Oregon Department of Human Services

# 2025 Quality Measurement Program Training Data Collection and Reporting for Oregon Residential Care and Assisted Living Facilities

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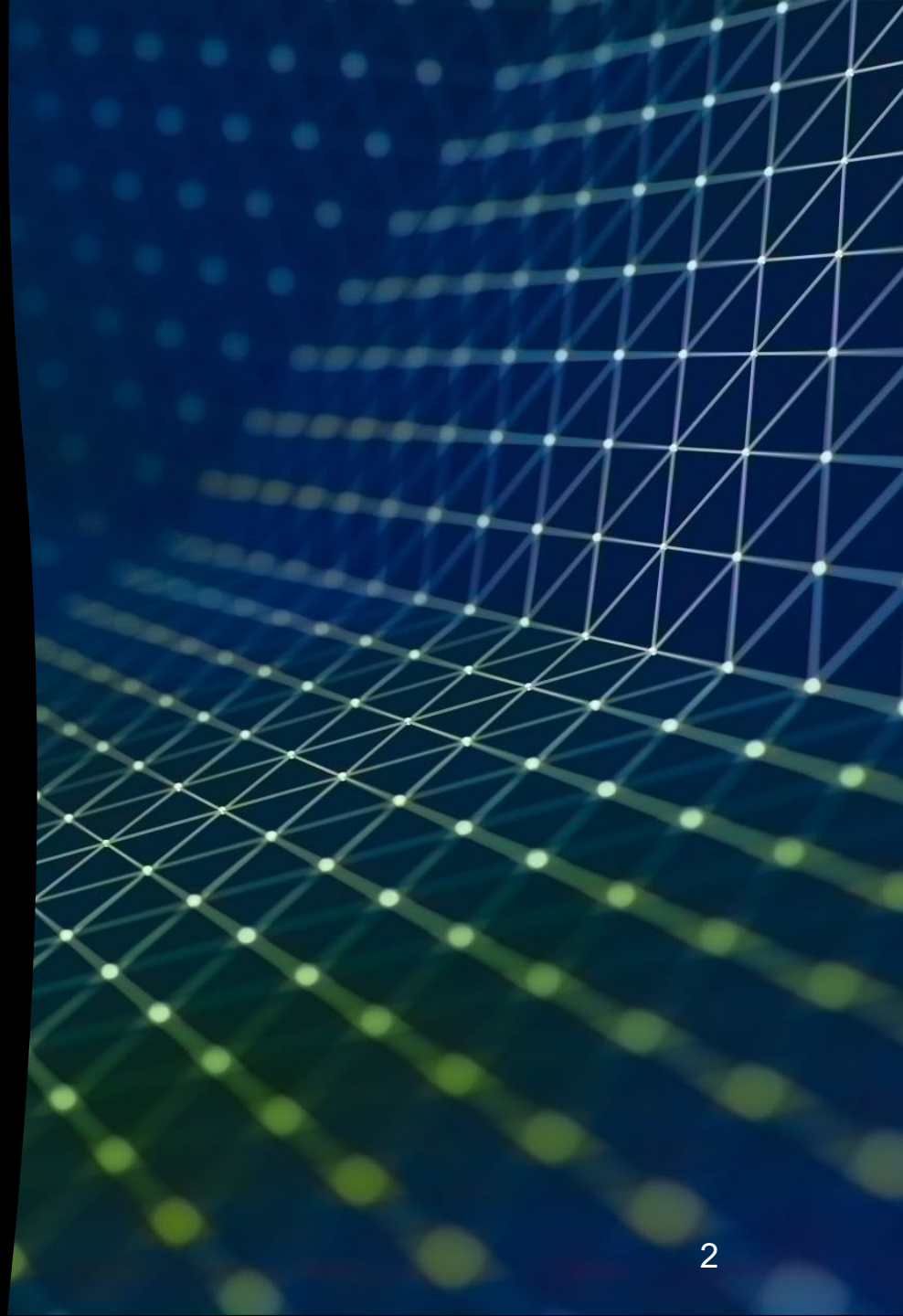
I learning

# Learning Objectives

By the end of this training, participants will:

- Understand the importance of quality measurement
- Learn how to track and report each metric accurately
- Identify key deadlines and compliance requirements
- Apply best practices to improve data accuracy



# 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


# Quality metrics data corresponds to the facility license

# Metric 1: Retention of direct care staff

**Why it matters:** Higher retention improves continuity of care

**Data to track:**

- Hire dates for all direct care staff
- Total direct care staff employed from Jan. 1 to Dec. 31, 2025
- Total direct care staff on Dec. 31, 2025

**Calculation:** Retention rate = (Staff employed all year) ÷ (Total staff at year-end)

# Direct Care vs. Non-Direct Care Staff

## Direct Care Staff

- Assisting with **activities of daily living** (ADLs)
- Medication **admivistration**
- Leading **individualized activities** from a resident's care plan
- **Supervising or supporting** residents
- **Serving meals** (but not preparing them)

## Non-Direct Care Staff

- Activities staff
- Administrative staff
- Maintenance
- Kitchen staff who prepare meals (but do not directly serve them to residents)

Staff classification impacts Metric 1: Direct Care Staff Retention
Report only staff whose primary role is personal care

# Example: Retention of direct care staff

Facility A has 40 direct care staff on December 31, 2025.
25 of them were employed since January 1, 2025.
Retention Rate = 25 ÷ 40 = 64%

**Remember**: The number of direct care staff who worked all year or longer must be less than or equal to the number of direct care staff on Dec. 31, 2025.

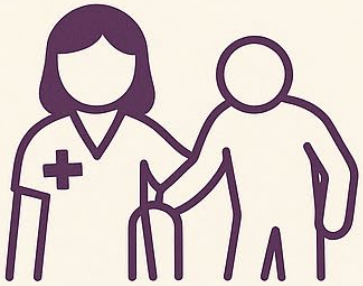
# Metric 2: Compliance with on-time staff training

**Why it matters:** Training helps staff give better care and keep residents safe and healthy.

**For each staff person employed by the facility during 2025 for any length of time, facilities should track:**

- The date hired.
- The date they left employment, as applicable.
- Whether they are direct care or non-direct care:
  - Universal workers are considered direct care staff.
  - Activities staff are considered non-direct care staff.
- The date each element of the required training was completed

# Types of Staff



## DIRECT CARE STAFF

- Medication administration
- Activities of daily living
- Resident supervision
- Serving meals

## NONDIRECT CARE STAFF

- Activities staff
- Admin staff
- Other staff

Staff classification impacts **Metric 2: On-time staff training.**
Track and report direct care and nondirect care staff separately.

# Calculation: Training Compliance

- Facility B employed 50 staff in 2025.
- 45 of them completed all required training on time.
- Compliance Rate = 45 ÷ 50 = 90%

**Remember**: The number of staff trained on time must be less than or equal to total number of employed at any time during 2025.

# Example 1: On-time training Compliance

- A direct caregiver is hired on Dec. 4, 2025.
- They complete their pre-service orientation requirements on Dec. 6, 2025.
- However, they have not completed their required 30-day training for direct care staff on Dec. 31, 2025.
- **Did this caregiver complete required training by Dec. 31, 2025?**
- **Yes.** This caregiver was hired on Dec. 4, 2025, and completed pre-service orientation requirements.

# Example 2: Training Compliance

A direct caregiver is hired on Oct. 2, 2025. They completed their pre-service orientation requirements on Oct.6, 2025.

They also completed their required 30-day direct care staff training on Nov. 3, 2025.

**Did this caregiver complete their pre-service and required 30-day training on time?**

**No.** This direct caregiver completed their pre-service orientation before starting required training within 30 days of hire. However, they did not complete all required training within those 30 days. Instead, the caregiver completed the required 30-day training on Nov. 3, 2025,33 days after the hire date; therefore, they did not complete their required training on time.

# Example 3: Training Compliance

A direct caregiver was hired on Dec. 12, 2024, and completed their annual in-service training by Dec. 9, 2025.

**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: Training Compliance

In 2025, a facility employed 37 staff at some point during the year. This included direct and non-direct care staff, including those who left employment before the end of the year. Of these 37 employees, 33 completed all required training within the timeframes set by rule based on their length of employment.

# Example 4, continued

Q1: What percentage of direct care staff at this facility completed their required training on time?

A1: To calculate the percentage of direct care staff who completed training on time, divide the 22 staff members who completed training on time by the 25 total direct care staff hired in 2025. This results in **88 percent of direct care staff completing their required training on time.**

| Type of staff | Total number of staff employed during 2025 | Number of staff completing required training on time |
|---|---|---|
| Direct care staff | 25 | 22 |
| Non-direct care staff | 12 | 11 |
| Total staff | 37 | 33 |

# Example 4, continued

Q2: What percentage of non-direct care staff at this facility completed their required training on time?

A2: To calculate the percentage of non-direct care staff who completed training on time, divide the 11 staff members who completed training on time by the 12 total non-direct care staff hired in 2025. This results in **92 percent of non-direct care staff completing their required training on time.**

| Type of staff | Total number of staff employed during 2025 | Number of staff completing required training on time |
|---|---|---|
| Direct care staff | 25 | 22 |
| Non-direct care staff | 12 | 11 |
| Total staff | 37 | 33 |

# Metric 2: Getting it right!

- Remember to include **all** staff hired by the facility for any length of time during 2025.
- The number of staff who completed training on time must be less than or equal to the number of staff hired during the reporting year.
- The total number of direct care staff hired during the year will be greater than the number of direct care staff on Dec. 31, 2025, as reported in Metric 1.

# Metric 3: Resident falls with injury

**Why it matters:** Falls are a primary cause of resident injury and can lead to premature death.

**Data to track June through November 2025:**

- The **number of residents** living in the facility on the last day of each month, June through November 2025.
- The **number of falls with an injury** that involved residents living in the facility for each month, June through November 2025.
- The **number of residents who fell with injury** during the month.
- The number of residents who **fell with injury more than once** during the month.

# Example: Resident falls with injury

At the end of June 2025:

- 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.

# Example: Resident falls with injury, continued

| Data field | Data reported |
|---|---|
| Total number of residents on the last day of June 2025 | 40 |
| Total number of falls with injury during June 2025 | 5 |
| Number of residents who fell with injury during June 2025 | 4 |
| Number of residents who fell more than once with injury during June 2025 | 1 |

# Metric 3: Getting it right!

- Remember to report falls data separately for each month, June through November.
- The number of residents reported on the Oct. 31 census for metric three is the same as the Oct. 31 census for metric 4.
- Create a system to record resident falls data at the end of each reporting month to ensure accuracy.

# Metric 4: Antipsychotic medications for nonstandard use

**Why it matters:** Misuse of antipsychotics can pose risks of harm to residents.

**Data to track October 2025:**

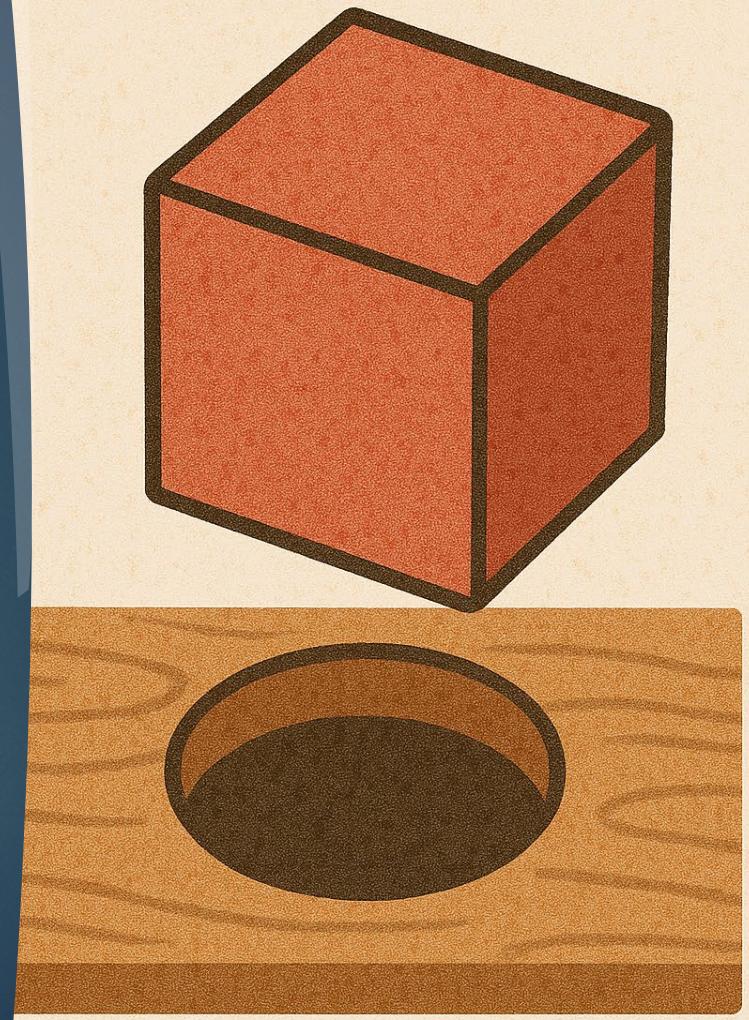
- The number of residents living in the facility on the October 31, 2025 census.
- Medication orders – Review each medication administration record (MAR) to identify:
  - Residents prescribed an antipsychotic medication
  - Residents with diagnoses that meet exclusion criteria
  - Residents who do not have an exclusionary diagnosis prescribed scheduled antipsychotic medication for nonstandard use
  - Residents who do not have an exclusionary diagnosis prescribed PRN (as needed) antipsychotic medication for nonstandard use

# Medication uses

Doctors often prescribe medications for their standard uses because there is evidence to support their effectiveness and safety for those specific conditions.

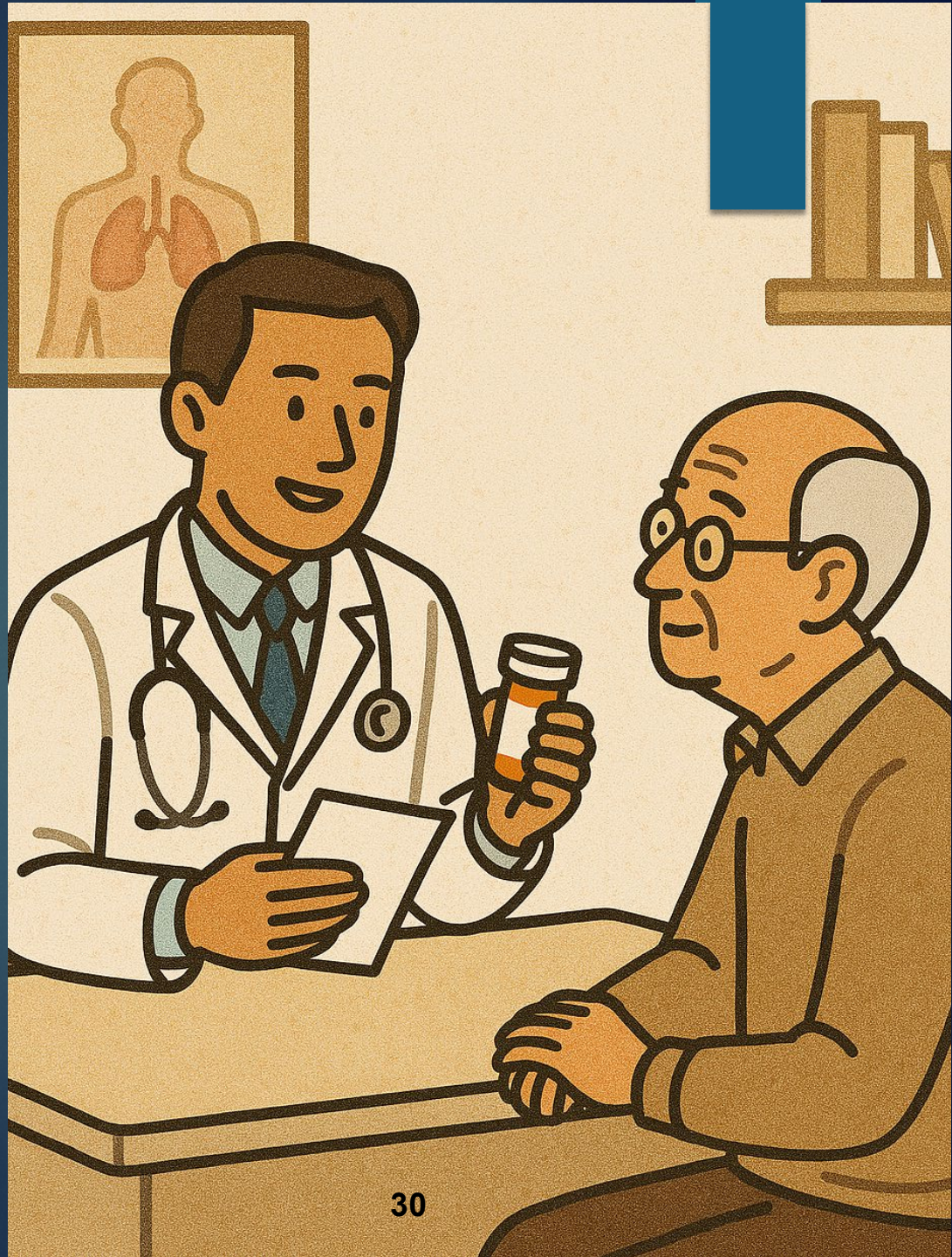
Therefore, **a standard use of a medication** refers to using a medication to treat a symptom or disease for which there is evidence.

**A nonstandard use of a medication** is every other use. Nonstandard uses are not FDA approved and are not evidence based.



Examples of nonstandard use include giving an antipsychotic to:

- Try to address wandering,
- Cause sedation
- Attempt fall prevention.



If a resident has an exclusionary diagnosis, this makes any antipsychotics they take standard use.

Therefore, we would not count them for metric four.

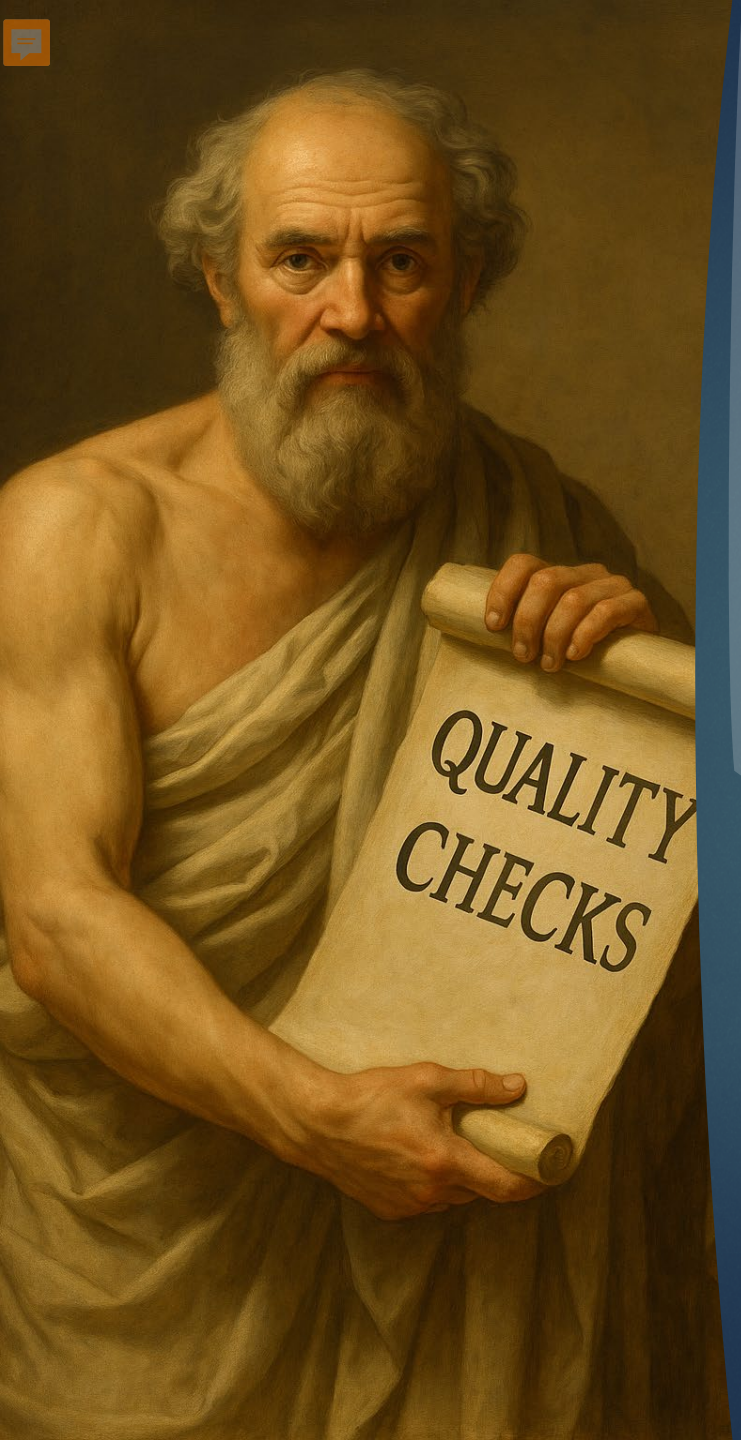
# Not all correct or incorrect

Metric four is a measure of nonstandard uses of antipsychotics.

This measure is not defining standard or nonstandard as all correct or incorrect.

# Metric 4: Step-by-step

1. Count the residents on the Oct. 31, 2025 census.
2. Count the residents who have a prescription for an antipsychotic medication (Table 13).
3. Subtract residents with conditions on the exclusions list (Table 14).
4. Count the residents with scheduled antipsychotics for nonstandard use.
5. Count the residents with PRN antipsychotics for nonstandard use.




# Metric four quality checks

To help ensure internal consistency in your responses, the following should hold true:

- 4d (total residents with nonstandard use) should be less than or equal to 4e (scheduled nonstandard use) 4f (PRN nonstandard use)
- 4e plus 4f should be at least equal to 4d but could be as large as 2 times 4d.

# Metric #4: Example 1

| Item | What to Report | Count |
|---|---|---|
| 4a | Residents on census Oct. 31, 2024 | 52 |
| 4b | Residents with an antipsychotic prescription | 14 |
| 4c | Of those in 4b, number with an "excluded diagnosis" | 10 |
| 4d | 4b minus 4c–**total residents with nonstandard use** | 4 |
| 4e | Of those in 4d, number with scheduled nonstandard antipsychotics | 4 |
| 4f | Of those in 4d, number with PRN nonstandard antipsychotics | 4 |

| Item | What to Report | Count |
|---|---|---|
| 4a | Residents on census Oct. 31, 2024 | 52 |
| 4b | Residents with an antipsychotic prescription | 10 |
| 4c | Of those in 4b, number with an "excluded diagnosis" | 10 |
| 4d | 4b minus 4c–**total residents with nonstandard use** | 0 |
| 4e | Of those in 4d, number with scheduled nonstandard antipsychotics | 10 |
| 4f | Of those in 4d, number with PRN nonstandard antipsychotics | 10 |

# Metric #4: Example 2

**Can you find the error?**

# Metric #4: Example 2

| Item | What to Report | Count |
|---|---|---|
| 4a | Residents on census Oct. 31, 2024 | 52 |
| 4b | Residents with an antipsychotic prescription | 10 |
| 4c | Of those in 4b, number with an "excluded diagnosis" | 10 |
| 4d | 4b minus 4c–**total residents with nonstandard use** | 0 |
| 4e | Of those in 4d, number with scheduled nonstandard antipsychotics | 10 |
| 4f | Of those in 4d, number with PRN nonstandard antipsychotics | 10 |

# Find the mistake:

| Item | What to Report | Count |
|---|---|---|
| 4a | Residents on census Oct. 31, 2024 | 40 |
| 4b | Residents with an antipsychotic prescription | 8 |
| 4c | Of those in 4b, number with an "excluded diagnosis" | 4 |
| 4d | 4b minus 4c–**total residents with nonstandard use** | 4 |
| 4e | Of those in 4d, number with scheduled nonstandard antipsychotics | 2 |
| 4f | Of those in 4d, number with PRN nonstandard antipsychotics | 0 |

## Metric #4: Example 3

**Can you find the error?**

# Find the mistake:

| Item | What to Report | Count |
|---|---|---|
| 4a | Residents on census Oct. 31, 2024 | 40 |
| 4b | Residents with an antipsychotic prescription | 8 |
| 4c | Of those in 4b, number with an "excluded diagnosis" | 4 |
| 4d | 4b minus 4c–**total residents with nonstandard use** | 4 |
| 4e | Of those in 4d, number with scheduled nonstandard antipsychotics | 2 |
| 4f | Of those in 4d, number with PRN nonstandard antipsychotics | 0 |

# Metric #4: Example 3

# Metric 4: Use Tables 13 and 14 for accuracy.

**Table 13:** Lists all antipsychotics alphabetically, brand names and generics are included.

**Table 14:** Exclusionary diagnoses. If a resident has a diagnosis on this list, they are NOT included in the metric four count.

Prescribers may express exclusionary diagnoses differently than the exact wording on the table. Use professional judgement.

# Metric 4: Getting it right!

- Consult the list of antipsychotic medications (table 13) and the list of exclusionary diagnoses (table 14 in the Provider Instructions.)
- If a resident has an exclusionary diagnosis, do not count them as taking a nonstandard antipsychotic.
- The number of residents on the Oct. 31 census should match with the census reported for Oct. falls.

# Metric 5: Resident survey (all facilities) and a family survey (memory care facilities only)

Why it matters: Resident and family feedback informs service improvements.

**Measure:**

- **All facilities:** Resident satisfaction with facility care, services, staff and meals.
- **Memory care facilities**: Family satisfaction with facility care, services and staff.

**Data to report:**

- Count of resident/family responses.
- Participation rates.

## Facilities contract with a CoreQ customer satisfaction vendor who will present these CoreQ questions to residents once a year:

1. When 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?

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Residents respond using this scale:
Poor = 1, Average = 2, Good = 3,
Very Good = 4, Excellent = 5

# Facilities will also report:

- The number of residents who received the survey
- The number of residents who returned the survey with at least one question answered
- The number of residents who completed the survey and answered all questions
- The name of the CoreQ customer satisfaction vendor the facility used
- The method for survey administration, such as,: in writing, by phone, in person, online.

# Memory care facilities contract with a CoreQ customer satisfaction vendor who will present these CoreQ questions to family once a year:

1. When 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?

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**Residents respond using this scale:**

Poor = 1, Average = 2, Good = 3, Very Good = 4, Excellent = 5

# Memory care facilities will also report:

- The number of family members who received the survey
- The number of family members who returned the survey with at least one question answered
- The number of family members who completed the survey and answered all questions
- The name of the CoreQ customer satisfaction vendor the facility used
- The method for survey administration, such as: in writing, by phone, in person, online.

# Metric 5: Increasing Valid Resident Survey Data

**2024 Reporting Snapshot**

- 420 facilities submitted valid survey data
- 131 facilities submitted invalid survey data
- 24 facilities **did not report** Metric 5
- 155 facilities (27%) excluded from analysis

**Common Issues**

- No surveys sent or no responses received
- Only 1 response submitted (minimum of 2 required)
- Response count exceeds number of surveys distributed
- Duplicate records or mismatched totals

**How to Improve Your Results**

- Use the **QMP Data Worksheet** to track surveys and responses
- Confirm that su**rveys sent = surveys reported**

# Metric 6: Administrator tenure

**Why it matters:** Leadership consistency supports quality of care, staff morale and resident satisfaction

**Data to track (automatically collected from ARS):**

- Administrator **start and end dates**
- Any **gaps in service of 30 days or more**
- Total **continuous tenure** (adjusted for breaks)
- **Number of unique administrators** who served during 2025

**No action required!** You do **not** need to submit separate data for this metric. This metric is calculated using the **Administrative Reference Summary (ARS)** records your facility already submits.

# Metric 6: Data entry

- Only entry required: name of administrator of record on Dec. 31, 2025
- Designation must be on file via form SDS 0566 (submit upon hire)
- Tenure is calculated from Department records based on that form

# Example 1A: Cumulative tenure

- Jane Doe was hired as administrator on Jan. 15, 2023.
- Jane took a leave of absence from June 12, 2024, to July 25, 2024.
- Jane returned to work on July 26, 2024, and served continuously
- through Dec. 31, 2025.

**ODHS' cumulative tenure calculation based on ARS records:**

- First work period: Jan. 15, 2023 – June 11, 2024 (514 days).
- Second work period: July 26, 2024 – Dec. 31, 2025 (524 days).
- Total days worked: 1,038 days > Converted to 34.1 months.

# Example 1B: Uninterrupted tenure

- Jane Doe was hired as administrator on Jan. 15, 2023.
- Jane took a leave of absence from June 12, 2024, to July 25, 2024.
- Jane returned to work on July 26, 2024, and served continuously through Dec. 31, 2025.

**ODHS' uninterrupted tenure calculation:**

- Continuous work since July 26, 2024 > 17.5 months uninterrupted.


# Example 2: Unique administrators of record

At **Facility XYZ**, three different administrators served in 2025:

1. **John Smith** – January 1 to March 15
2. **Jane Doe** – March 16 to September 30
3. **Alex Johnson** – October 1 to December 31

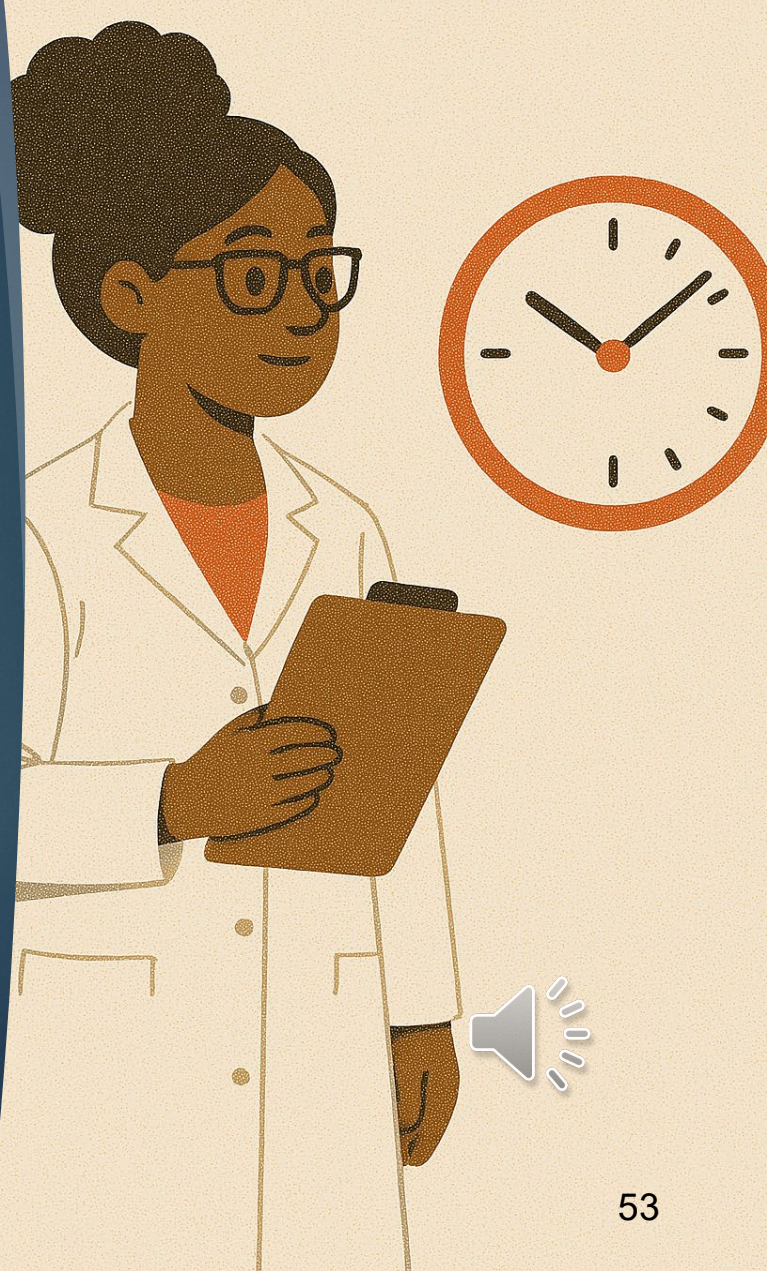
The facility reports **three unique administrators** for the year.

# How will data be reported?

- Data will be reported online using a link that will be published by a provider alert in December 2025. Stay tuned!
- Use the **2025 QMP Data Worksheet** to prepare for data entry
- Keep a secure, accessible copy of all submitted data for your records.

# Reporting deadlines and compliance

- Data submission deadline: Jan. 31, 2026.
- Please report early.
- Providers may request confirmation data has been received by email.
- Non-compliance may result in penalties.



# Resources and support

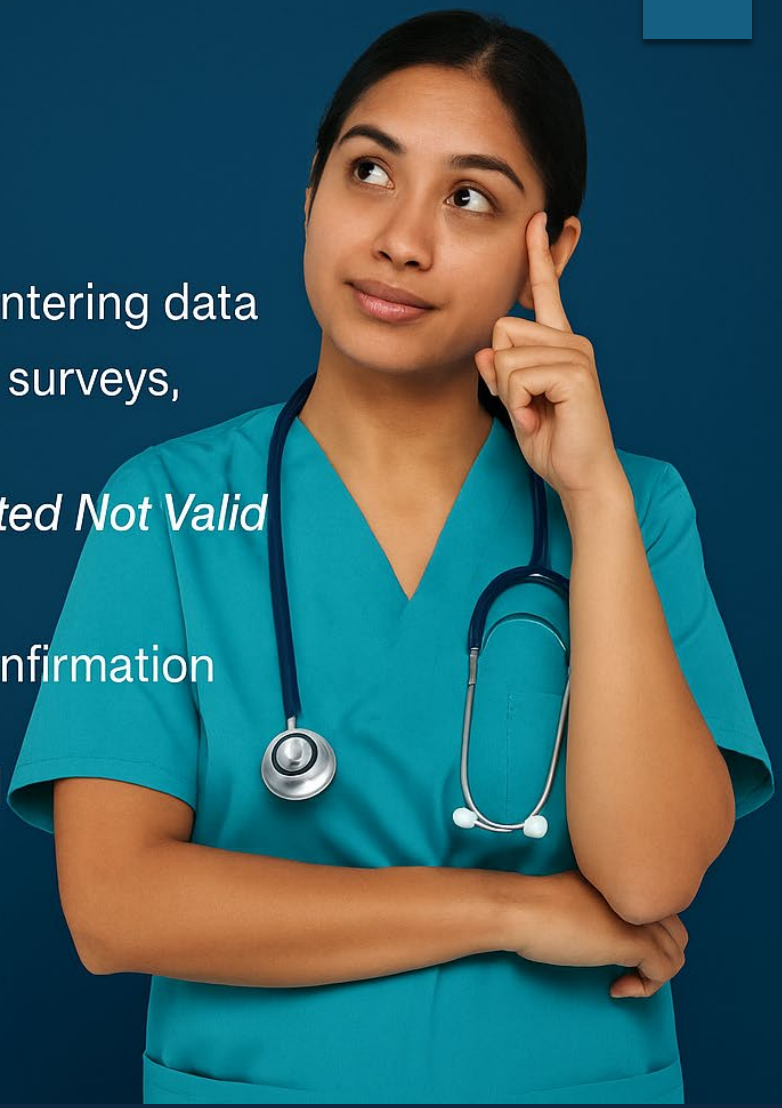
Visit the QMP website for training materials:

- QMP Provider Instructional Guide
- Data Collection Instructions and Screenshots
- 2025 QMP Data Worksheet
- Provider Training Handout

# What to Remember About 2025 QMP Reporting

- Use the QMP Data Worksheet before entering data
- Track staff, training, falls, medications, surveys, and administrator tenure
- Check your math—logic errors = *Reported Not Valid*
- Submit data by January 31, 2026
- Contact us if you're unsure or need confirmation

Keep a copy of your submitted data for your records



# Thank you!

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Program website link: https://www.oregon.gov/odhs/licensing/community-based-care/pages/quality-metrics.aspx