Quality Measurement Program Reporting 2024 Data

Oregon Department of Human Services

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Consult Key Documents to Report 2024 Metrics

1. QMP Provider Instructional Guide
2. Data Collection Instructions and Screenshots
3. Provider Training Handout

All available on the program website

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

Learning Objectives

1 Understand the program's purpose and legal basis

2 Review the five metrics in detail

3 Learn how to report your 2024 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

Program Goals:

The highest possible quality of care for residents

Measure quality | Provide information for comparison | Highlight areas for improvement

WHY?

Improvement!

2024 Quality Metrics

RED highlights a change for 2024

1. Retention of direct care staff
   - All year
2. Compliance with staff training
   - All staff employed at anytime during 2024
3. Number of falls with injury
   - June through November
4. Prescriptions for antipsychotics for a non-standard use
   - October
5. Results of annual satisfaction survey
   - Once in 2024

Reporting Details for 2024

The Metrics in Depth

Metric One

Retention of Direct Care Staff

Why: Experienced staff = better resident care

Measure: Percentage of direct care staff who have maintained employment with the facility for the duration of the year

Data to report:

1. Number of direct care staff who have worked in the facility 12 months or longer

2. Number of current direct care staff on payroll at end of calendar year

Facilities should track: Direct care staff hire dates to be able to report this data

Metric One Retention of Direct Care Staff

Retention =

$$\frac{\text{Total \# of direct care staff employed by facility for the entire year or longer (1/1/24 – 12/31/24)}}{\text{Total \# of direct care staff employed at end of calendar year (12/31/24)}}$$

Example: Metric One

On 12/31/24: Facility has **39** direct caregivers.

25 of the 39 direct caregivers have been continuously employed since at least 1/1/24.

The calculation: 25 ÷ 39 = 0.6410 = 64%.

This facility had a **64% staff retention rate for 2024.**

Metric One - Report highlighted numbers.

Metric Two

Compliance With Staff Training Requirements

Why: Trained staff lead to better care & higher job satisfaction

Measure: Number of staff employed at anytime in 2024 who completed all required trainings on time given their length of employment.

Metric Two

Compliance With Staff Training Requirements

Data facilities need to track for this measure:

For each staff person employed by the facility during 2024:

- The date hired
- The date they left employment, as applicable
- Whether direct care or non-direct care:
  - Universal workers are considered direct care staff
  - Activities staff are non-direct care staff
- The date each element of the required trainings for 2024 was completed

What is your system to track the training compliance of every staff employed by your facility in 2024?

If you don't have a system, use the optional training tracker Excel sheet on the QMP website.

Metric Two

Compliance With Staff Training Requirements

Data to report for direct care (DC) staff:

- Total number of direct care staff employed at any time during 2024?

- Of these, how many completed their training on time, given their length of employment during 2024?

Metric Two

Compliance With Staff Training Requirements

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

- Total number of nondirect care staff employed at any time during 2024?

- Of these, how many completed their training on time, given their length of employment during 2024?

Metric Two

Compliance With Staff Training Requirements

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 elements according to direct care or nondirect care status and length of employment.

- If a staff left employment during 2024, they are only responsible for trainings that were due at the time they left employment.

Metric Two Compliance with Staff Training

When: Tracking 1/1/24 – 12/31/24

Training Compliance = $\dfrac{\text{Total number of staff employed at any time during 2024 who have completed \textbf{all} required training modules by the required dates, given length of employment}}{\text{Total number of staff employed at any time during 2024}}$

Example: Metric Two

During 2024: Facility had 95 employees. 85 of those employees completed their training on time.

The calculation: 85 ÷ 95 = 90% received required training.

Example: Metric Two

A direct caregiver was hired on 12/4/2024. They completed their preservice orientation requirements on 12/6/2024. They have not yet completed their training due within 30-days of hire by 12/31/2024. Did they complete required trainings by 12/31/2024, given their length of employment?

- **Yes**. They were hired on 12/4/2024. They completed preservice orientation requirements 12/6/2024. Required 30-day training is not due until 1/3/2024.

Example: Metric Two

A direct caregiver was hired on 10/2/2024. They completed their preservice orientation requirements on 10/6/2024. They completed their required 30-day training for direct care staff on 11/3/2024. Did they complete their required training on time, given their length of employment?

- **No.** They completed the required 30-day training three days late on 11/3/2024, 33 days after date of hire.

Example: Metric Two

A direct caregiver was hired on 12/12/2022. They completed their annual in-service training by 12/9/2024. Did this caregiver complete their required annual in-service training on time, given their length of employment?

- **Yes.** They completed their required annual in-service training before their hire anniversary.

Example: Metric Two

A direct caregiver was hired on 11/13/2022. They completed training required within 30 days of hire 12/29/2022, 18 days late. **They were out of compliance for 2022 reporting.**

In 2024, this same caregiver completed their annual in-service training by 11/12/2024. Did this caregiver complete their required annual in-service training on time, given their length of employment?

- **Yes.** They completed required annual in-service training before their anniversary date. **The deficiency from 2022 does not carry forward.**

Metric Three

Number of Resident Falls That Result in Injury

Why: Learning about fall causes will help identify methods to prevent future falls

Measure: Number of resident falls that resulted in injury each month, June – November

Data to report:

1. Number of residents living in the facility
2. Number of falls with injury
3. Number of residents who fell with injury
4. Number of residents who fell more than once with injury

Metric Three: Example

Number of residents living in facility 6/30/24	40
Total falls with injury in June 2024	5
Number of residents who fell with injury in June 2024	3
Number of residents who fell more than once with injury during June 2024	1

Metric Three - Report highlighted numbers for each month, June - November 2024.

Metric Four

Antipsychotic Medications Prescribed for Non-standard Use

Why: Promote resident-centered evaluation when prescribing antipsychotic medications and explore concerns about perceived misuse

Measure: Prescriptions for scheduled and PRN antipsychotics for nonstandard use

Data to report:

In October 2024, how many residents had:

1. A prescription for a regularly scheduled antipsychotic for a non-standard use?

2. A prescription for PRN antipsychotics for a non-standard use?

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, or to attempt fall prevention.

Metric four is a measure of nonstandard uses of antipsychotics.

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

Metric Four

Antipsychotic Medications Prescribed for Non-standard Use

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.

Metric Four

Antipsychotic Medications Prescribed for Non-standard Use

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

- 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 (PRN) medication, is there a reason? If not, contact the prescriber.

Metric Four

Antipsychotic Medications Prescribed for Non-standard Use

Process:

1. Count the residents on the census 10/31/2024.

2. Count the residents who have a prescription for an **Antipsychotic Medication** (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.

Metric Four: Table

Data Field	Data Reported
Residents on the 10/31/2024 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 2024.

Metric Four

Antipsychotic Medications Prescribed for Non-standard Use

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.

Metric Five

Resident Experience & Satisfaction

CoreQ Required Questions:

1. In recommending this facility to your 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?

Questions are answered using this scale:

Poor (1), Average (2), Good (3), Very Good (4), Excellent (5)

Metric Five

Resident Experience & Satisfaction

Why: Hearing directly from residents provides direct feedback to improve services. An annual resident satisfaction survey is conducted by an independent entity once during 2024

Measure: Resident satisfaction with facility care, services, staff and meals

Data to report:

1. Count of resident responses
2. Participation rates

Know Before You Survey

- Facilities must use a customer satisfaction vendor through CoreQ.org

- All the data facilities enter, both the participation data and response data, will come from 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.

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.**

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.

QMP Pro Tips

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. 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.

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

QMP Pro Tips, 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.

7. Use the optional **2024 Data Collection Worksheet** to create your own data record. (Available on the QMP website).

Data Collection for 2024

1. Submit data by January 31, 2025, to comply with the law

2. Data collected through survey link that will be shared through a Provider Alert

4. The 2024 survey uses Qualtrics software, same as in 2022

5. The *2024 Provider Guide* is available on the program website

Reporting Window and Deadline

- The Qualtrics data collection link will open January 1, 2025

- Enter facility data by 11:59 pm on January 31, 2025

Questions?

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