Assisted Living Report Card Advisory Group Meeting

Date: 12/01/2020
Location: Zoom virtual meeting hosted by University of Minnesota

Attendance

Advisory Group Attendee	Organization
Ann Thole	Minnesota Board on Aging
Jeff Bostic	LeadingAge Minnesota
Patti Cullen	Care Providers of Minnesota
Todd Bergstrom	Care Providers of Minnesota
Lindsey Krueger	Minnesota Department of Health
Elizabeth Warfield	Managed Care Organizations (PrimeWest)
Angie Kluempke	Managed Care Organizations (Medica)
Sean Burke	Minnesota Elder Justice Center
Kristine Sundberg	Elder Voice Family Advocates
Genevieve Gaboriault	Ombudsman for Long Term Care
Dr. Jane Pederson	Stratis Health
Heidi Haley-Franklin	Alzheimer's Association

Staff and presenters	Organization
Valerie Cooke	Department of Human Services
Peter Spuit	Department of Human Services
Rachel Shands	Department of Human Services
Odi Akosionu	University of Minnesota
Tetyana Shippee	University of Minnesota
Tricia Skarphol	University of Minnesota

Observers	Organization
Jean Peters	Elder Voice Family Advocates
Becky Walsh	Manager Care Organizations (PrimeWest)

Agenda

- Introduction of new attendees
- Review comments and questions about September 28, 2020 meeting notes
- Review a DHS legislative technical change regarding Minn. Stat. 256B.439
- Provide an update on assisted living quality literature published since the 2019 literature review
- Discuss the staff quality domain
- Discuss possible data sources to support the staff quality domain

DHS legislative technical change related to Minn. Stat. 256B.439

- DHS is seeking to clarify its authority to receive basic contact information for residents and residents' primary family contact in order to conduct resident and family quality surveys. This authority is needed to support the Nursing Home Report Card, as well as the forthcoming Assisted Living Report Card.
- To clarify its authority, DHS is seeking support from the 2021 Minnesota Legislature to add a technical change to the existing law (Subd. 3c). This language would also provide protection to providers.
- The new subdivision would state something like the following: "For the purposes of conducting consumer surveys, the commissioner may request client and associated key representative contact information and providers must furnish the contact information available to the provider."

Update on assisted living quality literature

- Since the 2019 literature review, the U of MN identified 26 new peer-reviewed references (6 related to COVID-19) and 10 new grey literature resources references (state reports, state and national AL associations, AL community op-eds). The 9 assisted living quality domains identified in the first literature review appear to remain prominent.
- <u>Of the peer-reviewed references not related to COVID-19:</u>
    - 9 related to resident quality of life
        - Mood, cognitive health, physical activity, using technology
    - 9 related to resident health outcomes
        - Falls
    - 3 related to resident & family satisfaction
        - Cost of care
    - 1 related to service availability
    - 1 related to physical & social environment
        - walkways
    - 2 related to care services & integration
        - Health information technology
    - 1 related to core values & philosophy
    - 1 related to safety

        - citations

- Main categories of peer-reviewed references related to COVID-19:
    1. Strategies to reduce COVID-19 transmission within AL communities-Resident health outcomes
    2. Approaches to mitigating the impact of social distancing, self-quarantine and isolation (staff, resident quality of life)
        - There was nothing in the COVID-19 literature, but the updated literature review found studies that discussed dementia and cognitive decline.

Discussion of the staff quality domain and possible data sources

- Measures of staff quality identified in the literature:
    1. *Person-centered approaches to staff quality*: 1) staff empowerment; 2) collaboration among staff; 3) communication among provides/direct care workers); 4) burnout/stress; 5) supports (institutional, supervisor, emotional, coworker); 6) job satisfaction; and 7) resident-centered job satisfaction among staff
    2. *Administrative approaches to staff quality*: 1) staff turnover; 2) staff training; 3) consistent assignment; 4) employee qualifications; 5) staffing ratios; 6) retention of direct care staff; and 7) compliance with staff training requirements
- Indicators or tools used to measure person-reported domains
    - Person-Directed Care (PDC) and Environmental Support for PDC measure
    - Person-Centered Practices in Assisted Living questionnaire (PC-PAL)
    - "Staff Experience working with Demented Residents"
    - Job Attitude Scale (JAS)
    - Work Stress Inventory
    - CoreQ-Staff
- Other indicators to measure staff quality
    - Observable Indicators of Quality-Assisted Living
    - Nurse/staff availability (RN Hours)
    - Dementia care quality indicators
    - Staff Performance Reviews
    - Staff training

Breakout groups to discuss staff quality domain

Advisory Group members were placed into a breakout group that included 1 moderator and they were asked to discuss the following questions: 1) Is anything missing from the subdomains and indicators lists from the 2019 literature review?; 2) What do you think matters most when measuring staff quality?; and 3) How could we measure it and what would the data source be? Breakout discussions lasted 10 minutes. Some groups discussed each question, whereas others had more robust discussions around 1 or 2 questions. Appendix A provides discussion summaries for each question among the 4 groups.

Short-term and long-term priorities for this group

From the ideas generated during the breakout discussions, facilitators asked Advisory Group members what we should prioritize in the short-term and long-term related to measuring staff quality. This list in its entirety can be found in Appendix B. The most frequently mentioned short-term priority was staff retention.

Summary of comments and questions raised at the meeting

Questions/commented related to DHS legislative technical change:

1. A group member thought it would be a good idea to run this by an attorney specializing in HIPAA to ensure the proposed statute does protect providers.
    - Care Providers of Minnesota can have an attorney review to make sure it complies with HIPAA regulations for providers.
2. A group member wondered how confidentiality of individuals who participate in surveys will be reassured. She also had a concern regarding retaliation against residents.
    - All vendors who conduct surveys for DHS will have a business associate agreement in place, in addition to the data privacy laws that currently exist.
    - Providers only receive summary information and do not know who participated in the survey, even for face-to-face interviews. All survey respondents provide consent by stating that they either agree to participate or decline to participate when approached to complete a survey.
3. There was a question on how survey responses are recorded, does one take priority over another, if both a resident and family member complete a survey?
    - The state intends to survey both the resident and family, regardless if one or the other responds. Residents' responses to quality of life questions and family responses to satisfaction questions are collected through separate survey instruments and the results are reported as separate quality measures.
4. A clarifying question was asked: Does survey information provided to DHS come from both resident and family information?
    - Yes, we would like information from both residents and family members or key contacts. They still have the choice to consent to the survey when contacted, but we want the ability to contact them so that they can make an informed choice about whether to participate or not.

Questions/comments related to the updated literature review:

5. A group member was interested to know when the COVID-19 articles were done.
    - These articles were published between April 2020 and October 2020.
6. A group member wondered about the lack of staffing research and thought there is much more to learn about this issue.
    - There was no updated research related to staffing except in the COVID-19-related articles. There have been a number of op-eds and blog posts focusing on the well-being of long-term care staff, need to payment reform, and need to address racism for long-term care staff indicating a policy interest in the area. However, it takes longer to be published in peer-reviewed literature.

7. An advisory board member was interested to know if infection control was included in any of these research studies.
    - Infection control was only addressed in the COVID literature, discussing the importance of early surveillance to help reduce the spread of COVID-19.
8. A group member asked if the COVID-19 literature addressed caring for those with dementia in assisted living.
    - There was nothing in the COVID-19 literature specifically focused on dementia, but the updated literature review found studies that discussed dementia and cognitive decline as quality measures.
9. A group member commented that she feels the quality of care is not being drilled down far enough.
    - Resident quality of life and resident health outcomes had the most articles over the past year, although around half of health outcomes were looking at falls as the main outcome. This is because falls are a measureable outcome in peer-reviewed literature based on available data.
10. There was a comment that the length of social isolation is also a factor to be considered, in addition, to considering the timing of when facilities can "open up".
    - If the advisory board feels this is an important issue to monitor, the U of MN can continue to provide literature updates as it related to COVID or quality in assisted living.

Questions/Comments related to measuring staff quality:

11. A group member commented that it is interesting that staff compensation and benefits are not part of the person-centered measures; it would seem that such measures would put some of the other measures in correct context. For example, as the CAB member noted, at some level, stress and burnout are a part of many, if not all jobs, but people usually make a cost/benefit analysis of how much stress they will tolerate based on how well they are being compensated.
    - Many op-eds that have come out recently have focused on compensation and benefits as measures that are missing. Rethinking this systems issue will be important if we want to ensure that we have a sustainable workforce.

Appendix A: Advisory Group member breakout group discussion notes

Question 1: Does anything seem to be missing from the subdomains and indicators lists from the 2019 literature review?

Group 1 responses:

- Critical incidents data, like Office of Health Facility Complaints
- Office of Ombudsman for Long Term Care reports and concerns
- Staff tenure – staying long-term
- Advancement opportunities / professional development for staff
- Language barriers and perceptions of quality of care concerns
- Organizational culture / empowerment of staff / support of staff

Group 2 responses:

- Is training effective? Does it equate to staff skills and improved outcomes? Are we actually able to see a change in how people practice and how care is delivered? Group member commented: That really resonates with me. Dementia competency-based training module. People go to training because it's required, but they don't always follow through with practice recommendations.
- Compensation and benefits. There are issues about how to gather that data. But we need this in order to have a complete picture.
    - Is there data to show that people are willing to take on more stress if they are compensated more?
    - At a more fundamental level, the compensation is about recruitment and ability to even hire staff. Having enough people to do the work, willing to do the harder stuff. What we hear about in greater Minnesota for this low-wage health care work is: why would I take this high stress job when I could work in fast food for the same amount of money?
    - Both issues are interesting. Are we able to recruit people who are willing to look at this as a profession, not just a job? And then on the flip side, how does stress and burnout relate to your ability to provide quality care?
    - If you are compensated more, you may be willing to take on a higher level of stress.
- Another issue – some sort of cultural component. People who don't think that the providers they have can relate to them. How is this measured and taken into account? How to measure successfulness of this exchange?

Group 3 responses:

- Compensation and benefits (staff)
- Physical nature of work in LTC vs. other sectors (target) in how this related to compensation
- Large variability in size, people (characteristics, complex health needs as an example) served in comparing staff experience in ALCs
    - This can impact staff collaboration. Staffing ratios might look different across ALCs
    - Management supports – What does this look like?

Group 4 responses:

- Full-time vs part-time staff and benefits
- Need to consider which measures are system-level change and which ones the facilities can actually control. For example, Elderly Waiver does not pay for nursing services, so AL communities that have residents on those waivers will not have reimbursement for higher clinical need levels.

Question 2: What do you think matters most when measuring staff quality?

Group 1 responses:

- Staff ratios, 24-7
- Burn-out and stress of staff (and this dovetails with staffing ratios)
- Number of part-time versus full-time staff
- Staff feeling that they have enough time to provide softer supports

Group 3 responses:

- Staff retention and how you achieve this. Providers can easily come up with this information. It's difficult to build on your program (implement improvement strategies) without figuring out the retention piece.
- Training is really important and a good place to start, especially considering the ease of implementation in light of the AL report card and measures that are easy to understand and translate.
- Job satisfaction

Group 4 responses:

- Clinical expertise is very important as we have seen with COVID
- Staff retention
- Recruitment
- Staff supports
- Staff training
- Ratios of staff to residents

Question 3: How could we measure it? What would the data source be?

Group 3 responses:

- It was felt that facilities already report on staff training. Retention and training can be report by providers, but standardization across facilities is needed.
- A satisfaction survey would need to be conducted by an outside source, perhaps the state, and again this survey would need to be standard across all facilities

Group 4 responses:

- Department of Employment and Economic Development as one source

Appendix B: Advisory Group short-term and long-term priorities related to staff quality

Advisory group short-term priorities

- Outcomes of training
- Staff retention-wages/benefits/”hero pay:
- Staff recruitment
- Staff retention
- Not sure if pay and benefits matters as a whole since all have the same issue
- Staff burnout
- Cultural education for diverse workforce
- Find a contractor to do a staff satisfaction survey.
- Training opportunities and funding
- Burnout, compensation, retention
- ID data to be collected as part of initial licensing
- Staff ratios
- Prioritize data that does not require risk adjustment

Advisory group long-term priorities

- Staff retention
- Enhance the professionalism of our workforce
- Is caregiving a career or a job?
- Focus on outcome based measures
- Systemic changes to Elderly Waiver rate setting to pay for clinical expertise
- Establish living wages for all caregivers