Assisted Living Report Card Advisory Group Meeting

Date: 03/22/2023
Location: Zoom virtual meeting hosted by University of Minnesota

Attendance

Advisory Group Attendee	Organization
Jeff Bostic	LeadingAge Minnesota
Patti Cullen	Care Providers of Minnesota
Todd Bergstrom	Care Providers of Minnesota
Lindsey Krueger	Minnesota Department of Health
Crystal Holloway (PrimeWest)	Lead Agency / Managed Care Organizations
Angie Kluempke (Medica)	Lead Agency / Managed Care Organizations
Kristine Sundberg	Elder Voice Family Advocates
Dr. Jane Pederson	Stratis Health

Staff and presenters	Organization
Valerie Cooke	Department of Human Services
Lauren Glass	Department of Human Services
Rachel Shands	Department of Human Services
Tetyana Shippee	University of Minnesota
Tricia Skarphol	University of Minnesota
Kelsey Einertson	University of Minnesota

Observers	Organization
Linda Gustafson	Retired physical therapist, family caregiver
Steve Sauerbry	Family caregiver (1/28/2022)
Michaun Shetler	Care Providers of Minnesota
Parichay Rudina	Ombudsman for Long Term Care
Carolyn Perron	Community member

Agenda

- Welcome, roll call, introduction of new attendees, and overview of agenda

- University of Minnesota present:
    - Updated findings from the 2021-22 resident and family survey data analysis and recommendations for report card ratings development
- Department of Human Services (DHS) present:
    - Updates on the process for AL licensure survey measure development
- University of Minnesota Present:
    - Staffing measure overview for report card ratings development

University of Minnesota updated findings and recommendations for resident and family survey data

- The University of Minnesota (U of MN) conducted a statistical method called factor analysis to determine the domain construction (groupings) for resident surveys. Results from this analysis will help the U of MN determine if any changes need to be made to questions or domains.

Factor Reliability: This psychometric validation used statistical methods to determine the reliability of questions asked in the resident surveys. This step is important to ensure the surveys are evidence based.

- The U of MN found good internal consistency, meaning similar items are related but each contributes some unique information, for all but three domains.
- The domains with good internal consistency were:
    - Food
    - Staff
    - Engagement
    - Security
- The domains that did not have good internal consistency were (this means that items are redundant):
    - Environment
    - Autonomy
    - Culture

Domains without good internal consistency:

- The U of MN presented the questions that currently make up the environment, culture, and autonomy/choice domains in the resident surveys
- Environment:
    - How often are the common areas well maintained? *For example, are the dining areas clean, visiting areas in good condition, etc.?*
    - How often is it quiet enough for you to sleep here?

    - How often are there places for residents to socialize with other residents?
- Culture:
    - How often are there opportunities for you to practice your religious or spiritual beliefs here?
    - How often are the people who work here respectful of your religious or spiritual practices?
    - How often are the people who work here respectful of your culture? *For example, do the people who work here respect your traditions, language, and way of dressing?*
- Choice/Autonomy:
    - How often can you decide how to spend your time each day?
    - How often do you spend as much time outdoors as you would like?
    - How often are you allowed to personalize your room?
    - How often are the services you receive here provided the way you want? *For example, help you get with bath or dressing, help with cleaning your room, etc.*
    - How often are you as involved in decisions about he services you receive here as you want to be?

Creating one combined domain

- The U of MN is proposing that environment, culture, and choice/autonomy be combined into a single domain. This domain has been given a placeholder name of "climate" but can be changed before launching the report card website.
- The three domains are highly correlated with each other, meaning that they are currently measuring similar constructs.
- The new domain would have an excellent model fit and reliability.
- Advisory group members expressed agreement with this proposal.

Correlations among items and domains:

- Questions 27 and 30 were found to be perfectly correlated, meaning they measure exactly the same construct and are interchangeable.
    - Question 27: How often can you decide how to spend your time each day?
    - Question 30: How often are the services you receive here provided the way you want?
- The U of MN is proposing that question 30 be dropped from the survey and question 27 be kept.
    - Advisory group members expressed agreement with this proposal.

Summary

- All of this work is preliminary and based on pilot data. Final decisions will not be made until the same analysis can be run on the full data set that the U of MN will be receiving at the end of June. The U of MN will present on the results from the full data set at a future advisory board meeting.

Advisory Group questions and comments for the U of MN presentation

Question: For the domains with lower internal consistency, even if we do combine them into one domain, do we then need to rewrite any questions so they measure what we think they are measuring?

> Response: When we look at the individual questions, all of them are performing well except for question 30. When we combine the environment, culture, and choice/autonomy questions into a single domain, we get a high internal consistency. We understand that there was a reason these domains were initially created, and some stakeholders might like to have individual domains for things like spirituality or environment, etc. However, from a researcher's standpoint, internal consistency is important so that we can trust that the scores are meaningful, and by combining the domains the reliability is good.

Comment: A concern from my perspective has always been that there could be too many questions on the survey, so if the science supports removing any questions, I am in favor of it. I do not like the name "climate" for the combined domains.

> Response: Climate was a placeholder name created by the U of MN, and we would want input from the advisory group to create the permanent name for the domain. Environmental climate is a term used in academic literature, but that may not resonate with consumers, so we would like to find a term that makes the most sense.

Comment: I agree with the pervious comment, less is always better on surveys. I am in support of going with question 27 instead of question 30, it seems to be getting at what we want.

Question: How do we handle residents who have become so used to being institutionalized and being in the current environment that they no longer have high expectations and would feel that their needs are being met? I'm not sure if that can be handled via modeling or if it would need to be looked at over time.

Response: There is a lot of literature on this topic, and you are getting at the idea of an "institutionalization trajectory" and how that impacts expectations. I don't think we can get at this issue with these questions unless we also had data on the residents expectations and could combine the two data sets. I don't think that the data we have gets at how becoming socialized into the environment aligns with expectations.

Question: Will you be analyzing the data by facility size? We don't know if there is a difference between a small homelike facility and a traditional large, assisted living facility, so will you be addressing that?

Response: Yes, we will do that.

Updates on the process for AL licensure survey measure development

- Minnesota stakeholders identified staffing, resident health outcomes, and safety as the domains most important to them. This was determined by answers on surveys from a variety of stakeholders. Prior to each Advisory Group meeting, Minnesota DHS plans to provide all advisory group members with a list of the tags relate to the three most important domains (staffing, resident health outcomes, and safety), and to get feedback on what the advisory group members feel belong or don't belong in those measures. This will help decide which tags will end up feeding into the ratings for the measures.
- The staffing measure will be presented and discussed at this meeting, the next meeting will cover the resident health outcomes measure, and then the safety measure will be at the following meeting.
- The next step will be deciding whether to use investigations data, and how to use it in the measures. This work will be led by the U of MN and their recommendations will be presented at these meetings for feedback and input.

Advisory member feedback

- How can we best engage advisory group members in the process of AL licensing survey measure development? DHS has created some possible options to help with this:
    - Scheduling drop-in feedback sessions in-between advisory group meetings
    - Longer meeting times
    - More frequent meetings
    - Less meeting time spent on updates and presentations, more on group member discussion

    - In-person meetings
    - Others?
- DHS addressed and wanted feedback on the following recommendations from advisory group members:
    - Recommendation: The Department of Health's licensing survey process is still new for both providers and surveyors. We recommend delaying inclusion of survey based measures on the AL report card.
        - DHS plans to include these measures beginning in the first quarter of 2024 after one full round (2 years) of licensing surveys have been completed.
    - Recommendation: DHS should not publish AL report card ratings based on AL licensing data until the process of reconsiderations for AL licensure survey findings has been completed.
        - DHS plans to publish ratings based on initial survey data and revise ratings when/if any contested survey tags are overturned.

Advisory Group questions and comments on the process for AL licensure survey measure development presentation

Question: When the first round of data comes in, the recommendation from some members of the advisory group is to wait until there is another full year's data to publish it. I feel having the initial evaluation is always good. Why do they want to delay it?

Response: Some of the concern we are hearing is that the licensing surveys are new to all and this would allow more time for both the survey process to improve and for providers to adjust to the survey process.

Question: I feel that an initial evaluation is good unless they are saying that the process isn't valid. I look at it as an initial process of what you are going to hear. The data we saw is pretty relative right? That's what was shown in the beginning?

Response: To clarify, the first presentation was about quality of life and family surveys that we are sending out which is a separate measure. This feedback was based on the MDH licensing surveys that they give every 2 years to facilities as part of the licensure process.

Comment: Our concern is based on experiences with the nursing home report card survey where we had a decade of results to analyze before the measure was put in. There hasn't been enough time in these advisory group meetings to talk through the

rationale. R There is still training occurring of both the providers and surveyors and we think it will take time for everything to settle in and we don't want results posted that might have inconsistencies of the first year of the survey process. Let's give this process a bit more time.

Staffing measure overview by the U of MN

- The U of MN mapped state statutes or tags to the quality domains that were identified in the literature.
- Tags were mapped to the 3 domains rated the most important by stakeholders: resident health outcomes, safety, and staffing.

Staffing domain mapped tags overview

- 39 tags were mapped to staffing
    - Policy- 1 tag
    - Documentation- 3 tags
    - Staff availability- 5 tags
    - Staffing specific to DC (dementia care) license- 10 tags
    - Competency- 20 tags
- Why include 20 tags for competency? After breaking it down into subgroups, we found that even though there were a lot of tags in certain subgroups, they were different enough to include to at least get stakeholder feedback. We were more inclusive of what was found rather than removing things without feedback.

Literature review of staffing subdomains

- We find a number of items make up staffing quality and we call these subdomains. State statutes measure a few of the items that measure staff quality:
    - Employee qualifications
    - Collaboration among staff
    - Communication
- However, state statutes to not measure these items that make up staff quality:
    - Close staff relationships
    - Staff empowerment
    - Burnout/stress
    - Supports (institutional, supervisor, emotional, coworker)
    - Job satisfaction
    - Resident-centered job satisfaction
    - Consistent assignment

Staffing domain scope and severity data

- Based on the first 150 licensure surveys conducted between September 2021 and May 2022, the majority of tags assigned to the staffing domain are level 2 violations meaning no actual harm but the potential for more than minimal harm.
- The vast majority of tags cited were in level 2F, meaning it is widespread. The two most commonly cited tags in 2F were:
    - Tag 470; develop and implement a staffing plan that ensures sufficient staffing and that someone is available 24 hours a day.
    - Tag 1470; orientation must contain certain topics.
- Level D means isolated, and 2D has the next highest number of tags cited. The 2 most commonly cited tags in 2D were:
    - Tag 650; the facility must maintain a current record of paid employees that includes their licensure job descriptions.
    - Tag 1440; supervision of staff providing delegated nursing services

Advisory Group questions for U of MN

Question: There are so many process tags, is there a way to focus on outcome related tags? Not sure what the staffing domain is trying to measure in a report card given that AL communities all have a different staffing plan.

> Response: When we started with this process, we did a lot of work to identify what measures of quality matter to folks. We know that resident quality of life was number one, family satisfaction was number two, and staffing was number three. It was supported by about 1,000 surveys, as well as a technical expert. Clearly it is a measure that is important to consumers and providers so we want to measure it in some say. There was discussion of doing a staff survey to get at staff satisfaction, staff empowerment, etc. But that needs resources that we don't currently have. We do have these surveys that are required and done by MDH. This measure of staffing gets at staff training and professionalism rather than staffing ratios.

Comment: I think it's true that staffing is the backbone of all long-term care. I think over the years we have made the mistake of putting so much emphasis on measuring how good the processes are but really it's the relationships between staff and residents that is the key to quality and safety. If we get too focused on just measuring competencies, it keeps us stuck in the idea that the most important thing is the process and the task but really for quality and safety the biggest part of what we do is the interpersonal relationships.

Response: I hear you saying that staffing quality is very important and we should measure it, but the other aspect is staff relationships with residents and each other. The literature and technical advisory panels have shown that is important but we don't have data on it right now. What we are tying to do, is start delivering this mandate to consumers and other stakeholders to produce some measure of quality that gets at staffing, acknowledging that it's not comprehensive because we don't have the data yet. So do we wait until we have perfect data for all aspect of quality we want? Or do we start somewhere, and that somewhere is the metrics that we currently have.

Comment: What I'm struggling with on this subject, is looking at it in the extremes, we have a report that MDH posts on their website which the average consumer would find difficult to read and probably wouldn't tell them what they want to know. So we're trying to take that information and present it in a way that is meaningful, which is a good idea. But what do we think is actually meaningful? What things are important when we look at these survey tags, like which ones actually affect the outcomes? The training things are good, but that's a yes or no answer, it's just checking a box.

Response: I hear you, and that's why it's good that we have a variety of stakeholders represented here, including some consumer representatives. Do they want to know that the community is not in compliance with training? It's a pretty crude measure, but if it's a no then maybe they should know that and we can pull it from the data that we currently have.

Comment: It is too bad the overall grouping is "competency" - seems what we are wanting is to assess "professionalism"

Response: We can change the name of the grouping.

Breakout group discussions:

- Groups were asked the following 2 questions:
  - Which tags especially belong in this measure? Why?
  - Which tags don't belong in this measure? Why?
  - Responses are located in appendix A

Upcoming Advisory Group work

- Meeting notes and materials will be posted on the project website: www.mn.gov/dhs/assisted-living-report-card
- Next Advisory Group meeting: May of 2023

Appendix A: Advisory Group member breakout discussion notes

U of MN breakout group questions and Advisory Group responses

Breakout questions:

1. **Which tags especially belong in this measure? Why?**
    a. Group 1:
        i. Include a larger number of tags, rather than fewer. Safety science recognizes the importance of process to outcomes. Would like to see process measures included.
        ii. This is publicly available information, so including it is a good thing. Consumers can recognize what they are seeing.
        iii. Not against the process measures, but it's about "are they doing it or are they not." If I was a consumer, I would want to know are they meeting the minimum staffing requirements.
        iv. I don't want to say the process is not important. But the outcome would be whether you have the right amount of staff. Training becomes perfunctory so not sure if it is valuable.
        v. The more stuff you put in, the less meaningful. The hard choice is to pick the ones that are meaningful.
        vi. Is the common ground in weighted measures. Awake staff, staff available, etc. - could those have greater weight in the values we are identifying?
        vii. Not every AL would have something cited. Or the things that are cited are not detrimental. So which ones that are being cited and at what level do we need to be concerned?
        viii. The group needs to decide what is meaningful "scope and severity" and how do you elevate the tags that are the most meaningful?
    b. Group 2:
        i. As a consumer, they do want to know if the staff are trained on these measures. And are they under the supervision of appropriate staff? Personal experiences with family being given wrong meds, etc.
        ii. As long as the consumer knows that there is a process in effect to train in new staff, and understanding the process at the facilities is an important piece of information
        iii. The level of supervision is hard to get at with the training tags. After someone has passed initial training, the supervision they receive can be a gap.

iv. Staff changes and leadership changes have been common. Staff are not allowed to perform these competencies until they are trained.
v. Caregivers tend to defer to the residents' wants even if it goes against training. Walking the line between following training and following what the resident wants can be difficult.

c. Group 3:
i. This should be a focus on making sure that minimum requirements are met: staffing plan, staff available 24/7, access to RN, awake staff and competent staff. This would get rid of half
ii. We should look at levels they are being cited (levels 3 and 4). We should not look at levels 1 and 2
iii. Similar feedback as the comment above. If we put everything, it defeats our purpose. What are the basic things everyone should have? What are the things we can't do without?
iv. We would be very concerned with delays. We've grown to be confident with MDH surveys. I stress caution about any delays. Survey info is very important and should be available.
v. At what point does AL need to have a medical director? or someone in addition to an RN? just having a clinician available 24/7 is not enough.
vi. Is there reason to add access to telemedicine?
vii. Concern with what "access" to RN actually means. Is it timely access to the RN? I appreciate Jane's comments about the medical director being needed.
viii. In terms of numbers, not sure what is the magic number. It's about which ones are the important pieces included there.

d. Group 4:
i. Group 4 did not have the chance to read through the tags. They were generally supportive of the idea of having group members review tags and provide their reactions, however.
ii. It was expressed that if a tag is cited at a higher scope and severity, that would make it meaningful to include in a staffing measure.

2. Which tags don't belong in this measure? Why

a. Group 2:
i. Several minimum standards are repeated, and it is just too much. Have detailed notes on this but can't access currently.
ii. It is a big list to go through during the breakout group. More time would be helpful.

b. Group 3:
i. Consider sending a survey to everyone on tags and ask them to prioritize.

ii. Why do we feel the need to have fewer tags in the measure? Why should we cut some?