

Oregon Residential Care and Assisted Living  
**Quality Measurement Program**  
**Provider Instruction Guide**

**Revised: January 2, 2020**



## Oregon’s Residential Care and Assisted Living Quality Measurement 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 Department of Human Services (DHS);
- Directed the Council, in consultation with DHS, 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 DHS 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 limiting the burden to facilities in tracking and reporting data as much as possible. Members of the Council are listed below.

Required representatives:	Appointed members:
Oregon Patient Safety Commission	<b>Sydney E. Edlund</b> , MS, Director of Research and Analytics, Oregon Patient Safety Commission
Residential care facilities representative	<b>Mauro L. Hernandez</b> , PhD, Principal, ita partners
Alzheimer’s advocacy organization	<b>Sara E. Kofman</b> , Public Policy Director, Oregon Alzheimer’s Association
Practitioner with geriatric experience	<b>Dr. Maureen Nash</b> , MD, MS, FAPA, FACP, Medical Director, Providence ElderPlace Oregon
Academic representative with expertise	<b>Paula Carder</b> , PhD, Portland State University
Academic representative with expertise	<b>Carolyn A. Mendez-Luck</b> , PhD, MPH, Oregon State University
Long Term Care Ombudsman	<b>Fred Steele</b> , JD, MPH, State Long-Term Care Ombudsman
Department representative	<b>Ann McQueen</b> , PhD, MS, Research and Policy Integration Manager, Office of Aging and People with Disabilities, Oregon Department of Human Services

**Responsibility of RCFs and ALFs to report metrics annually:**

By law, all residential care and assisted living facilities (including those with memory care endorsements) are required to track and report annually 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, and
5. Results of annual resident satisfaction survey conducted by a third party.

Each RCF and ALF shall submit the required quality metrics data to the Department using a web-based Quality Metrics Application (the “QMA” or “App”). **The first reporting cycle will begin with facilities tracking 2020 data and reporting it via the App in early in 2021.** Metrics data will then continue to be required by January 31<sup>st</sup> of each year after that for the previous year’s data.

**This Guide:**

This Guide was created to give facilities the background information and instructions needed to successfully track and report all data that is required by law. It contains information about the reasons for collecting data related to each metric, as well as details about how and what data to collect and the frequency that data needs to be collected.

In addition to this Guide, the Department and partners will conduct a series of trainings, including webinars that will be posted on the Community Based Care provider webpage: <https://www.oregon.gov/DHS/PROVIDERS-PARTNERS/LICENSING/CBC/Pages/QM-Program-Provider-Resources.aspx>.

The chart below shows important dates to note:

<i>Tracking Year for Facilities</i>	<i>Provider Deadline for Entering Data into the App</i>	<i>Data Reported by DHS to Facilities and Public</i>
Calendar Year 2020	January 31, 2021	July 1, 2021
Calendar Year 2021	January 31, 2022	July 1, 2022
Calendar Year 2022	January 31, 2023	July 1, 2023
Calendar Year 2023	January 31, 2024	July 1, 2024

The following chart indicates the frequency and duration of time that each of the quality metrics is to be tracked in 2020:

<b>Metric #</b>	<b>Metric Name</b>	<b>Data Collection Frequency</b>	<b>Duration of Time</b>
1	Retention of Direct Care Staff	Once, after 12/31/20 (for 2020)	Full calendar year
2	Compliance with Staff Training Requirements	Once, after 12/31/20 (for 2020); monthly tracking tool is available/recommended.	Full calendar year
3	Number of Resident Falls with Injury	Monthly, from 7/1/2020 to 12/31/2020*	Last six months of calendar year*
4	Use of Antipsychotic Meds for Non-standard Use	Report daily for all 31 days of October 2020.	31 days (October of each year)
5	Results of Annual Satisfaction Survey by 3 <sup>rd</sup> party	Once, between 1/1/20 and 12/31/20	Once a year, at any time

*\* For the first year of the Quality Measurement Program, providers must only report data for Metric 3 for the last six months of the year. In subsequent years, providers will be expected to report data for all 12 months of the year.*

**Annual Report:**

The Department will compile the information received from all residential care facilities and assisted living facilities and publish an annual report describing statewide patterns and trends. This report will be available online to be used by facilities and the general public to evaluate and compare facilities. Quality metrics data will eventually be posted as part of each facility’s record on the Long-term Care Settings Search Tool website:

<https://ltclicensing.oregon.gov/>

**Please note:**

New facilities that open during 2020 are not required to submit any metrics data for 2020. These new facilities will be required to track data beginning in 2021 and will have to enter data into the App by January 31, 2022.

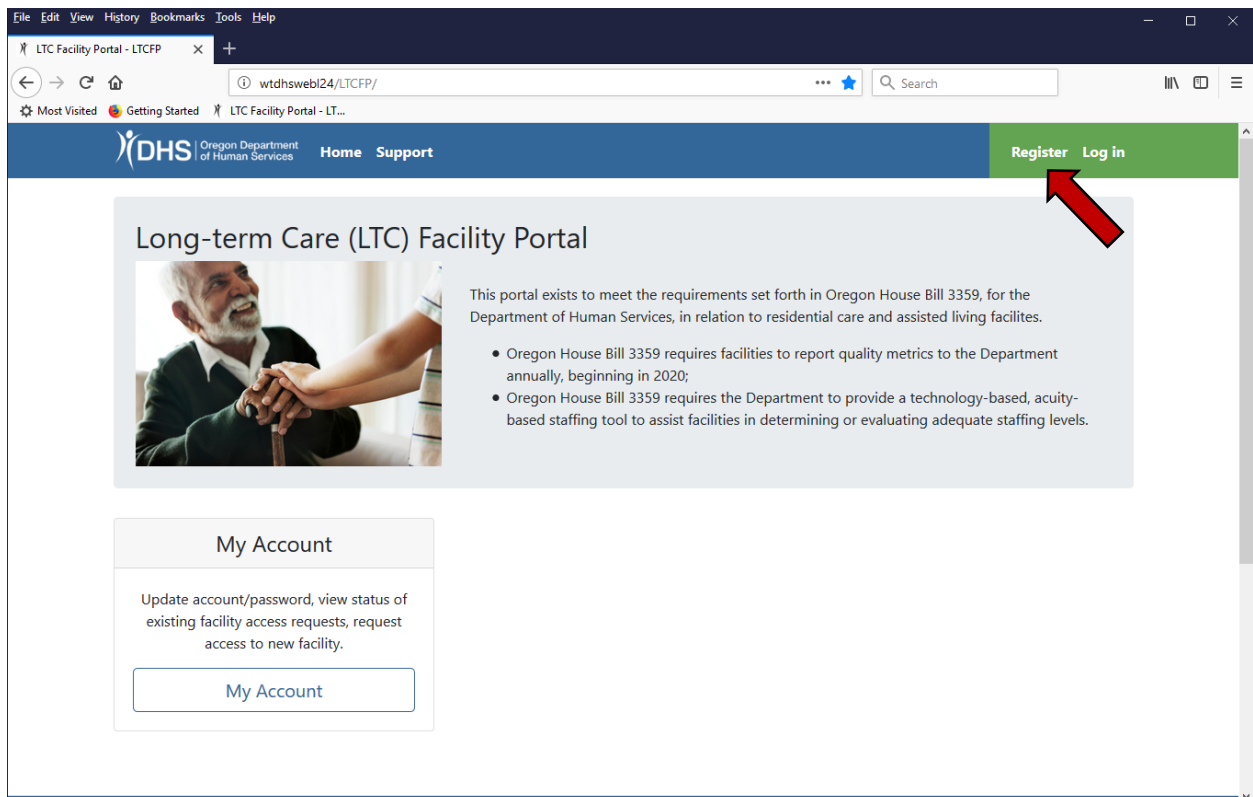
**Questions and Contacts:**

We encourage you to familiarize yourself with the information in this Guide and refer back to it whenever you have questions. If you still have questions after referring to this Guide, please contact your assigned policy analyst within the Office of Safety, Oversight and Quality or send your question to the Community-Based Care Team via email at:

[QualityMetrics.Acuity@dhsosha.state.or.us](mailto:QualityMetrics.Acuity@dhsosha.state.or.us).

## Step 1: Access the Long-term Care Facility Portal

- Open your browser and go to the Long-term Care Facility Portal website at: <https://ltcfacilityportal.oregon.gov/>
- Click “Register” at the top right corner of the screen.



## Step 2: Enter Information to Request an Account

- Enter your information in all of the required fields.
- Choose and confirm a secure password you will remember.
- Click the green “Add facility” button to search for your facility from the list of licensed facilities.

The screenshot shows a web browser window with the URL `wtdhsweb124/LTCFP/Account/Register`. The page title is "Account Registration Request". The header includes the DHS logo and navigation links for "Home" and "Support", along with "Register" and "Log in" buttons. The main content area features a green box with the DHS logo and instructions: "To register for access to the Long-term Care (LTC) Facility Portal and the tools contained within, please provide the requested information and click the 'Register' button below." Below this is a "Register" button. To the right is a registration form with fields for "First Name \*", "Last Name \*", "Phone Number \*", "Email \*", "Password \*", and "Confirm password \*". Below these fields is a "Facilities" section with an "Add Facility" button and a text prompt: "Please search for and select the facility(ies) to which you need access." The footer contains contact information for "Oregon DHS – Aging & People with Disabilities" and a "Quick Links" section with links to "QMA Provider Instructions", "CBC Facilities Page", "DHS Office of Safety, Oversight and Quality", "Oregon Department of Human Services", "ADRC of Oregon", "Long-Term Care Ombudsman Program", "Long-Term Care Facility History Search", and "Oregon Home and Community-Based Services".

### Step 3: Search for Your Facility

- Type your facility’s name into the “Search” field or use the page selection feature to find the facility you are associated with.
- If you will be entering data for more than one facility, the application will let you add more facilities using the same process described above.

Search Facilities

Facility ID	Facility Type	Name	Address	City
50R307	RCF	A Touch of Grace	2156 Brookhurst Street	Medford
50M098	RCF	Aaren Brooke Place	995 N Oregon St	Ontario
70M001	ALF	Adams House Assisted Living	121 Cordelia Drive	Myrtle Creek
50R378	RCF	Adara Oaks Manor	931 NE Linden Avenue	Gresham
50R417	RCF	Advocate Care	13033 South East Holgate Blvd	Portland
70A002	ALF	Alderwood Assisted Living	131 Alder St	Central Point
50R315	RCF	All Comfort Residential Care Facility	9347 SW 35th Avenue	Portland
70M003	ALF	Alpine House Assisted Living	204 N Park St	Joseph
50R371	RCF	Applegate House of Grants Pass	1635 Kellenbeck Ave	Grants Pass
70M022	ALF	Applegate Place	1465 East Central	Sutherlin

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1 2 3 4 5 6 7 8 9 10 ... > >>

## Step 4: Submit Your Account Registration Request

- Once you have selected the facility or facilities you will be entering data for, click the blue “Register” button on the left side of the screen.
  - This will send an auto-generated request for account approval to the Safety, Oversight and Quality Unit. The approval process may take one to three (1-3) business days.
  - You will also receive an auto-generated email at the address you provided requesting that you verify your email address. Please do so as soon as possible.

The screenshot shows the 'Account Registration Request' page on the LTC Facility Portal. The page includes a header with the DHS logo and navigation links. The main content area features a registration form with the following fields:

- Name: Ann McQueen
- Phone: (503) 555-1234
- Email: ann.e.mcqueen@state.or.us
- Password: (masked with dots)

Below the form is a section for selecting facilities. It includes an 'Add Facility' button and a table of existing facilities:

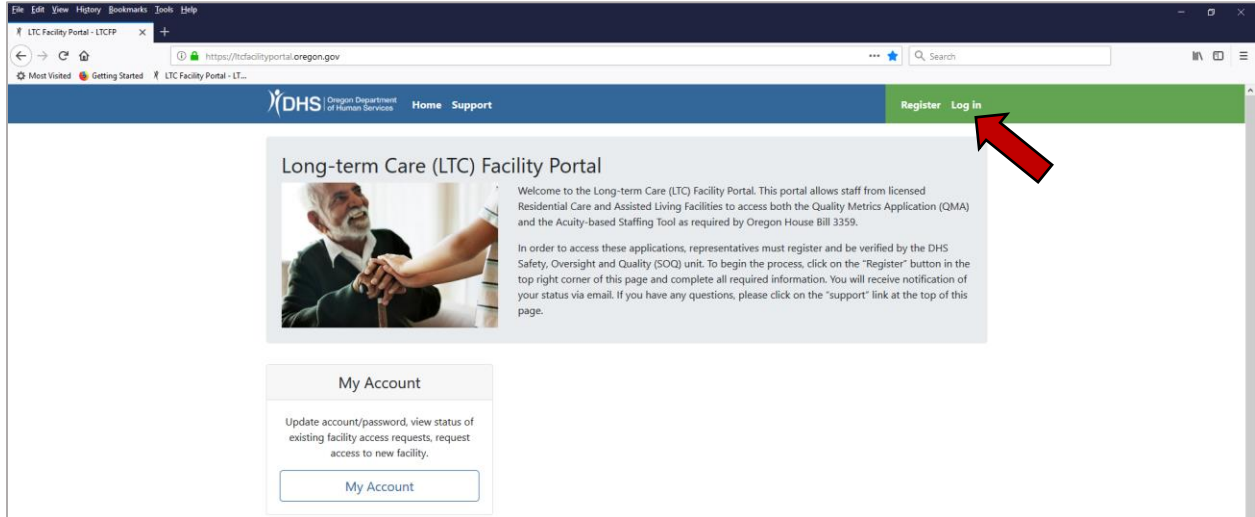
Facility ID	Facility Name	Address	Action
50R216	Capital Manor Retirement Commu	1955 Dallas Hwy NW	Remove
70M080	Rose Schnitzer Manor	6140 SW Boundary St	Remove

A red arrow points to the 'Register' button on the left side of the form.

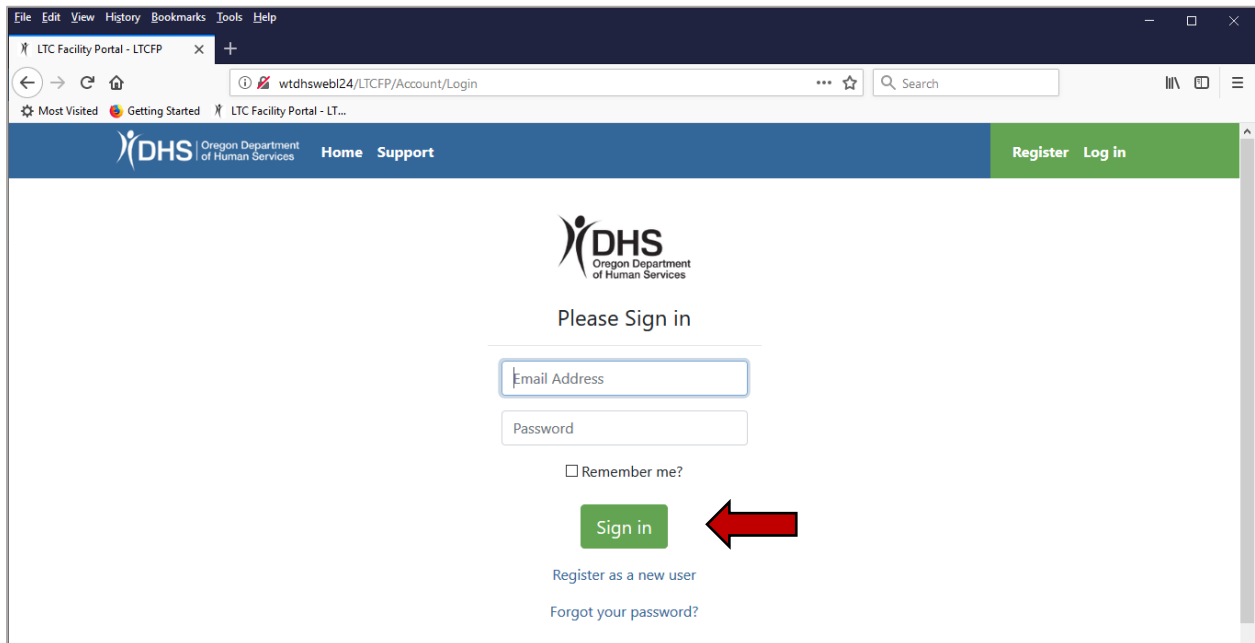


## Step 5: Sign In to Your Account

- One to three (1-3) business days after submitting your request for an account (Step 4), visit the application website again at: <https://ltcfacilityportal.oregon.gov/>
- Click “Log In” at the top right corner of the page.



- Enter the email address and password you used to register for your account in Step 2.
- Click the green “Sign in” in the middle of the page.



## Step 6: Select the Quality Metrics Application

- Once you have successfully logged in to the Long-term Care Facility Portal with your email and password, you will see a box titled “Quality Metrics” toward the bottom of the page.
- Click the box to enter the Quality Metrics Application. (The Quality metrics Application, or “the App,” is where you will enter your data for the five required Metrics.)

The screenshot shows a web browser window displaying the Long-term Care (LTC) Facility Portal. The browser's address bar shows the URL `wtdhswbi24/LTCFP/`. The page header includes the DHS logo and navigation links: Home, Facility Tools, and Support. On the right side of the header, there are links for My Account and Log Off. The main content area is titled "Long-term Care (LTC) Facility Portal" and features a photograph of an elderly man being assisted. Below the photo, there is a paragraph explaining the portal's purpose and a list of bullet points regarding Oregon House Bill 3359. At the bottom of the page, there are two main sections: "My Account" and "Quality Metrics". The "My Account" section includes a description of account management options and a "My Account" button. The "Quality Metrics" section includes a description of the data entry process and a "Quality Metrics" button.

## Step 7: Select Your Facility to Enter the Quality Metrics Application

- Upon entering the Quality Metrics Application, click on the facility for which you wish to enter data.

**Quality Metrics Application (QMA)**

**Your Facilities**

Please select from your approved facilities, listed below, to begin entering metric data, view past metric data and to view other facility details. If you feel that the list below is incomplete or inaccurate, please visit the [My Account](#) page to view the status of your existing facility access requests and/or request access to a new facility.

Facility ID	Facility Name	Address
50R415	Windsong at Eola Hills	2030 Wallace Road NW, Salem, OR 97304

**Facility Reporting Requirements**

Facilities are required, by law, to report annually on specific metrics. Each Residential Care Facility (RCF) and Assisted Living Facility (ALF) shall submit the

- Check to make sure all of the information for your facility is correct. If any information is incorrect, send a message with the correct information to: [QualityMetrics.Acuity@dhsosha.state.or.us](mailto:QualityMetrics.Acuity@dhsosha.state.or.us)
- Click on the Metric set you would like to visit and use the Provider Instruction Guide to assist you with detailed information on each metric.

**Facility Details**

[Quality Metrics Home](#)

**Facility Metric Sets**

Year	Status	Metric 1	Metric 2	Metric 3	Metric 4	Metric 5	
2019	Open / Active	Not Started	Not Started	Not Started	Not Started	Not Started	<a href="#">Get Started</a>

**Facility Information**

Facility Name: Windsong at Eola Hills  
 Facility Type: Residential Care Facility  
 Facility ID: 50R415  
 Administrator Name: Stacey Flint  
 Phone: (503) 912-4551  
 Email: sflint@windsongmemorycare.com  
 Address: 2030 Wallace Road NW  
 City: Salem  
 State: OR  
 Zip: 97304

\*If any of the above information is incorrect, please contact the Safety, Oversight and Quality Unit to have the information updated. Please visit the [Support](#) page for the best way to contact the Safety, Oversight and Quality Unit.

# 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 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 Facilities Need to Track for this Measure:**

- **The hire date for each direct care staff member<sup>1</sup>** –to determine which direct care staff have been employed for at least a year as of 12/31/2020.
- **The total number of direct care staff employed at your facility** (regardless of hire date) on 12/31/2020.

## **Reporting Timeline for this Measure:**

- **Tracking:** Facilities will need to begin tracking the data for this measure on 1/1/2020 and track through 12/31/2020.
- **Reporting:** Data collected 1/1/2020 – 12/31/2020 will need to be entered into the App by 1/31/2021. No extensions will be given to facilities who do not enter data by 11:59pm on 1/31/2021.

<sup>1</sup> “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.

## What Facilities Need to Do:

1. In January of 2021, count the number of direct care staff (both part-time and full-time) employed as of 12/31/2020, whose start date was on or before 1/1/2020 AND who had no breaks in employment during the past year. Enter this number into App field **1a**.
2. At the beginning of 2021, count the total number of direct care staff (both part-time and full-time) employed on 12/31/2020 (regardless of hire date). Enter this number into App field **1b**.

The Quality Metrics Application will calculate your retention score as a percentage, rounded up or down to one decimal place, as follows:

$$\text{Retention}^2 = \frac{\text{Total number of direct care staff continuously employed by facility from 1/1/2020 (or before) – 12/31/2020.}}{\text{Total number of direct care staff employed on 12/31/2020.}}$$

### Example:

- A facility has a total of 39 direct care staff employed as of 12/31/2020.
- Twenty-five of those direct care staff have been continuously employed at the facility (with no breaks in employment) since 1/1/2020 (or before).
- The App calculates the facility's retention rate as  $25 \div 39$ . In other words, this facility had a **64.1% staff retention rate for 2020**.

### Hints and Tips:

- New facilities that open during 2020 are not required to submit any metrics data for 2020. These new facilities will be required to submit data beginning in 2021 and will have to submit their first report by January 31, 2022.
- To be considered "direct care staff," facility management will need to use best professional judgment in deciding if the staff person provides assistance with ADLs on a regular basis.
- Both full-time and part-time staff should be counted, as long as staff were employed for the entire year.
- Staff can still be counted as "employed continuously" if they were on approved leave for any reason during the year. As long as the staff person is still on your payroll at the end of the year, they can be counted as employed.

<sup>2</sup> Reference source: Formula for calculating staff retention is from American Health Care Association (AHCA) 2012 Staffing Report

## **Quality Metric #2: Compliance with Staff Training Requirements**

### **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, as well as the number of hours of training needed in specific topic areas.

This metric measures the percentage of **all staff** who have completed all required trainings by the required date(s). This metric includes all staff hired by a facility, including care staff, food service, maintenance, activities, health services, administration, and any other staff hired by a facility. It also includes both full-time and part-time workers.

### **Data Facilities Need to Track for this Measure:**

Facilities must have a system to track all of the following:

- **The name of each staff person and whether the person provides direct care<sup>3</sup> or non-direct care.**
  - Direct care staff who are considered “universal workers”<sup>4</sup> must complete all required training for all job duties included in their universal worker description.
- **The total number of staff** (part-time and full-time, direct care and non-direct care) working in the facility on 12/31/20.
  - Even if a staff person works part-time count them as one staff person, since they will still be required to complete all training for their position.

<sup>3</sup> “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.

<sup>4</sup> “Universal Workers,” as defined in OAR 411-054-0005(84), are facility employees whose assignments include other tasks (for example, housekeeping, laundry, or food service) in addition to providing direct resident services. Universal workers do not include administrators, clerical or administrative staff, building maintenance staff, or licensed nurses who provide services as specified in OAR 411-054-0034.

- **The date each staff person was hired.**
  - For direct care staff, this is the date each person began to provide direct care.
  - For non-direct care staff, this is the date each person began performing specific job responsibilities.
  - If direct care staff have worked for:
    - less than one year, they are considered “**new direct care staff**”
    - one year or more, they are considered “**experienced direct care staff**”
- **The date each staff person left facility employment** (termination date), if applicable.
- **The date each staff person completed each required training**

All required trainings for each category of staff and the deadlines for completing those trainings are listed in the charts on the following pages:

**Training Requirements for Assisted Living & Residential Care Facilities  
(Without Endorsed Memory Care)**

<b>Training requirement</b>	<b>Deadline to complete training</b>	<b>New Direct Care Staff (employed less than a year)</b>	<b>Experienced Direct Care Staff (a year or longer)</b>	<b>Non-Direct Care Staff</b>
<b>Pre-Service Orientation for ALL Staff - - OAR 411-054-0070 (3)</b>				
Resident rights	By hire date	✓	-	✓
Abuse reporting	By hire date	✓	-	✓
Infection control	By hire date	✓	-	✓
Fire safety and emergency procedures	By hire date	✓	-	✓
Food handling (if employee is to prep food)	By hire date	✓	-	✓
<b>Pre-Service Orientation for All Direct Care Staff - - OAR 411-054-0070 (4)</b>				
Pre-service dementia training	Before providing care	✓	-	-
Pre-service orientation to ind. residents	Before providing care	✓	-	-
<b>Training Within 30 Days of Hire for Direct Care Staff - - OAR 411-054-0070 (5)</b>				
Service plans	Within 30 days of hire	✓	-	-
Activities of Daily Living (ADLs)	Within 30 days of hire	✓	-	-
Changes associated with aging	Within 30 days of hire	✓	-	-
Change of condition	Within 30 days of hire	✓	-	-
Required assessment	Within 30 days of hire	✓	-	-
Food safety	Within 30 days of hire	✓	-	-
Medication & treatment administration	Within 30 days of hire	✓	-	-
<b>Annual In-Service Training for Direct Care Staff - - OAR 411-054-0070 (6)</b>				
6 hours annual dementia training	By anniversary of hire date	-	✓	-
6 hours training on “other” topics	By anniversary of hire date	-	✓	-



**Training Requirements for Endorsed Memory Care Communities  
Licensed as Assisted Living or Residential Care Facilities**

<b>Training requirement</b>	<b>Deadline to complete training</b>	<b>New Direct Care Staff (employed less than a year)</b>	<b>Experienced Direct Care Staff (a year or longer)</b>	<b>Non-Direct Care Staff</b>
<b>ALL STAFF - Pre-Service Orientation - - OAR 411-054-0070 (3)</b>				
Resident rights	By hire date	√	-	√
Abuse reporting	By hire date	√	-	√
Infection control	By hire date	√	-	√
Fire safety and emergency procedures	By hire date	√	-	√
Food handling (if employee is to prep food)	By hire date	√	-	√
<b>ALL STAFF - Pre-Service Dementia Training - - OAR 411-057-0155 (2)(b)</b>				
Education on dementia process	Before providing care	√	-	√
Techniques for responding	Before providing care	√	-	√
Strategies for addressing social needs	Before providing care	√	-	√
Preventing wandering and elopement	Before providing care	√	-	√
Using person-centered approach	Before providing care	√	-	√
Effect of environmental factors	Before providing care	√	-	√
<b>ALL STAFF - Training Within 30 Days of Hire - - OAR 411-057-0155 (2)(c)</b>				
Family support and role of family	Within 30 days of hire	√	-	√
Evaluating and reporting behaviors	Within 30 days of hire	√	-	√
<b>DIRECT CARE STAFF - Pre-Service Training - - OAR 411-057-0155 (3)(a)</b>				
Identifying and addressing pain	Before providing care	√	-	-
Providing food and fluids	Before providing care	√	-	-
Reducing antipsychotic use	Before providing care	√	-	-
Providing personal care to individual res	Before providing care	√	-	-
<b>DIRECT CARE STAFF - Training Within 30 Days - - OAR 411-057-0155 (3)(b)</b>				
Use of supportive restraining devices	Within 30 days of hire	√	-	-
<b>DIRECT CARE STAFF - Training Within 30 Days of Hire - - OAR 411-054-0070 (5)</b>				
Service plans	Within 30 days of hire	√	-	-
Activities of Daily Living (ADLs)	Within 30 days of hire	√	-	-
Changes associated with aging	Within 30 days of hire	√	-	-
Change of condition	Within 30 days of hire	√	-	-
Required assessment	Within 30 days of hire	√	-	-

<b>Training requirement</b>	<b>Deadline to complete training</b>	<b>New Direct Care Staff (employed less than a year)</b>	<b>Experienced Direct Care Staff (a year or longer)</b>	<b>Non-Direct Care Staff</b>
<b>Continued - DIRECT CARE STAFF - Training Within 30 Days of Hire - - OAR 411-054-0070 (5)</b>				
Food safety	Within 30 days of hire	√	-	-
Medication & treatment administration	Within 30 days of hire	√	-	-
<b>DIRECT CARE STAFF - Annual In-Service Training - - OAR 411-057-0155 (3)(c)</b>				
6 hours annual dementia training	Hire date anniversary	-	√	-
6 hours training on “other” topics	Hire date anniversary	-	√	-

**Reporting Timeline for this Measure:**

Tracking: Facilities will need to begin tracking the data for this measure on 1/1/20 and track through 12/31/20.

Reporting: Data for this measure must be entered into the App by 01/31/2021.

**Please Note:** To assist facilities with tracking and calculating the data needed for this metric, the Department has developed a **Training Tracker** using Excel that facilities may download and use for free.

The tracker is available at: <https://www.oregon.gov/DHS/PROVIDERS-PARTNERS/LICENSING/CBC/Pages/Quality-Metrics.aspx>.

Click on the “(insert link for tracker here)” button to download the tracker.

Instructions for the use of the tracker are contained within the tool itself. No technical assistance for its use will be available.

Use of the Department’s tracker is completely optional; however, facilities must have some means of tracking the needed data for this measure.

**What Facilities Need to Do:**

1. In January of 2021, count the total number of staff who were employed in the facility on 12/31/20. Enter this number into App field **2a**.
2. At the same time, count the total number of staff who completed all required training modules for the past year by the required dates according to that employee’s job category. Enter this number into App field **2b**.
  - (Use the two charts on the previous pages to determine the required trainings and deadlines for each staff category.)

**Example:**

As of 12/31/20, a facility has 95 staff employed. This includes both part-time and full-time staff. Of the 95 staff employed, 85 completed all of their training within the required timeframes required by Oregon Administrative Rule.

Type of staff	# of staff completing required training on time	# of staff total
<b>Residential Care &amp; Assisted Living Facilities</b>		
New Direct Care Staff	20	22
Experienced Direct Care Staff	36	40
Other Staff	10	10
<b>Endorsed Memory Care Communities</b>		
NEW Memory Care Staff	5	6
Experienced Memory Care Staff	10	12
Other Memory Care Staff	4	5
<b>As of 12/31:</b>	<b>85</b>	<b>95</b>
<p><b>QMA will calculate compliance rate: <math>85 \div 95 = 0.8947 = 89.47 = 89.5\%</math></b></p>		

The App will calculate compliance with training with **89.5% as the percentage of employees who received all required training on time.**

*Please Note: The percentage highlighted in the chart above will be automatically calculated by the Department's Excel Training Tracker, should you choose to use that tracker.*

### **Hints and Tips:**

- New facilities that open during 2020 are not required to submit any metrics data for 2020. These new facilities will be required to submit data beginning in 2021 and will have to submit their first report by January 31, 2022.
- This metric addresses ALL staff in the facility, while QM #1 only addresses direct care workers.
- If an employee works some hours in direct care and some hours outside of direct care, facility management will need to use best professional judgment in deciding if the staff person provides assistance with ADLs on a regular basis. If the answer to that question is “yes,” then the staff person should be considered “direct care staff” and must meet all the training requirements for direct care staff.
- The administrator of the facility is required to complete the pre-service training, as a “non-direct care staff.”
- The “date of hire” is the date by which pre-service training for *all staff* must be completed, as required in OAR 411-054-0070(3). (For *direct care staff*, there are certain pre-service requirements that do not need to be completed by the hire date, but instead need to be completed before care is provided.)
- There may be times when the facility will use direct care workers employed by a staffing agency. These staff are required to have the same training as facility direct care staff, even though they are not technically facility staff. These agency staff should be counted in the facility's metrics.
- Contracted employees, such as individuals who work for a contracted services company that provides food services, housekeeping services, or maintenance services, should be counted if they have any direct contact with residents.
- Staff who are shared with another facility on the same campus also need to be counted, if they have any direct contact with residents. This means that the training documentation for shared staff may be maintained at a different facility. However, by the January 31, 2021 deadline, the training information for shared staff needs to be entered into the App, just like the training information for all other staff.

## **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 note that not all falls are preventable, and not all falls are serious enough to cause injury. Facilities with more residents at risk for falls will likely have consistently higher numbers for this metric, whereas facilities with lower numbers of residents at risk for falls would have lower numbers for this metric. This is to be expected.

For all facilities, it is crucial for staff to learn as much as possible about why falls are occurring and to determine what may be done to lessen the number and severity of falls as much as possible.

### **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.**
  - These injuries generally require outside intervention and may require splints, sutures, surgery, casting or further examination (e.g., for possible neurological injury).
  - These injuries frequently involve the resident leaving the facility for assessment and/or treatment and/or they may require home health care.

### **What Facilities Need to Do:**

This metric requires tracking four (4) data points for each month, July – December (or a total of 24 data points for the first year). Facilities may enter data into the App following each month or all at once at the end of the year.<sup>5</sup>

The App will calculate the annual average for each of the four fields.

Please note: **Partial data cannot be used.** If a facility fails to report any falls data on any month, averages will not be calculated, and the facility will be listed as not reporting data for this measure. In other words, all 24 fields in the App must have data entered into them for a facility to receive credit for completing this measure.

### **Data Facilities Need to Track for this Measure:**

For each month, from July – December, facilities must provide the following four (4) data points:

1. Total **number of residents living in the facility on the last day of each month.** Enter this number into the correct row and column on the App table for this metric.
2. Total **number of falls with injury that involved residents living in the facility on the last day of each month.** Enter this number into the correct row and column on the App table for this metric.
3. **Number of residents living in the facility on the last day of the past month who fell with injury during each month.** Enter this number into the correct row and column on the App table for this metric.
4. **Number of residents living in the facility on the last day of the past month who fell more than once with injury during each month.** Enter this number into the correct row and column on the App table for this metric.

Again, facilities may enter data into the App each month or all at once at the end of the year.

### **Reporting Timeline for this Measure:**

**Tracking:** Facilities will need to begin tracking the data for this measure on 7/1/2020 and track through 12/31/2020.

<sup>5</sup> For the first year of the Quality Measurement Program, facilities are only required to report Metric 3 data for the last six months of the year. In subsequent years, facilities will be expected to report Metric 3 data for all 12 months of the year.

**Reporting:** Data for this measure must be entered into the App by 1/31/2021. No extensions will be given to facilities who do not enter data by 1/31 at 11:59pm.

**Example:**

A facility tracks its falls data and enters it into the App as shown below. The App will calculate averages for all of the rows as shown in the grey highlighted column at the far right. (Note: Calculations will occur after facilities have entered data and will not be visible.)

For example, as of the end of March (3/31/2020):

- There were a total of 44 residents living in the facility.
- The facility had five falls with injury.
- Three residents fell with injuries.
- One of those three residents fell more than once.

The averages shown in the highlighted column to the right will be reported to the public. Each facility will have four averages reported on their behalf for the year.

	Jul	Aug	Sep	Oct	Nov	Dec	Average Reported to Public
Total # of <b>residents</b> on last day of the month	40	38	36	38	36	40	38
Total number of <b>falls with injury</b> during the past month	4	5	5	4	6	6	5
Number of <b>residents</b> who <i>fell</i> with injury during the past month	2	3	3	3	4	3	3
Number of <b>residents</b> who <i>fell more than once</i> with injury during the past month	1	1	2	1	2	2	1.5

### **Hints and Tips:**

- If a resident has a fall with injury outside of the facility during a family outing, when no facility staff are present, the fall should not be counted.
- If a resident has a fall with injury during a facility activity outside of the facility, the fall should be counted.
- If a resident is in the hospital or a nursing facility on the last day of the month, the resident should be counted in the total number of residents if they are still on your facility census.
- If a resident is at the facility on a respite basis, and they fall with injury, that fall should be counted.
- All falls with injury should be counted if there is any visible indication of the fall.
- The best professional judgment of staff should be used to determine whether a fall with injury occurred in examples such as the following:
  - 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.
  - If bruising is noted a few days after a fall, and staff believe the bruising is due to the fall.



## Quality Metric #4: Antipsychotic Medications Prescribed for Nonstandard Use

### Background and Reason for Tracking:

Antipsychotic medications were designed to treat symptoms of psychosis due to a variety of causes. Antipsychotics have helped numerous people live more productive lives by treating these psychotic symptoms.

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 and care routines. Thorough assessment, knowledge about each individual's history and current preferences, and adequate staffing and staff training related to behaviors are all crucial elements in providing person-centered care. Medications including antidepressants, antianxiety, and antipsychotics can also be part of a person-centered plan.

There is concern antipsychotic medications are being overused in facilities to calm undesirable behavioral and psychological symptoms of residents with dementia. Thus, the goal is for facilities to ensure antipsychotics are only prescribed following a person-centered assessment and careful consideration of the specific needs of each individual resident, as well as ensuring these medications are used in conjunction with ongoing non-pharmacological approaches (such as meaningful activities).

The purpose of this metric is to encourage the appropriate use of antipsychotics, not to discourage all use of antipsychotic medications. It is recognized there are evidence-based reasons for prescribing antipsychotic medications for residents. Data is needed to determine the prevalence of nonstandard antipsychotic medication use and to encourage facilities to examine their use of these medications.

The first step is to measure the number of residents receiving nonstandard antipsychotic medications. This includes tracking both scheduled (routine)<sup>6</sup> and PRN

<sup>6</sup> A **scheduled medication** is prescribed by a qualified practitioner to be used regularly, often for a specific time period

(as needed)<sup>7</sup> prescriptions for nonstandard<sup>8</sup> antipsychotic medications. Facilities will be provided a list of specific antipsychotic medications<sup>9</sup> that must be tracked for this purpose.

**How to Measure:**

Facilities must begin by tracking all residents with prescriptions for **non-standard antipsychotic** medication, as indicated on the MAR<sup>10</sup> for the entire month of October 2020. (October 1 – 31).<sup>11</sup> This includes prescriptions for both regularly scheduled (routine) and PRN (as needed) antipsychotic medications.

**Data You’ll Need to Track for this Measure:**

Use the 31-day time period **from October 1 – 31, 2020** as the measurement period.

1. At this end of this 31-day time period, count the **total number of residents in the facility**. Enter this number into the App field **4a**.
2. Review each MAR and determine which **residents were prescribed an antipsychotic on the Food and Drug Administration list provided in Appendix A**. (This includes both regularly scheduled and PRN prescriptions.)
3. **Exclude** any residents who have a diagnosis listed on the following **“Exclusions List.”**

Exclusions List	
<ul style="list-style-type: none"><li>• Schizophrenia</li><li>• Schizoaffective Disorder</li><li>• Huntington’s Disease</li><li>• Tourette’s Syndrome</li><li>• Bipolar Disorder</li></ul>	<ul style="list-style-type: none"><li>• Nausea/Vomiting</li><li>• Depression</li><li>• Autistic Disorder</li><li>• Hospice Care</li></ul>

<sup>7</sup> A **PRN medication** means medications and treatments prescribed by qualified practitioner to be administered as needed. (PRN stands for “pro re nata” which loosely translates to “as needed”)

<sup>8</sup> A **non-standard use** is an antipsychotic prescribed for a use other than the uses approved by the FDA

<sup>9</sup> The Food and Drug Administration (FDA) list; **see Appendix A**

<sup>10</sup> MAR stands for “Medication Administration Record.”

<sup>11</sup> Used by AHCA/NCAL Quality Initiative

4. Of the residents remaining after excluding those based on the “Exclusions List,” determine how many of these residents:
  - a. Were prescribed a **non-standard**<sup>12</sup>, **scheduled**<sup>13</sup> **antipsychotic** medication<sup>14</sup>, as indicated on the MAR<sup>15</sup> during the 31-day time period.<sup>16</sup> Enter this number into the App field **4.b**
  - b. Were prescribed a **non-standard PRN**<sup>17</sup> **antipsychotic** medication, as indicated on the MAR at the end of the 31-day time period. Enter this number into the App field **4.c**

The App will calculate:

- Percentage of residents with **scheduled** non-standard prescription for an antipsychotic drug
- Percentage of residents with **PRN** non-standard prescription for an antipsychotic drug

These values will be publicly reported for each facility.

Tracking: Facilities will need to begin tracking the data for this measure on 10/1/2020 and track through 10/31/2020 (entire month of October).

Reporting: Data collected 10/1/2020 – 10/31/2020 must be entered into the App any time after 10/31 of 2020 but before 1/31/2021. No extensions will be given to facilities who do not enter data by 1/31/2021 at 11:59pm.

**Example:**

- A facility has 52 residents living in the facility as of 10/31/2020.
- Of these, 34 residents had at least one prescription for an antipsychotic medication between 10/1/2020 and 10/31/2020.
  1. Exclusions:
    - Of these, 3 residents had conditions listed on the Exclusions List.

<sup>12</sup> A **non-standard use** is an antipsychotic prescribed for a use other than the uses approved by the FDA

<sup>13</sup> A **scheduled medication** is prescribed by a qualified practitioner to be used immediately, for a specific time period

<sup>14</sup> Use the Food and Drug Administration (FDA) list; **see Appendix A**

<sup>15</sup> MAR stands for “Medication Administration Record.”

<sup>16</sup> Used by AHCA/NCAL Quality Initiative

<sup>17</sup> A **PRN medication**<sup>17</sup> means medications and treatments prescribed by qualified practitioner to be administered as needed

- That leaves 31 residents receiving antipsychotics for non-standard purposes.
2. Scheduled versus PRN (as needed) prescriptions
- Nineteen of the 31 residents had at least one prescription for a **scheduled** antipsychotic for a non-standard purpose between 10/1/2020 and 10/31/2020.
  - Twelve of the 31 residents had at least one prescription for a **PRN** antipsychotic for a non-standard purpose between 10/1/2020 and 10/31/2020.
  - One resident, who moved out on 10/22/2020, had a prescription for a scheduled antipsychotic for a non-standard purpose during the reporting period; however, **since this resident moved out before 10/31/2020, they are not included in the calculation.**

Using the reported information for this metric is as follows for the example facility, the Quality Metrics Application calculations were:

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

$$\frac{\% \text{ of residents with non-standard use of an antipsychotic drug} \quad \# \text{ of residents with scheduled non-standard antipsychotic drug use indicated on the MAR}^{18} \text{ on 10/31}}{\text{Total \# of residents in the facility as of 10/31}}$$

= 19/52 = .365 = **36.5%** of residents had at least one prescription for a scheduled antipsychotic for a non-standard purpose between 10/1/2020 and 10/31/2020.

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

$$\frac{\% \text{ of residents with PRN use of an antipsychotic drug} \quad \# \text{ of residents with PRN use of nonstandard antipsychotic drug as indicated on the MAR on 10/31}}{\text{Total \# of residents in the facility on 10/31}}$$

= 12/52 = .231 = **23.1%** of residents had at least one prescription for a PRN

(as needed) antipsychotic for a non-standard purpose between 10/1/2020 and 10/31/2020.

**Hints and Tips:**

- If a resident has both a scheduled and a PRN antipsychotic prescription, then both prescriptions are counted, so the resident would be counted under each category.
- If a resident is in the hospital or a nursing facility on the last day of the month, the resident should be counted in the total number of residents (if they are still on your facility census).

## 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.

The Quality Measurement Council chose to adopt the CoreQ questions for assisted living (AL) to measure satisfaction for this metric. CoreQ questions were developed by a team including, Nicholas Castle, Ph.D., 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 and post-acute care settings, CoreQ has been independently tested as valid and reliable. You can learn more about the CoreQ questions and other information about CoreQ at: [www.CoreQ.org](http://www.CoreQ.org).

To ensure measurement of this metric is unbiased and consistent with standard practice and legislative requirements, satisfaction surveys using CoreQ questions are required to be conducted by a ***contracted third party***. Each facility must contract with a CoreQ vendor to complete a yearly survey. Facilities will receive the results from the third-party vendor and enter them into the App.

It is important to note that surveys may be administered in different ways (i.e., by mail, by phone, etc.). Facilities are encouraged to check with their vendors to learn about best practices for who and how to provide assistance to residents in completing the survey.

### **How to Measure:**

Facilities will not need to perform any measurement for this metric; however, facilities will need to contract with a CoreQ approved vendor (for a list of these, go to [www.CoreQ.org](http://www.CoreQ.org) and click "Customer Satisfaction Vendors" at the top of the page).

**Third-party vendors will use the following CoreQ questions, and the following 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?

**Reporting Timeline for this Measure:**

Tracking: Facilities will need to ensure a third party with CoreQ vendor experience conducts a survey sometime during 2020. The facility will then need to enter survey data from the vendor into the App.

Reporting: Data for this measure must be entered into the App by 1/31/2021. No extensions will be given to facilities who do not enter data by 1/31/2021 at 11:59pm.

- If fewer than 10 responses are gathered for the facility, responses will not be shared at the individual facility level; however, they will be counted as part of regional and state averages.

**What Facilities Need to Do:**

Facilities will not need to track any data for this metric themselves; however, facilities will need to contract with a CoreQ approved vendor (for a list of these, go to [www.CoreQ.org](http://www.CoreQ.org) and click “Customer Satisfaction Vendors” at the top of the page) to perform at least one resident satisfaction survey per year.

**Example:**

- The facility goes to [www.CoreQ.org](http://www.CoreQ.org) and clicks on the “Customer Satisfaction Vendors” link at the top of the page.
- The facility chooses one of the vendors to hire.
- The facility and the vendor agree on a date or date range when the vendor will conduct the survey, ensuring results will be shared with the facility before

January 31 of the following year. (Facilities must enter survey data from 2020 into the App by January 31, 2021.)

- The vendor conducts the survey, determines results, and sends them to the facility by the agreed-upon date.
  - Facilities should ensure that vendors are willing and able to calculate an average for each of the four CoreQ items, corresponding with each data field in the App.
- The facility will enter data sent by the vendor into the App fields by January 31, 2021.
- If fewer than 10 responses are gathered for any facility, data for that facility will not be shared at the individual facility level; however, they will be counted as part of overall regional and state averages.

### **Hints and Tips:**

- The facility will be responsible for paying for the surveys to be conducted by a third-party vendor.
- Facilities will need to enter the average scores for each CoreQ item provided by the vendor into the App; vendors will not have access to the App.
- Surveys may be administered in different ways (i.e., by mail, by phone, etc.).
- For this metric, only residents can be interviewed; *family members may not complete the survey as a proxy for any resident.*
- The method of administration, as well as the cognitive ability to respond to questions, will likely mean some residents will be unable to participate.
- In order to protect confidentiality of residents and to maintain a fair measurement process, facilities with fewer than 10 responses will not have results individually reported. (Their results will, however, be used to calculate statewide and regional averages.)
- 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 just a “snapshot in time,” and it is expected that some residents who are included in the survey may have left the facility by the time the survey data is entered into the App.



## Appendix A:

### First-Generation Antipsychotics

<b>Generic Name</b>	<b>Brand or Trade Name</b>
Chlorpromazine	Thorazine
Droperidol	Inapsine
Fluphenazine	Prolixin
Haloperidol	Haldol
Loxapine	Loxitane
Perphenazine	Trilafon
Pimozide	Orap
Prochlorperazine	Compazine
Thiothixene	Navane
Thioridazine	Mellaril
Trifluoperazine	Stelazine

### Second-Generation Antipsychotics

<b>Generic Name</b>	<b>Brand or Trade Name</b>
Aripiprazole	Abilify
Asenapine	Saphris
Clozapine	Clozaril
Iloperidone	Fanapt
Olanzapine	Zyprexa
Paliperidone	Invega
Quetiapine	Seroquel
Risperidone	Risperdal
Ziprasidone	Geodon
Lurasidone	Latuda