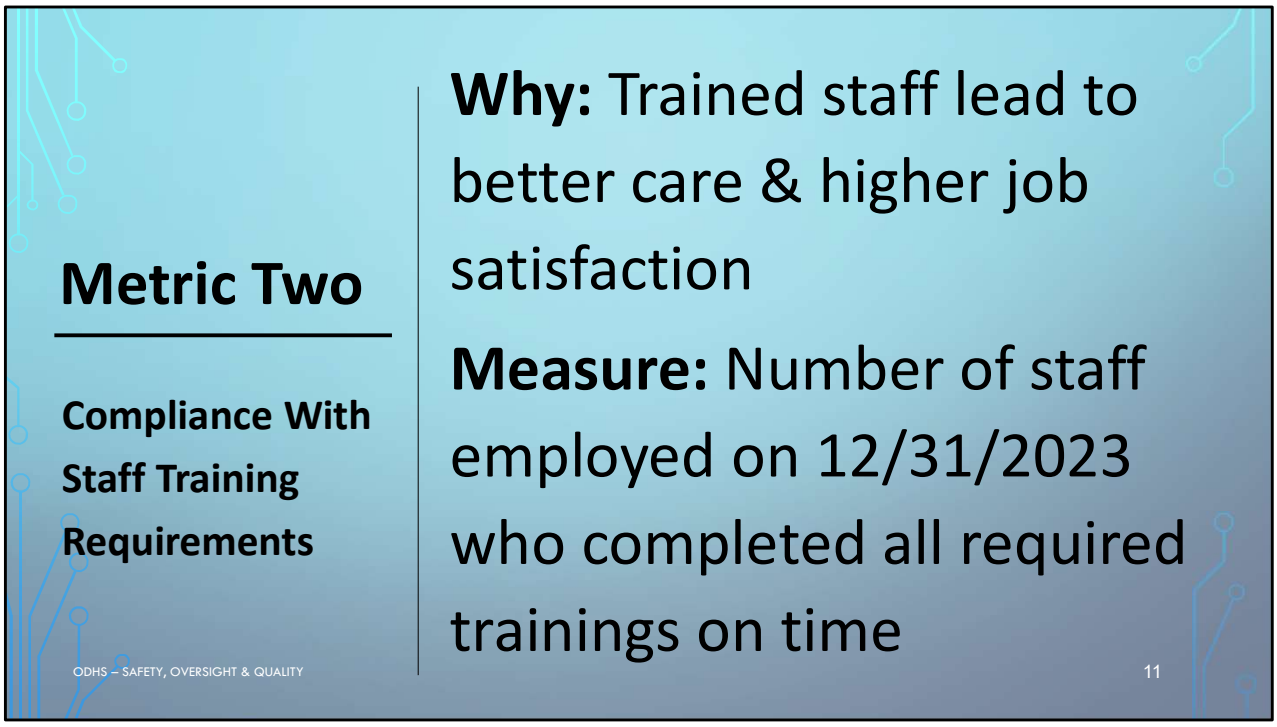
Now is the time to be thinking about how you will gather the information and which member of your team will wrangle the information needed to report on staff retention. You don't want to set you and your team up for a late night at the end of January!

Be sure to focus on direct care staff for this measure:

- Make sure you pay attention to defined terms like "direct care staff." This definition is in the rules, and it's provided in the *Provider Guide*.

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.

Activities staff are considered direct care staff for QMP and training purposes. It is essential for all staff who interact regularly with residents to have adequate training. Activities staff may not perform direct care on a regular basis but must be well trained in the cognitive/emotional experience, basic hands-on tasks such as transfer and ambulation assistance, may even assist with eating at times. They are also responsible for assisting residents with other ADLs and should be fully trained in resident care. For purposes of the acuity - based staffing tool (ABST) however, activities staff are not categorized as direct care workers since activities staff are not readily available and/or focused on meeting the daily ADL needs of residents.



Metric two is compliance with training for all staff, both direct care and non-direct care staff. Read the slide for the details of what data to report.

Background and Reason for Tracking:

For the health and safety of residents, it is essential to have trained staff caring for residents in facilities. Staff who are well-trained provide residents better care and services and experience greater satisfaction with their jobs. Oregon Administrative Rules outline training topics and training deadlines.

Facilities must have a system to track training for compliance and survey purposes already. ***This metric is changed for 2023: Facilities must report training compliance for all staff employed on 12/31/2023, regardless of their hire date.*** In 2022, facilities only reported compliance for staff hired in the last quarter who were employed on 12/31/2023.

Tables summarizing the required trainings are in the companion *Provider Guide*.

Metric Two

Compliance With Staff Training Requirements

Data to report for direct care (DC) staff:

- Total number of DC staff employed on 12/31/23
- Total number of DC staff employed for 30 days or less on 12/31/2023
  - Of these, how many staff are on track to complete or have completed required training on time?
- Total number of DC staff employed for 31 days to a year on 12/31/2023
  - Of these, how many staff are on track to complete required training on time?
- Total number of DC staff employed more than a year on 12/31/2023
  - Of these, how many staff completed their required annual in-service training?

Track direct care and non-direct care staff separately.

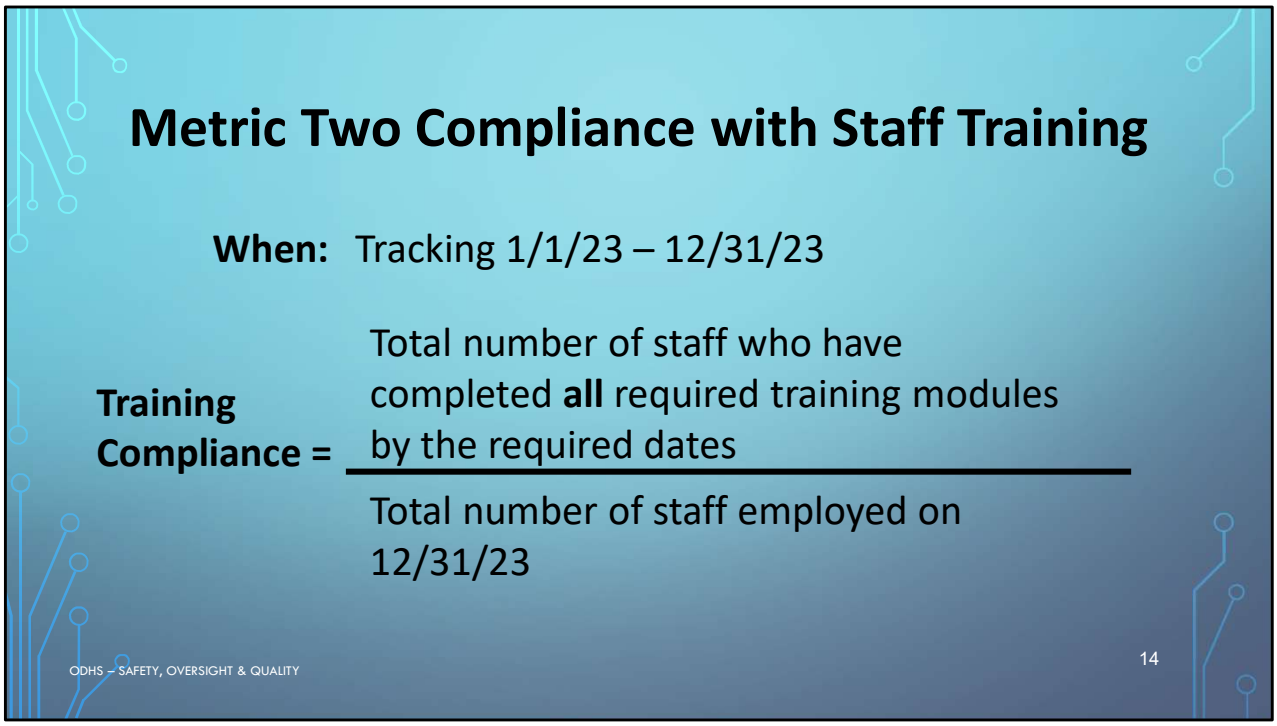
Metric Two

Compliance With Staff Training Requirements

Data to report for non-direct care (NDC) staff:

- Total number of NDC staff employed on 12/31/23
- Total number of NDC staff employed for less than a year on 12/31/2023?
  - Of these, how many staff are on track to complete or have completed required training on time?
- Total number of NDC staff employed for more than a year on 12/31/2023
  - Of these, how many staff are on track to complete required training on time?

Track direct care and non-direct care staff separately.



The formula for tacking compliance with staff training is simple: The **percentage** of staff who completed training on time is the total number of staff employed on 12/31/2023 who completed training on time during the year divided by the total number of staff employed at the end of the year. The complexity with this metric is making sure the different training elements for all employees (not just direct caregivers as in measure one) are recorded in a way that can be summarized for program reporting requirements.

Review the formula on the slide. We'll apply the formula to an example on the next slide.

Example: Metric Two

On 12/31/23: Facility had 95 employees. 85 of those employees completed their training on time.

The calculation: 85 ÷ 95 = 89.5% received required training.

Metric Two - Report highlighted numbers.

Read the slide to apply the calculation to an example.

Now is the time to be thinking about how you will gather the information and which member of your team will wrangle the information needed to report on staff retention. You don't want to set you and your team up for a late night at the end of January!

Be sure to focus on direct care staff for this measure:

- Make sure you pay attention to defined terms like "direct care staff." This definition is in the rules, and it's provided in the *Provider Guide*.

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.

Metric Two: Table

Type of staff	# of staff completing required training on time	# of staff total on 12/31/23
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%		

Metric Two - Report highlighted numbers.

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Facilities will report two numbers for this metric:

1. The number of staff employed by the facility on 12/31/23
2. The number of these staff who completed training on time

While only the two highlighted numbers are reported for quality measurement, notice how the chart is organized to help determine those numbers: Staff are identified by their type as "new" or "experienced" and as "direct care" or "non-direct care."

Example: Metric Two

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.

Staff compliance with training timelines is determined by their length of employment.

Example: Metric Two

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.

Staff compliance with training timelines is determined by their length of employment.

Example: Metric Two

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.

Staff compliance with training timelines is determined by their length of employment.

Example: Metric Two

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. Is this caregiver counted as "in compliance" with training for 2023 quality measurement program reporting?

- **Yes.** This caregiver is counted as completing their required trainings on time for 2023 quality measurement reporting. The deficiency from 2022 does not carry forward.

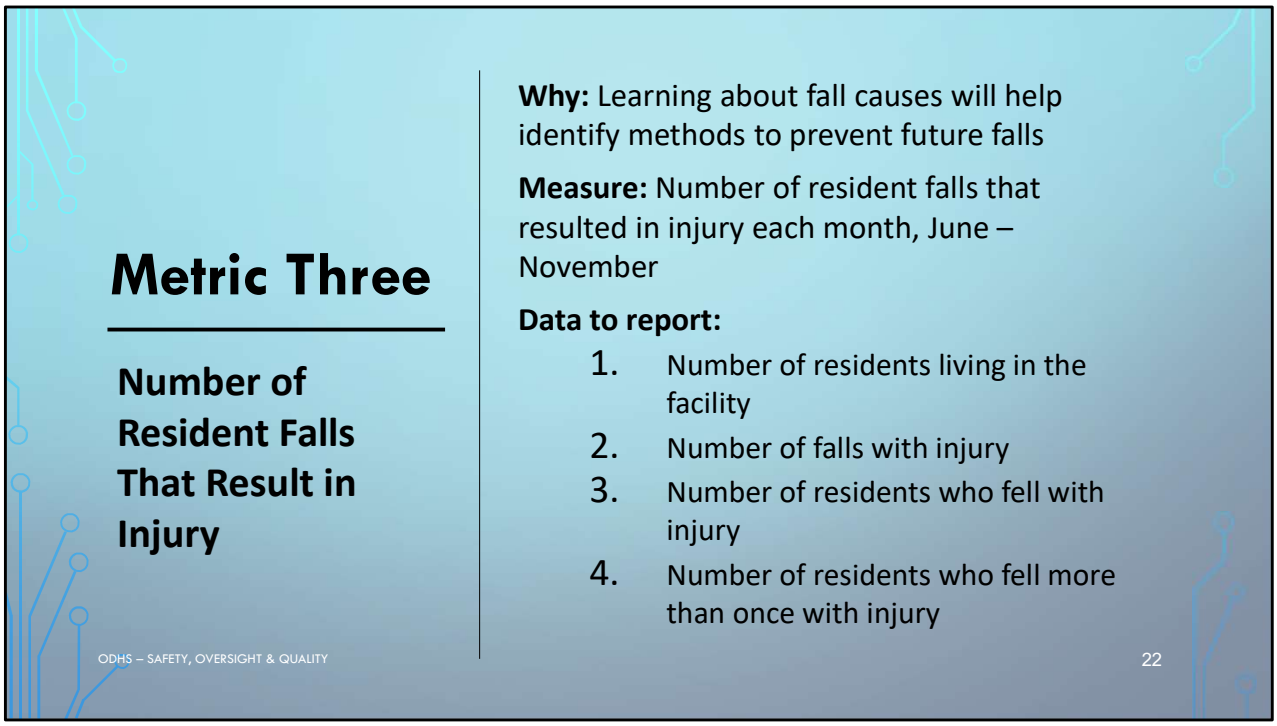
Only measure compliance for trainings due in 2023. Past training deficiencies do not carry forward.

Metric Two: 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.

The administrator of the facility is required to complete preservice training as a **non-direct care staff**.



Background and Reason for Tracking

Falls are a primary cause of resident injury and can lead to premature death. It is important to note that 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 may be done to lessen the number and severity of falls as much as possible.

Metric three is a count of resident falls resulting in injury during six months in 2023: June, July, August, September, October, and November. Facilities will collect data for each month. The data for the six months will be entered into the data collection tool by January 31, 2024.

The *Provider Guide* includes definitions for "fall" and "injury." In many instances, the person evaluating the data will need to make a judgment call about whether an event or injury fits the definition of a fall. Do your best to report accurately, but don't feel you need to run any particular event by the program. We are available to

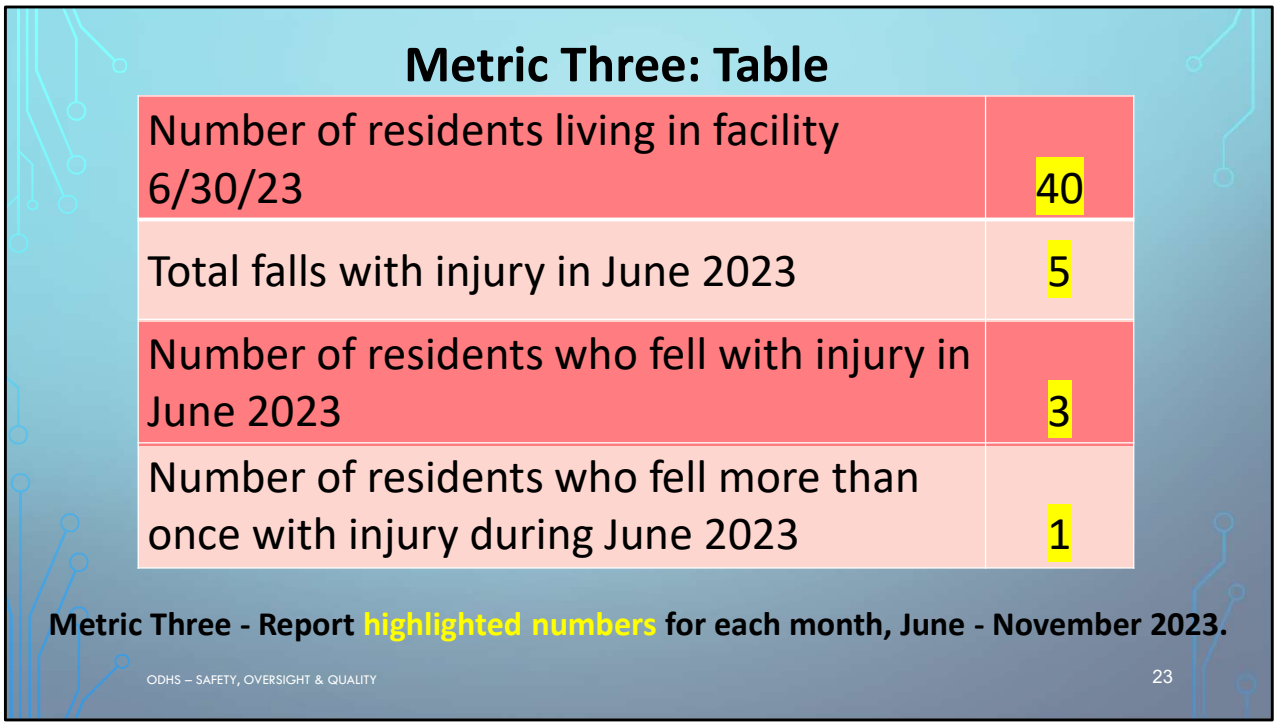
provide technical assistance, but don't expect you to seek confirmation of every instance where you need to exercise professional judgment.

Please observe there are four pieces of data needed to report Metric three: (Review slide). The next slide provides an example.
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

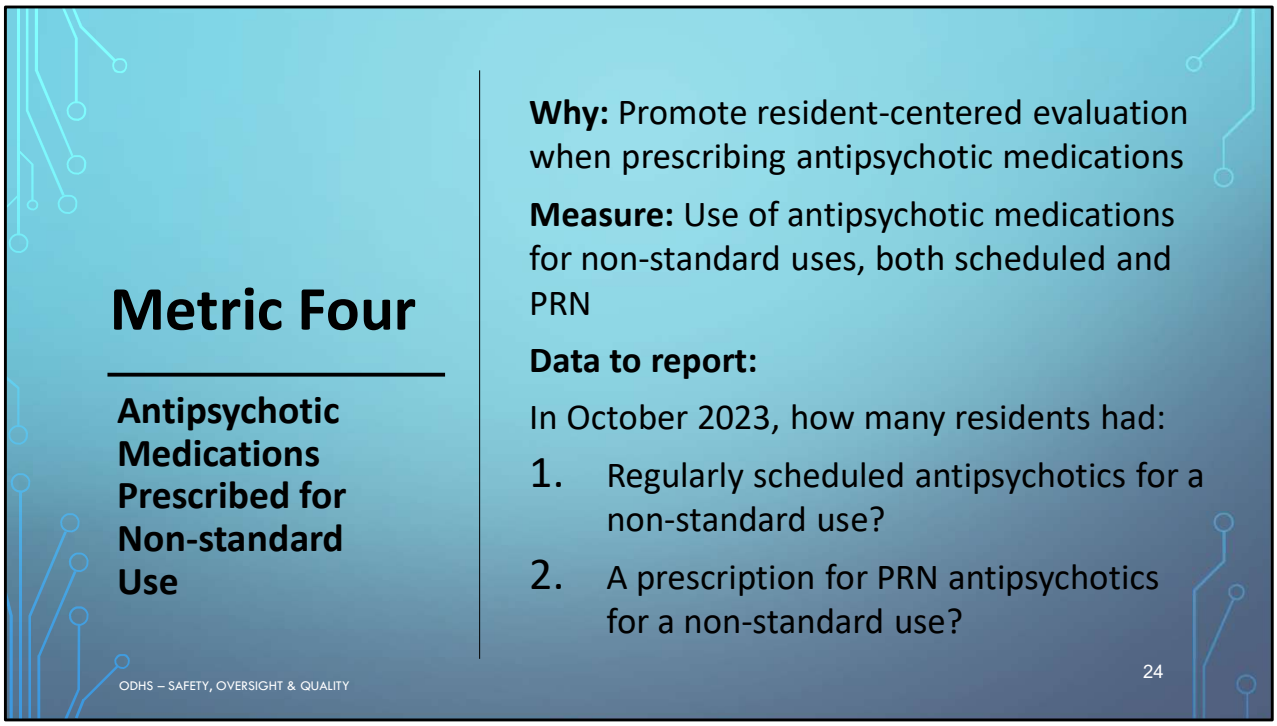
An **injury** is defined as any of the following:

- Bruise, abrasion or wound requiring simple intervention such as dressing, ice, limb elevation, topical medications, oral pain medications, etc.
    - These injuries may be treated within the facility or may involve a resident leaving the facility for care.
- 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
    - These injuries generally require outside intervention and may require splints, sutures, surgery, casting, or further examination (e.g., for possible neurologicalinjury).
    - These injuries frequently involve the resident leaving the facility for assessment and/or treatment and/or they may require home health care.



To report the count of resident falls with injury, track the four data points and enter the values into the corresponding cells. In this example, there were 40 residents living in the facility on 6/30/23. There were five falls with injury in June. Three residents fell with injury in June. There was one resident who fell more than once in June.

Facilities will collect and report data for the months June through November in 2023. You will report all the data collected during January 2023.



Reporting for Metric 4 has changed in 2023: For the first time we will be collecting numerical data. Facilities must report how many residents received an antipsychotic medication for non-standard uses. Before we explore the details of reporting, we'll review the background for this quality metric.

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 all crucial elements in providing person-centered care.

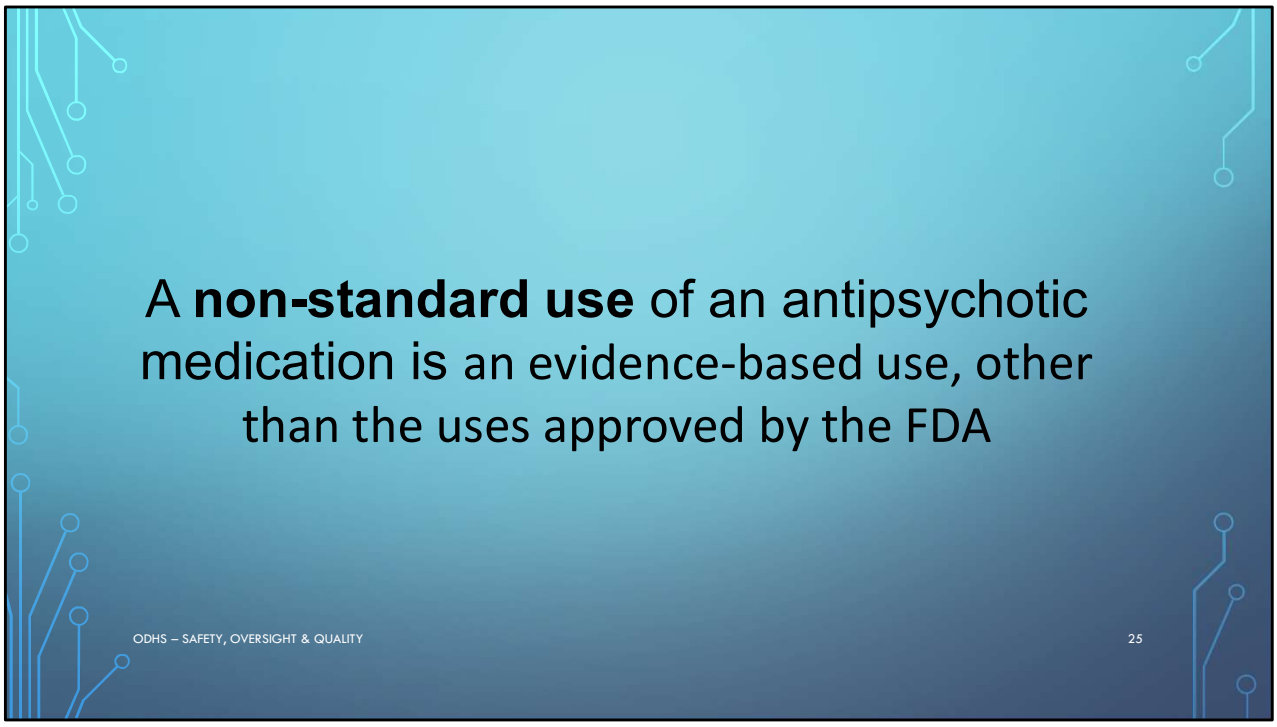
Medications including antipsychotics, antidepressants, antianxiety medications, and mood stabilizers can be part of a person-centered plan.

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.” 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 the purpose of the medication is “to treat the individual’s medical or psychiatric condition.”

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 uses. Data is needed to determine the prevalence of nonstandard antipsychotic use and to encourage facilities to examine the use of these medications with their residents.



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Metric Four

Antipsychotic Medications Prescribed for Non-standard Use

Process:

1. Count the residents on the census 10/31/2023. Residents who move before 10/31 aren't considered for this metric.
2. Count the residents who have a prescription for an **Antipsychotic Medication List** (Table A in the *Provider Guide*).
3. Remove the residents with conditions on the **Exclusions List** (Table B in the *Provider Guide*).
4. Count the residents with a scheduled antipsychotic for a non-standard use.
5. Count the residents with a PRN antipsychotic for a non-standard use.

No additional text.

Metric Four: Table

Data Field	Data Reported
Residents on the 10/31/2023 census	52
Residents receiving antipsychotics in October	34
Residents on the exclusion list	3
Residents with antipsychotics for non-standard use	31
Residents with scheduled antipsychotics for nonstandard use	19
Residents with PRN antipsychotics for nonstandard use	12

Metric Four - Report highlighted numbers for October 2023.

Metric Four

Antipsychotic Medications Prescribed for Non-standard Use

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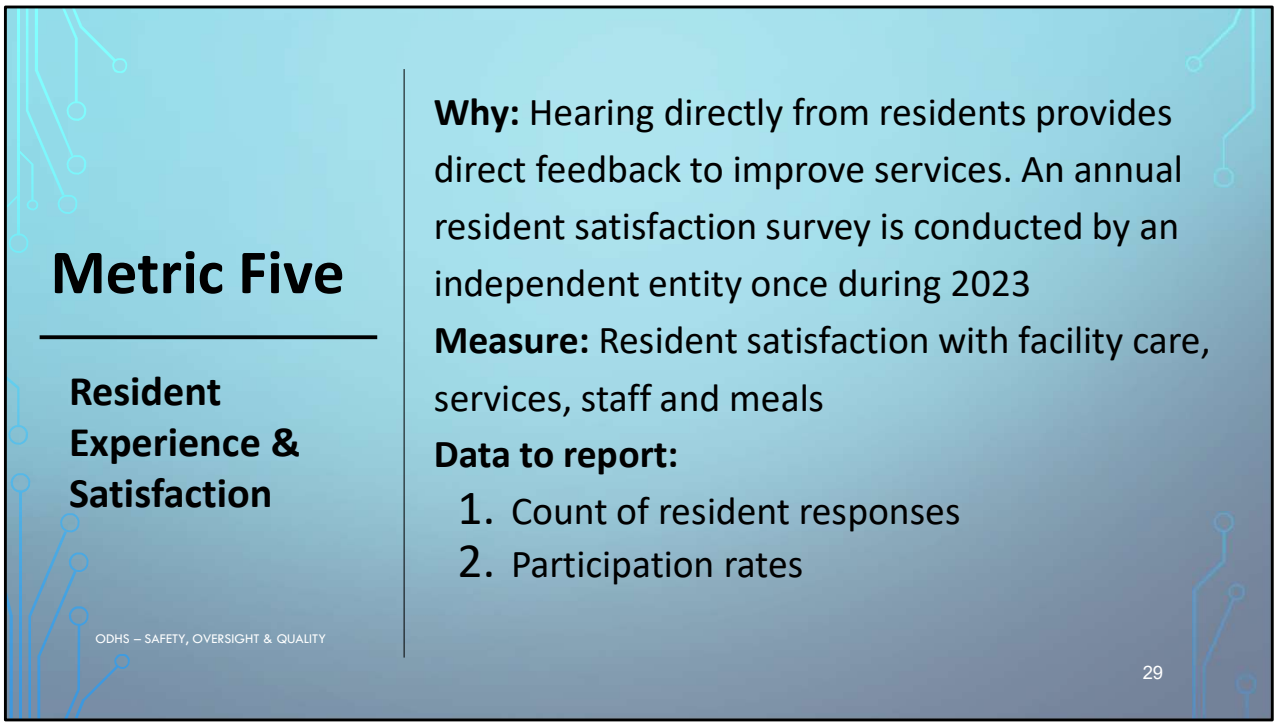
Action Items:

1. Work with your organization and institutional pharmacy to track the incidence of **non-standard** use of antipsychotics.
2. Train your staff & families on the appropriate use of antipsychotics and how to bring concerns about misuse forward to facility leadership and to APS if needed.

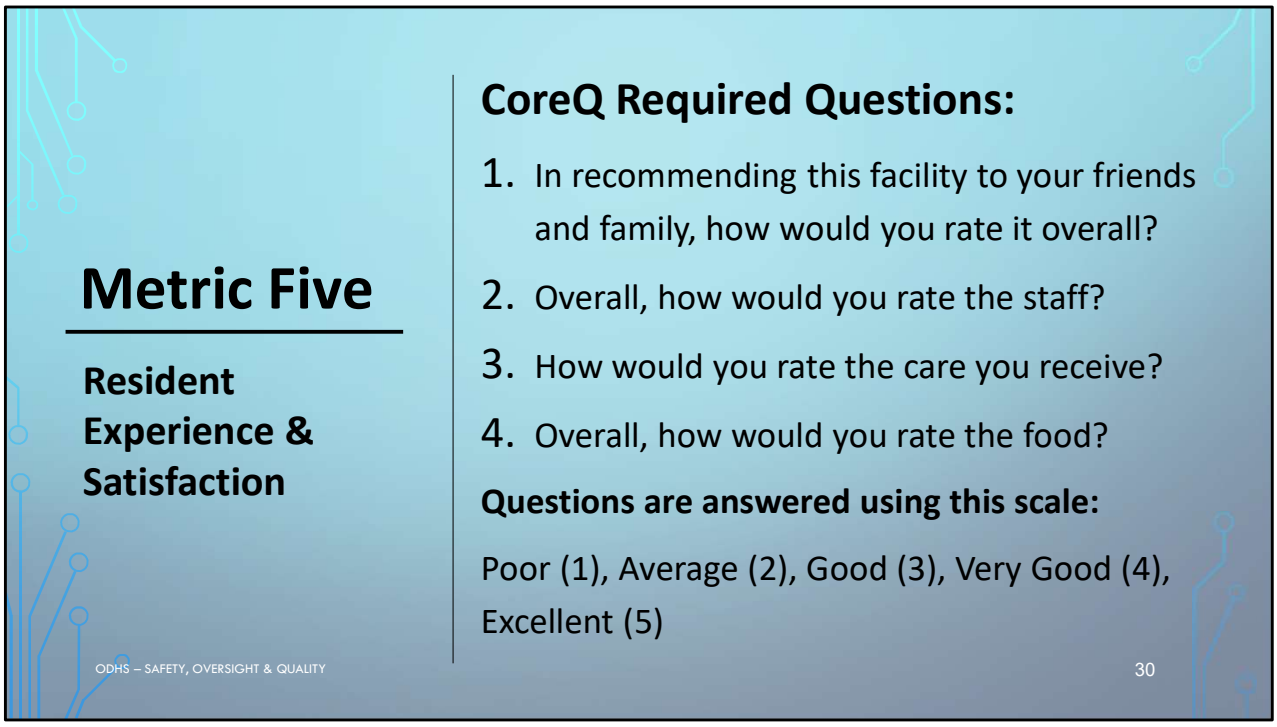


Background and Reason for Tracking:

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.



The slide presents the four questions for residents to answer with the CoreQ vendor.

Metric Five

Resident Experience & Satisfaction

Facilities will also report:

1. The number of residents who **received** the survey
2. The number of residents who **returned** the survey
3. The number of residents who **completed** the survey
4. The name of the CoreQ customer satisfaction **vendor** the facility used
5. The **method** for survey administration, i.e., in writing, by phone, in person, online.

These additional questions are part of the customer satisfaction survey data collection process.

Residents who should not be given the customer satisfaction survey

- BIMS score of seven or lower or MMSE score of 12 or lower
  - **If BIMS/MMSE is unknown, provide the survey anyway.** It is assumed that residents with cognitive impairment will not complete the survey.
- Have a court-appointed guardian
- On hospice
- Have been in the facility less than two weeks

Metric Five: Table

	# poor	# average	# good	# very good	# excellent
In recommending this facility to friends and family, how would you rate it overall?	6	6	1	15	2
Overall, how would you rate the staff?	5	7	3	4	12
How would you rate the care you receive?	2	6	7	13	0
Overall, how would you rate the food?	3	5	15	1	1

Metric Five - Report highlighted numbers.

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Metric Five: Table Example, cont.

The number of residents who received the survey	40
The number of residents who returned the survey	30
The number of residents who completed the survey	20
The name of the CoreQ customer satisfaction vendor the facility used	Assisted Living Analytics
The method for survey administration, i.e., in writing, by phone, in person, online.	Writing

Metric Five - Report highlighted numbers and answers.

Lessons Learned in 2022

1. Quality metrics data corresponds to the facility license. If a facility has two licenses on one campus, there will be two sets of quality metrics data reported.

2. Be careful to enter data into the correct cell. For example, 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.

4. Resident survey answers are reported by **a count of responses, not percentages** of responses.

Lessons Learned in 2022, cont.

4. Reporting is required even when a change of ownership or management takes place.

5. Provider Alerts, Provider Alerts, Provider Alerts!

6. Keep your Policy Analyst current on your administrator's email address.

Data Collection in 2023

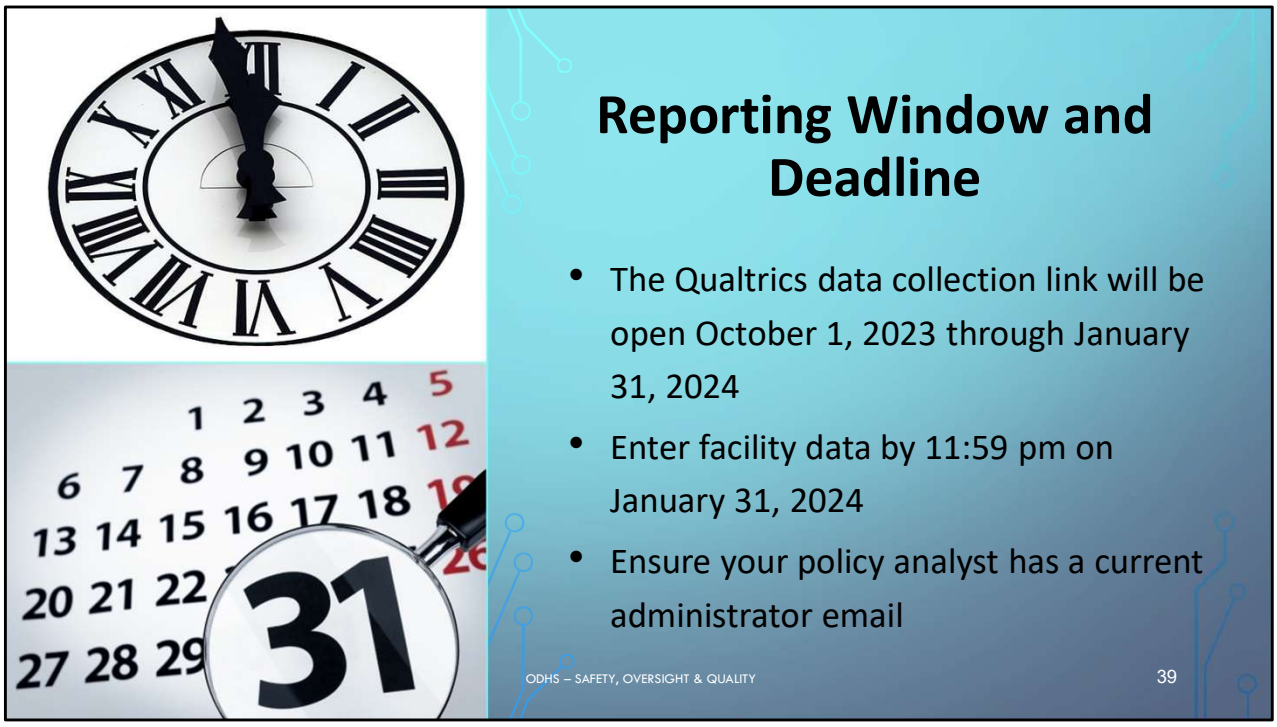
1. Submit data by January 31, 2024 to comply with the law.
2. Data collected through survey link that will be shared through a Provider Alert.
3. The link will also be emailed to the address on record for the administrator of record.

Data Collection in 2023, cont.

4. The 2023 survey will use Qualtrics software, same as in 2022.

5. The *2023 Provider Guide* is available on the program website.

6. A *Provider Guide* supplement containing screen shots of the survey link will be released soon.



No additional text.

Questions?

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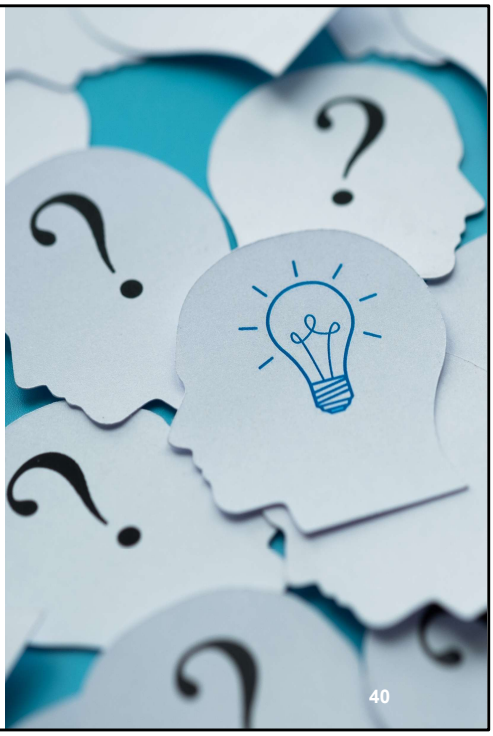

Thank you for reading this. Please reach out with any questions.