

Technical Report: Qualitative Component

Evaluation of the NF Payment Reform Legislation

2021 Report to the Legislature

Prepared for: Minnesota Department of Human Services

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Technical Report Abstract

The objective of this report is to describe the activities and findings from the qualitative component of the Minnesota Value Based Reimbursement evaluation. The report describes four data collection activities: discussion with provider quality councils, focus group interviews with providers, a state-wide survey of providers, and a focused survey of quality experts from throughout the Minnesota nursing home industry. Findings are described for each set of data, and recommendations for action are noted at the conclusion of the report.

Qualitative Component Overview

The Minnesota Value Based Reimbursement program (MN VBR) achieved the goal of increasing facility reimbursement and subsequently increasing facility expenditures for care-related services. However, the effect of MN VBR on care quality was less clear, as no meaningful increase in the MN VBR quality components was detected in previous quantitative analyses that could be directly attributed to the program. Additionally, wide variability occurred between facilities in regards to revenue, costs, care related expenditures and quality scores. The relationship between VBR reimbursement, costs, expenditure decisions and care quality remained unclear.

The goal of the qualitative component of the VBR evaluation was to explore contextual influences on facility decision making and perceptions of VBR in order to illuminate the results of quantitative analyses and inform MN VBR policy decisions to optimally align reimbursement policies, facility costs, and expenditure decisions to increase care quality. Data collection tasks completed to address that goal included:

- Targeted discussions with two state quality council groups
- Two focus group interviews comprised of quality specialists and facility administrators
- A survey of nursing home clinical leaders from throughout the State
- A targeted survey of quality experts

The methods, findings, and key summary points from the qualitative component of the VBR evaluation are discussed in this report.

Quality Council Discussion Groups

Discussions were held with the quality councils from Care Providers (9/9/20) and Leading Age (9/10/20). Each meeting lasted one hour, utilized a virtual platform, and was facilitated by Kathleen Abrahamson. Five quality council members participated in the Care Providers discussion, and approximately 15 persons participated in the Leading Age discussion. Representatives from the Minnesota Department of Human Services were present at both meetings. The discussion was focused upon the following questions:

1. How is quality information managed and communicated with in your facility teams? What persons/ roles are most involved in thinking about quality improvement? Acting upon quality measures?

2. What factors influence the relationship between performance on quality measures and spending? What are your thoughts on the general relationship between costs and quality?
3. What are some ways that the MN VBR program can best promote spending decisions that have a high impact on both care quality and cost efficiency?
4. We are interested in input on some of the specific MN quality indicators (QIs). In general, what are your thoughts on the quality indicators that address incontinence and toileting? Do the measures accurately reflect care quality in this area?
5. Similarly, we are interested in the MN QIs that address mobility and function. Do those measures accurately reflect care quality? Are those measures reflective of resident improvements or efforts to reduce decline?
6. Are there some MN quality indicators that you do not find useful or reflective of care quality? Why, and how could they be improved?
7. How could the MN quality indicators better address clinical areas that you see as top priority? Are there QIs that you find especially helpful in your decision making?

Meetings were recorded, and two VBR evaluation personnel (KA and KC) reviewed audio recordings and developed themes from participant responses. Common themes and ideas that emerged within the two meetings are noted below.

- **Poor care is costly, and financial success is tied to quality**

High functioning facilities are less likely to suffer costly outcomes such as poor inspection results, resident complaints, fines, and pressure ulcers. High quality facilities in general see financial success by providing a better product to the consumer.

- **Care cost related decisions are dependent upon leadership**

Improving state average and rank is important, and the link between costs and quality is often top-down, initiated by leadership and aimed at focusing on the most responsive measures. Some outcomes are able to be changed just by improving documentation and have lesser impact.

- **Performance on quality indicators (QIs) impacts decisions on resource allocation, but the relationship is often indirect and unclear**

It is common for staff committees to identify priority QIs at the facility level, which then are used to influence staffing and spending decisions. However, decisions of which QIs to target and how to allocate resources are frequently made independently from each other; staff suggest areas of quality improvement without consideration of costs or spending. It is often not a 'spend X to get Y' decision at the facility level.

- **The relationship between spending and care quality could be improved if facility staff had more information**

Knowing how to allocate funding to improve quality outcomes is a struggle for facility providers. Good quality should be reimbursed, but difficult to determine how best to target efforts to get rewarded for improved quality. Targeting information about costs and quality performance to facility level QAPI committees could assist in tightening the link between QIs and resource allocation. Programs like PIPP encourage a team approach, which is good. It is usually leadership who makes spending decisions based upon reimbursement, but a team approach that involves staff committees in that decision has a stronger impact on quality and should be encouraged.

- **QIs and VBR are complex and often not fully understood by those making decisions in facilities**

Requirements are difficult to explain to busy providers with other pressing priorities. The multitude of systems and programs (federal, state, multiple measures) contributes to the challenge of using the information to guide decisions at the facility level. A clearer understanding of the quality add-on's would also help decision making.

Particularly, lessening the number of QIs would be helpful. Too many areas to address with few resources, particularly in comparison to how hospitals are evaluated. The addition of more processes measures, which tend to be more easily understood by staff, as well as increased education and engagement with the program for nursing home staff would also be helpful.

- **Accuracy is key to quality measurement; measures do not always reflect the actual quality culture within a facility**

There is interest in creating more robust and broad measures that reflect overall quality, as opposed to many individual measures that each reflect only a small part of care. Examples included staff engagement, organizational culture, and organizational effectiveness. Defining quality more broadly would more accurately reflect quality, and be more understandable to staff who get frustrated when their efforts are reduced to a number and ranking. The QIs reflect one version of quality, 'DHS's version', and staff often have a different perception of what constitutes quality care.

The quality of life (QOL) measure is frustrating due to point in time measurement and a sampling approach that may not reflect the preferences of current residents. The way the measure is reported creates a 'norm' they aim to improve that often does not reflect the total culture of their facility. Suggestions included ongoing resident and/ or family focus groups to move beyond point in time and beyond rigid survey measures.

- **Person-centered quality and resident choice**

Calculating QI scores using the MDS is rigid and does not reflect variation in resident choices. This is particularly true of the incontinence QI, when some residents refuse active toileting plans in exchange for sleep or activities if incontinence management products are working well. Complete continence is a challenge and often not the resident's goal.

Overall there was a tone of wanting more comprehensive measurement and less dependence on the MDS for measures.

- **Punitive programs less motivating**

The system as a whole is too punitive, and positive programs such as PIPP are appreciated. More incentive type programs are needed. PIPP and QIIP are simple, understandable, narrow in focus, with clear timelines. Those programs are motivating. They also encourage much needed innovation, where as avoiding punishment for not meeting a threshold does not. These programs were viewed as financially lucrative as well.

- **VBR reimbursement threshold**

A stronger threshold is needed for the VBR reimbursement system that would have more impact on facilities. As it is now, the impact is very minimal on most facilities. The VBR score should be simpler and more understandable. It is not always clear how to improve the score, and QI efforts can feel like ‘throwing spaghetti to the wall to see what sticks’. Difficult to be strategic.

- **QIs that are clearly measured and responsive to QI effort are the most effective**

Infections, UTIs, antipsychotics (when prescribers are on board), and weight loss were described as well-measured and responsive QIs. Weight loss was helpful in that it creates a warning sign that can be acted upon to avoid clinical decline.

QIs that are measured most objectively are the easiest to manage, and adjusters/ exclusions can have a large effect on some scores (particularly weight loss and anti-psychotics). Adjusters and exclusions are not always well-understood at the facility level, furthering confusion.

- **Feedback on specific QIs**

- Incontinence is challenging to change and frustrates staff; measured too rigidly and staff unlikely to choose as a QI focus due to difficulty moving the score; inconsistent case mix reviews have exacerbated the problems with the QI, as have differences between federal and state measures.
- Incontinence, pain and behavior were the most commonly noted measures of difficulty. Weight loss, mobility and infections were the most commonly noted measures of clarity.
- Behavior score is very dependent upon your population, and is determined by your population more than your overall quality. A resident’s behavior may be dealt with appropriately and still continue daily depending on the resident’s diagnosis. Not always changeable or a measure of care quality.
- Pain is subjective, it is difficult to obtain the goal of no pain, and the differences between federal and state QIs in this area are confusing. Pain measure could be improved by bringing in assessments other than the MDS.
- Short stay pain is very dependent upon your population and unstable over time as the population changes.
- Restraints are so infrequently used that it is an easy success, but not reflective of overall quality

- Mobility measures are highly responsive and are a good focus to engage therapy staff with nursing. Walking and range of motion are particularly hard to move in the long stay population, which depresses scores, but progress can be made with effort and the measures reflect that effort.
- Overall number of falls is important to measure, as opposed to only falls with injury, because it is an example of an adverse event with potential impact, has a close connection with quality of care, and can impact QOL. One time big falls with injury are often related to other comorbidities, and frequent falls without injury allows for examination of the root cause of a quality problem. Frequent falls are important to families and also insurance companies.
- Weight loss makes an excellent PIPP outcome; it is clearly measured, responsive to efforts, and pairs well with other important aspects of quality such as skin care. QOL is a challenging PIPP outcome for reasons of measurement and subjectivity.
- **The Covid-19 Pandemic**

The pandemic has tightened resources, created immediate needs that take time away from strategic planning, and caused worries about possible systems changes as a result of pandemic related changes to care delivery and reimbursement. It was also noted that the pandemic is forcing some innovation, which could have a positive effect in the long term.

It is difficult to measure quality meaningfully now because of unique circumstance. Facilities are seeing dramatically increased use of pool staff. Also tired, stressed out staff. Mobility measures are changing as residents are confined to their rooms: less improvement in walking and increased falls. Anticipating changes in depression, behavior and weight loss QIs as the pandemic continues.

Focus Group Interviews

Focus group interviews were convened with the objective of obtaining provider perspectives from a sample of MN administrators and quality experts beyond the sample of providers that participated in the Leading Age and Care Provider quality councils. The goal was to triangulate data from three sources: discussion groups, focus group interviews, and surveys in order to obtain a comprehensive portrait of provider perspectives. Sampling, respondent invitation procedures, and discussion topics were approved by the Purdue University Institutional Review Board (IRB) prior to contacting respondents. A list of potential participants was provided to the research team by MN DHS, and invitation letters to participate in the focus groups were sent to 31 individuals from across the state. Focus group participants were divided into two separate interviews, one comprised of quality managers (10/22/20), and one comprised of administrators (10/23/20). Both interviews were held on a virtual platform, recorded, and moderated by Kathleen Abrahamson. Interview questions mirrored those used in the quality council discussions noted above, and focused upon quality measurement, the relationship between costs and quality, perceptions of the MN VBR, and other topics as directed by participants. In total data was collected from 7 participants; 5 quality managers and 2 administrators. Both meetings lasted approximately 1 hour. Because of the small sample size data is combined for the two groups in the findings section of this report to de-emphasize the input of any one individual. In

both groups each participant contributed to the conversation and data. Representatives from MN DHS were not made aware of who participated in these groups, and potentially identifying information such as facility location of participants will not be included in this report.

Audio recordings of the interviews were reviewed by two members of the research team (KA, KC), who individually took notes and identified pertinent themes within the data. Both analysts then reviewed the notes and discussed the themes until consensus was reached regarding the content of respondent statements. Results are provided as a list of over-arching themes supported by respondent comments presented in aggregate related to that theme.

- **Achieving excellent quality scores is rewarding**

Respondents in both groups noted the value of achieving high quality scores in regards to facility pride, community relations, recruitment of residents and staff, communication to boards of directors/ trustees, and motivation to continue hard work when times are challenging. In addition, despite the concerns surrounding quality measurement addressed in this report, it was noted multiple times in both interviews that QIs, in general, reflect care quality.

- **It takes investment to achieve high quality**

Investment in staffing is important, and VBR has assisted with wage increases. Spending decisions often revolve around the wants and needs of the staff more than any single quality indicator or quality score focus. That is particularly true of capital investments for equipment that may improve the efficiency or effectiveness of staff time. The VBR appeared to influence spending in that it increased revenue, but had little impact on resource allocation. There was agreement that the QIs were not “real time” and “not my go to” for spending decisions. Appreciation was noted for the PIPP program which creates tangible revenue through rate increases, removing the ‘lag’ of VBR.

- **VBP has little risk or impact on high performing facilities**

Respondents felt that most facilities, particularly those that are high performers, do not see the VBR threshold as a financial risk. The threshold may matter more for low performing facilities who struggle to achieve their goals. It was noted that because of rate equalization it can be difficult to increase revenue to invest in quality, and that for most facilities VBR provides a rare opportunity to see a revenue increase. However, respondents perceived a “performance punishment” for high performing facilities on some measures; they cannot improve given they have reached the top level of performance

- **The lag in reporting is a significant barrier to the use of quality indicators (QIs) for decision making**

A dominant theme throughout was frustration over the time gap between data submission for QIs and data reporting. Respondents noted they were often addressing different challenges, and perhaps a different set of residents, by the time QIs were reported for their previous efforts. Statements included, “We are on to something else by the time our scores are received” and “By the time we see the scores it is hard to remember what we were doing right”. They found this

particularly frustrating for direct care staff, who see a low QI score that may be related to a past resident, event, or challenge as not reflective of their current care efforts. “The delay in reporting makes it hard to celebrate our successes.” Respondents noted that negative events and poor performance on QIs “hangs with facilities for a long time”, which is frustrating to staff who feel they have made improvements.

The quarterly reporting of measures was mentioned frequently as a frustration in both groups, who found the reports arrived with such a delay that they were not useful. It was noted that Federal measures, reported more frequently and able to be tracked at the resident level, were most helpful to care staff in identifying issues and targeting interventions.

Relatedly, VBP payment is retrospective, which poses a challenge to stand-alone facilities who cannot diversify services or off-load costs in another area. A more timely system would improve the ability to invest in measurable quality.

- **Documentation plays a key role in performance on some QIs**

Respondents noted that Minimum Data Set (MDS) coding plays a significant role in performance on some QIs. A challenge to the validity of the measures is the variation in interpretation between facilities on some MDS items such as pressure ulcers, incontinence, and functional independence. “Everyone needs to play at the same level” for scores to be ranked or compared. Risk adjustment is necessary but confusing to staff, and targeting efforts becomes difficult when they are unsure “who is counted”. It was noted that nursing staff tend to document the highest level of function and may underestimate the amount of care or supervision they are providing, or may struggle to measure some indicators in their documentation such as level of incontinence.

- **Risk adjustment is necessary but confusing**

Respondents felt their staff did not always understand risk adjustments, “exclusions”, and “what triggers something and what does not”. It was noted that the exclusions should remove individuals for which the facility cannot influence the outcome, but this is not always the case. Examples provided included declines in mobility and incontinence. Respondents noted that often the staff feel they are helping the resident and providing good care, but then a decline happens because the resident is “not going to get better” and they are not given credit for their efforts. Examples of areas where risk adjustment could be improved included mobility exclusions for residents with neurological conditions, excluding some multi-use drugs such as Abilify from the anti-psychotic QI when used for depression, and excluding schizophrenia or related conditions from the QOL mood domain.

- **A more comprehensive view of quality is needed**

Federal and state measures differ, and there are many of them, and risk adjustment varies, which creates a system that one respondent described as “so complex it turns into a crap shoot”. Overall quality, aiming for a culture of quality and caring, and retaining good people were noted multiple times as more important indicators for decision making than tracking individual QIs. “What is the overall quality of our residents’ lives” was noted as more important than data. “The human component is missing from the data”, with family and staff relationships, and a lack of family

complaints given as examples of indicators of quality. Respondents particularly noted feeling powerless to improve performance on individual questions or domains in the quality of life (QOL) assessment. One respondent noted in regards to the challenge of addressing the QOL scores, “If you can improve the overall culture your scores will improve.”

- **Frustrations with the QOL measure**

Another significant theme in both groups was frustration regarding the QOL measure. Concerns included the annual survey which provided a ‘snap shot’ of one point in time that providers felt did not reflect the overall resident experience and was highly influenced by the events of the few days prior to the survey. It was noted that facilities could plan events or changes just prior to the survey to influence results. One facility used the QOL measure to guide the facility’s own regular assessment of targeted areas. Relatedly, respondents expressed concern that residents who are able to converse and answer questions may not have the ability to look-back over a week to respond to questions in a valid manner, such as residents with memory issues. There was concern that the results are lagging, and that staff feel disheartened when scores are low in QOL. Staff complain that results are not “real time” and do not reflect the true quality of life for residents.

The small sample can mean that a few negative answers can have a large effect on the facility score. A question that raised concern asks about having friends in the facility, and providers suggested a change to ‘is there anyone in the facility you look forward to seeing’ to reflect overall relationship quality in the facility as opposed to the varying definition of what it means to be a friend among residents. In addition, concerns were raised surrounding the Mood domain of the survey. Respondents discussed feeling like the survey was developed at a time when the industry and resident populations were very different than now, and that the QOL scores were not usable to improve actual quality.

- **Reflections on individual quality measures**

- Pain is difficult to improve, and staff feel powerless to make change in that area. It is very dependent upon your population, particularly for short stay residents. Addiction issues are important to address, and reports of pain often vary depending upon who is asking and in what context. The 7-day ‘look back’ on the MDS exacerbates the problem of pain measurement. Some pain may be inevitable with some conditions, such as arthritis, so it is challenging to achieve the goal. Also, having pain or not may not be a good measure of quality of care as long as the pain does not affect ones’ physical activities.
- Falls with major injury was recommended to be removed from the report card. The reasoning was that the outcome of injury was more related to the co-morbidities and condition of the resident than to the care provided. Two residents could fall and have different outcomes regardless of staff actions, and a resident may fall despite high quality care.
- Decline in function is frustrating to staff given some decline may be inevitable and not a reflection of poor care.

- Toileting without a plan is an easy measure to ‘fix’ given all that is needed is the addition of a plan. In that sense it does not capture quality of care, but is easy to move the needle. Case mix reviewers provide challenges to this measure, which can be frustrating.
- The way incontinence is measured does not reflect the quality of care provided. Someone can have small leakage and it is not reflective of staff efforts to assist the resident to the toilet. One respondent felt the measure ‘shamed’ residents who have minor incontinence by describing something normal as a poor outcome, and others agreed. Overall, there was frustration over measures where staff felt they had little impact on outcomes despite providing quality care.
- The short stay measures include residents who enter with a goal for an extended stay, which ‘muddies the water’ in trying to interpret short stay measures.

- **Appreciation of assistance from DHS**

Respondents appreciated the technical assistance from DHS, particularly in the interpretation of data and assistance to develop QI programming. It was acknowledged that DHS allows them to “have a voice” in the process, which was appreciated.

Provider Surveys: statewide survey

An online survey was distributed to MN nursing facility administrators and clinical leaders with the objective of obtaining a wider sample of provider perspectives to supplement and illuminate data obtained in the group interviews. The goal was to triangulate data from three sources: discussion groups, focus group interviews, and surveys in order to obtain a comprehensive portrait of provider perspectives. Sampling and respondent invitation procedures were approved by the Purdue University IRB prior to contacting respondents. A list of potential participants was provided to the research team by MN DHS, and invitation letters were sent to 421 individuals from across the state. Survey distribution began on 10/13/20 and ended on 11/8/20, with reminders sent to potential respondents during weeks 1 and 3 of distribution.

The statewide survey included seven sections: 1) Quality Measures and the Quality Report Card, 2) Weighting of components in the VBR equation, 3) Challenges regarding quality measurement, use of quality data, and participation in the MN VBR program, 4) Approach to improving care quality and participation in the MN VBR program, 5) The relationship between costs and quality, 6) The impact of COVID-19, and 7) Other feedback. The final statewide survey included 42 Likert-style items and 4 open-ended questions to collect additional feedback. The surveys also collected respondents’ demographic characteristics such as organization name and primary location, primary job title, job tenure, and the highest level of education.

- **Findings**

Twenty-nine of the 421 potential respondents completed the survey, a response rate of approximately 7%. It is likely that the low response rate is related to the Covid-19 pandemic

response efforts being expended by facility leaders throughout the state, although that cannot be determined definitively. Results, while informative, should be viewed in light of the small and likely non-representative sample size.

The 29 respondents reported the following job titles: administrators (52%), director of nursing (28%), quality coordinator (7%), assistant administrators (7%), or other quality leaders (10%). Respondents had been in their role for an average of 9 years (range 0.2-32), in their organization for an average of 12 years, (range 1-42), and in the nursing home industry for an average of 22 years (range 4-50). Eighty-nine percent of respondents had a bachelor's degree or higher, with 21% reporting a graduate degree.

Respondents were asked to report their level of understanding of the MN quality measures, the MN quality report card, and the MN VBR program. The majority (93%) reported at least of basic understanding of the quality measures, at least a basic understanding of the report card (96%), and the VBR program (86%).

Descriptive results are presented below based on each portion of the survey.

- **Quality Measures and the Quality Report Card**

Respondent perceptions of the clarity, validity, and usefulness of quality measures and the quality report card varied. For example, 62% of respondents agreed or strongly agreed that it was clear how the quality measures are calculated, while 28% disagreed the calculation of quality measures was clear. Responses were almost evenly divided between agree/strongly agree and disagree/ strongly disagree in regards to whether the measures reflected actual quality and whether there was clarity surrounding selection of measures for the report card. More respondents felt positively than negatively about measures reflecting priorities, and more felt negatively than positively about the clarity of the selection of measures for the report card, but the differences were minimal reflecting a varied view of the quality measures and report card among respondents. Frequencies for the quality measures and quality report card portion of the survey are provided in Table 1.

Table 1. Quality measures and the quality report card frequencies

MN quality measures and MN quality report card	Strongly Disagree	Disagree	Neither agree nor Disagree	Agree	Strongly Agree	Don't Know or Not applicable
1. It is clear how MN quality measures are calculated.	0	8 (27.6%)	3 (10.3%)	12 (41.4%)	6 (20.1%)	0
2. Current MN quality measures reflect the actual quality of care in my facility.	2 (6.9%)	9 (31%)	8 (27.6%)	9 (31%)	1 (3.5%)	0
3. Current MN quality measures reflect my priorities for care quality.	1 (3.5%)	5 (17.2%)	8 (27.6%)	14 (48.3%)	1 (3.5%)	0
4. It is clear how quality measures are selected for the MN quality report card.	1 (3.5%)	9 (31%)	7 (24.1%)	9 (31%)	3 (10.3%)	0
5. The MN quality report card calculation includes the most important aspects of care quality.	1 (3.5%)	12 (41.4%)	5 (17.2%)	11 (37.9%)	0	0

○ **Quality measures and decision making**

There was variation in the responses to questions addressing quality measures and decision making, reflecting varying perceptions in the area among respondents. For example, an even number of respondents strongly agreed/ agreed and disagreed that quality measures impact spending decisions overall. Almost half of the respondents strongly agreed/ agreed that quality measures are person-centered (43%) and are important to public reporting (47%), but the number of respondents selecting the neutral or strongly disagree/disagree categories was notable for each of these items. Frequencies for the quality measures and decision making portion of the survey are provided in Table 2.

Table 2. Quality measures and decision making frequencies

Quality measures and decision making	Strongly Disagree	disagree	Neither agree nor Disagree	Agree	Strongly Agree	Don't Know or Not applicable
1. MN Quality measures impact my spending decisions overall	0	12 (42.9%)	5 (17.9%)	9 (32.1%)	2 (7.1%)	0
2. MN Quality measures impact my spending decisions on staffing	0	13 (46.4%)	6 (21.4%)	7 (25%)	2 (7.1%)	0
3. MN Quality measures are person-centered and useful for individual care planning	2 (7.1%)	8 (28.6%)	6 (21.4%)	10 (35.7%)	2 (7.1%)	0
4. MN Quality measures and public reporting are important to our residents and families	2 (7.1%)	5 (17.9%)	8 (28.6%)	8 (28.6%)	5 (17.9%)	0

○ **VBR policy and decision making**

Over half of the respondents strongly agreed or agreed that VBR policy impacts spending overall (55%) and spending on staffing (52%), though the selection of the neutral category was sizable and the difference between those percentages and the percentage that selected strongly disagree/disagree was not sizable. Forty-five percent of the respondents noted that VBR policy promotes decisions that improve care while 31% disagreed. Thirty percent of the respondents noted that VBR accurately reflect what is needed to provide care while 35% disagreed. Most respondents (66%) strongly agreed/ agreed that VBR promotes data-based decision making. The frequencies for the items addressing VBR policy and decision making are noted in Table 3.

Table 3. VBR policy and decision making

VBR policy and decision making	Strongly Disagree	Disagree	Neither agree nor Disagree	Agree	Strongly Agree	Don't Know or Not applicable
1. MN VBR policy impacts my spending decisions overall	0	6 (20.7%)	7 (24.1%)	9 (31%)	7 (24.1%)	0
2. MN VBR policy impacts my spending decisions on staffing	0	6 (20.7%)	8 (27.6%)	8 (27.6%)	7 (24.1%)	0
3. MN VBR policy accurately reflects what is needed to provide quality care in my individual facility	1 (3.5%)	10 (34.5%)	9 (31%)	6 (20.1%)	3 (10.3%)	0
4. MN VBR policy promotes decisions that improve actual care quality for our residents	0	9 (31%)	7 (24.1%)	10 (34.5%)	3 (10.3%)	0
5. MN VBR policy encourages data-driven leadership	0	3 (10.3%)	7 (24.1%)	16 (55.2%)	3 (10.3%)	0

○ **Weighting of components in the VBR equation**

Respondents were provided with the current VBR equation and asked to create what they perceived to be an ideal weighting of components for the VBR equation based upon their experiences. Average responses somewhat mirrored the actual VBR equation for the long-stay residents with a lesser emphasis on QOL measures and increased emphasis on family satisfaction and state inspections than is currently used. It should be noted that the standard deviation for these averages is wide, indicating variability or lack of consensus among responses, and that averages are impacted by scores at the outside of the range such as zero, which was provided by respondents for the QOL and family satisfaction measures. Responses for the long stay equation are visualized in Table 4.

Table 4. Long-stay quality equation

	DHS score	Mean	Std. Dev.	Min	Max
Clinical Quality Indicator Score	40	40.7	16.9	10	90
Resident Quality of Life Ratings	40	34.1	13.8	0	55
Family Satisfaction Ratings	10	13.8	8.3	0	30
State Inspection Results	10	11.4	5.2	5	30

Responses addressing the short-stay quality equation differed from the current equation with respondents placing less emphasis on hospitalization and more emphasis on pressure ulcers and pain. Similar to the long-stay measures, the wide standard deviations and tendencies for means to be influenced by responses on the end of the range such as zero should be noted.

Table 5. Short-stay quality equation

	DHS score	Mean	Std. Dev.	Min	Max
Resident Experience Ratings	50	49.7	12.7	20	80
Percent of Hospitalizations	30	22.2	7.5	0	30
Prevalence of New or Worsening Pressure Sores	5	10.2	6.3	0	25
Prevalence of Residents who Report Moderate to Severe Pain	5	7.8	5.6	0	20
State Inspection Results	10	10.37	4.99	0	25

○ **Challenges regarding quality measurement, use of quality data, and participation in the MN VBR program**

Respondents were asked to report on the level of challenges posed by various aspects of implementing QI and participating in the VBR program. All respondents noted that staff turnover and time to plan quality efforts was at least somewhat challenging, and most noted that each of the other categories presented a challenge, with collecting data being the category with that respondents felt posed the least challenge. Responses regarding VBR program challenges are noted in Table 6.

Table 6. VBR program challenges

Challenges	Extremely Challenging	Challenging	Somewhat Challenging	Not at all Challenging	Don't know or Not applicable
1. Staffing levels or staff turnover.	14 (48.3%)	10 (34.5%)	5 (17.2%)	0	0
2. Limited financial resources to improve quality.	7 (24.1%)	10 (34.5%)	9 (31%)	3 (10.3%)	0
3. Time to develop and plan quality improvement efforts.	7 (24.1%)	11 (37.9%)	11 (37.9%)	0	0
4. Balancing the need to improve multiple quality measures; prioritizing measures to target.	2 (6.9%)	17 (58.6%)	8 (27.6%)	2 (6.9)	0
5. Collecting data to inform targeted quality improvement.	1 (3.5%)	8 (27.6%)	14 (48.3)	6 (20.7%)	0
6. Seeing improvements in quality that are not reflected in the MN quality report card.	4 (13.8%)	13 (44.8%)	8 (27.6%)	4 (13.8%)	0
7. Balancing improvement in quality measures with individual resident needs.	7 (24.1%)	12 (41.4%)	6 (20.7%)	4 (13.8)	0

○ **Approach to improving care quality and participation in the MN VBR program**

Respondents were asked to provide input on their efforts to improve their performance on quality measures. Consistently, the majority of the respondents strongly agreed or agreed that the facilities have used each of the listed approaches to improve their performance on quality measures. Approaches and their responses for approving the performance on quality measures are noted in Table 7.

Table 7. Approaches to improving performance on quality measures

To improve our quality measures, we:	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Don't know or Not applicable
1. Identify specific roles and responsibilities of team members involved with our quality improvement efforts.	1 (3.5%)	0	2 (6.9%)	15 (51.7%)	10 (34.5%)	1 (3.5%)
2. Have clear tasks and timelines.	1 (3.5%)	1 (3.5%)	5 (17.2%)	14 (48.3%)	8 (27.6%)	0
3. Regularly meet with team members and other staff.	1 (3.5%)	0	3 (10.3%)	4 (37.9%)	14 (48.3%)	0
4. Gather regular feedback on the progress of quality improvement efforts and resource needs.	1 (3.6%)	0	3 (10.7%)	14 (50%)	10 (35.7%)	0
5. Have a plan to assess our quality improvement efforts.	1 (3.5%)	1 (3.5%)	3 (10.3%)	14 (48.3%)	10 (34.5%)	0

○ **The relationship between costs and quality**

Respondents were asked to provide their opinions on the relationship between costs and quality. Most respondents strongly agreed or agreed that providing high quality care costs more than providing lower quality care (59%) and is cost effective (69%). However, the number of respondents selecting the neutral or strongly disagree/disagree categories on the impact of VBR program on quality care provision was notable (55%). Similarly, most respondents did not agree that residents and families look at facility quality scores when selecting the facility (62%). Responses regarding the relationship between cost and quality are noted in Table 8.

Table 8. The relationship between cost and quality

In regards to costs and quality:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Don't know or Not applicable
1. It is cost effective to provide high quality care.	3 (10.3%)	2 (6.9%)	4 (13.8%)	9 (31%)	11 (37.9%)	0
2. High quality care costs more than providing care of lower quality.	1 (3.5%)	7 (24.1%)	4 (13.8%)	10 (34.5%)	7 (24.1%)	0
3. Residents and families look at my quality scores when selecting my facility.	3 (10.3%)	3 (10.3%)	12 (41.4%)	7 (24.1%)	2 (6.9%)	2 (6.9%)
4. Poor care is more expensive to provide than high quality care.	4 (13.8%)	5 (17.2%)	4 (13.8%)	8 (27.6%)	7 (24.1%)	1 (3.5%)
5. In general, the reimbursement provided through the MN VBR program enables my facility to provide high quality care.	3 (10.3%)	2 (6.9%)	11 (37.9%)	8 (27.6%)	4 (13.8%)	1 (3.5%)

6) The impact of COVID-19

Respondents were asked to provide input on the impact of COVID-19 on aspects of care and quality measurement. The majority of the respondents noted that there has been a change in the culture of their organization (62%), their facilities had adequate amounts of personal protective equipment (76%) and had maintained performance on quality measures (62%). However, the majority of the respondents did not agree (in strongly disagree/disagree or neutral categories) that reimbursement has been adequate to meet their needs (79%). Similarly, the majority did not see the COVID-19 situation as an opportunity to make needed changes (82%). The majority noted that staff turnover has increased (89%), staff absenteeism has increased (72%) and there have been challenges maintaining staffing levels (73%). The majority of the respondents strongly disagreed or disagreed about the clarity and consistency of the messaging from government agencies regarding COVID-19 (76%). Responses regarding the impact of COVID-19 are noted in Table 9.

Table 9. The impact of COVID-19

Since the onset of the COVID-19 pandemic:	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Don't know or Not applicable
1. We have maintained our performance on quality measures.	0	5 (17.2%)	3 (10.3%)	17 (58.6%)	4 (13.8%)	0
2. We have maintained our staffing levels.	5 (17.2%)	12 (41.4%)	4 (13.8%)	7 (24.1%)	1 (3.5%)	0
3. Our staff turnover has increased.	2 (6.9%)	3 (10.3%)	3 (10.3%)	12 (41.4%)	8 (27.6%)	1 (3.5%)
4. Our staff absenteeism has increased.	2 (6.9%)	6 (20.7%)	2 (6.9%)	11 (37.9%)	7 (24.1%)	1 (3.5%)
5. We have had adequate amounts of personal protective equipment.	1 (3.5%)	4 (13.8%)	2 (6.9%)	18 (62.1%)	4 (13.8%)	0
6. Reimbursement has been adequate to meet the needs of our residents and facility.	5 (17.2%)	9 (31%)	9 (31%)	5 (17.2%)	1 (3.5%)	0
7. Messaging from government agencies has been clear and consistent.	12 (41.4%)	10 (34.5%)	3 (10.3%)	3 (10.3%)	1 (3.5%)	0
8. This was an opportunity to make needed changes.	4 (13.8%)	8 (27.6%)	12 (41.4%)	4 (13.8%)	1 (3.5%)	0
9. There has been a change in the culture of our organization	1 (3.5%)	3 (10.3%)	7 (24.1%)	12 (41.4%)	6 (20.7%)	0

7) Other feedback.

Respondents were asked to answer three open-ended questions regarding quality measures, the MN quality report card, VBR policy and the preparation during infectious diseases outbreaks/pandemics. Nineteen of the 29 survey respondents provided some feedback in at least one of the three questions. Because of the small sample size, the respondents' feedback is presented in list format to de-emphasize the input of any one individual. Respondents' original feedback is provided in Appendix A.

- **Summary of survey findings**

There was wide variability within many of the response categories, and the small and likely non-representative sample limits the interpretability of survey findings. However, some response patterns can be noted. Staffing, particularly during the COVID-19 pandemic, emerged as a challenge for many providers. It was also expressed that the provision of quality care is cost effective but also requires resources, that quality measures data-driven decision making in facilities. The variable responses to survey items asking about the relationship between spending, QI performance, and VBR is consistent with findings from group interviews which noted an unclear and often indirect relationship between these constructs.

Provider Surveys: expert panel

An online survey was distributed to MN nursing facility administrators and clinical leaders with the objective of obtaining expert perspectives on specific quality measures. Sampling and respondent invitation procedures were approved by Purdue University Institutional Board (IRB) prior to contacting respondents. A list of potential expert panel participants was provided to the research team by MN DHS, and invitation letters were sent to 61 individuals in the expert panel. Survey distribution began on 10/26/20 and ended on 11/8/20, with reminders sent to potential respondents during week 1 of distribution.

The expert panel survey included two sections: 1) Rating specific quality measures and the VBR equation, and 2) Rating structural quality measures on the report card. The final expert panel survey included 32 items. The surveys also collected respondents' demographic characteristics such as organization name and primary location, primary job title, job tenure, and the highest level of education.

- **Findings**

Seven of the 61 potential respondents completed the survey, a response rate of approximately 11%. Similar to the statewide survey, it is likely that the low response rate is related to the Covid-19 pandemic response efforts being expended by facility leaders throughout the state, although that cannot be determined definitively. Results should be interpreted in light of the small sample size.

The 7 respondents reported the following job titles: administrators (n=2), director of nursing (n=1), quality coordinator (n=1), other quality leaders (n=2). Respondents had been in their role for an average of 7 years (range 2-12), in their organization for an average of 8 years, (range 2-17), and in the nursing home industry for an average of 27 years (range 4-50). Six respondents had a bachelor's degree or higher, with two reporting a graduate degree.

Respondents were asked to report their level of understanding of the MN quality measures, the MN quality report card, and the MN VBR program. All reported at least of basic understanding of the quality measures and at least a basic understanding of the report card. The majority (71%) reported at least of basic understanding of the VBR program.

Respondents were asked to rate each long-stay, short-stay and structural quality measure based on four criteria:

Importance: This measure addresses an important area of clinical quality. The measure addresses a key aspect of care quality.

Validity: This measure reflects actual care quality. This is a good measure of the quality of care that we provide in this area.

Responsiveness: It is easy to achieve improvements in this measure with appropriate efforts and actions. The efforts we make in this area are reflected by changes in this measure.

Usability: This measure is useful in our QI decision making. Tracking our data in this area help us to improve our care.

Respondent indicated their level of agreement or disagreement on the importance, validity, responsiveness, and usability from 1-5 where 1 = “Strongly Disagree”; 2 = “Disagree”; 3 = “Neutral”; 4 = “Agree”; 5 = “Strongly Agree”. Descriptive results are presented below based on each portion of the survey.

- **Long-stay Quality Measures**

Average responses for each long-stay quality measures are visualized in Table 10.

Overall, the responsiveness (i.e., being easy to achieve improvements) of long-stay quality measures concerns the respondents more than other criteria. Quality indicators having a relatively lower responsiveness include the “Worsening or Serious Resident Behavior Problems”, “Worsening or Serious Bladder Incontinence”, “Prevalence of Falls with Major Injury”, and “State Inspection Results”. Most respondents agreed that all the long-stay measures address an important area of clinical quality. The validity of the measures “Worsening or Serious Resident Behavior Problems”, “Worsening or Serious Bladder Incontinence”, “Prevalence of Falls with Major Injury”, and “State Inspection Results” also caught some attentions. All long-stay quality indicators were considered as useful in QI decision making, except for “Prevalence of Physical Restraints”. It should be noted that the small size is very small and the standard deviations for some quality indicators are fairly wide.

Table 10. Long-stay quality measures (n=7)

	1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly Agree			
	Importance	Validity	Responsiveness	Usability
Clinical Quality Indicators	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Worsening or Serious Resident Behavior Problems	4.3 (.8)	2.7 (1.4)	2.1 (.7)	3.1 (1.5)
Prevalence of Depressive Symptoms	4.6 (.5)	3 (1.4)	2.7 (1.1)	3.1 (1.6)
Prevalence of Physical Restraints	3.6 (1.7)	3.3 (1.7)	2.7 (1.7)	2.7 (1.3)
Worsening or Serious Bowel Incontinence	3.4 (.8)	3.1 (1.2)	2.7 (.8)	3.1 (.7)
Worsening or Serious Bladder Incontinence	3.4 (.5)	2.6 (.8)	2.4 (.8)	3 (.6)
Prevalence of Occasional to Full Bladder Incontinence Without a Toileting Plan	3.6 (1.0)	3.3 (1.0)	2.7(1.4)	3(1.2)
Prevalence of Occasional to Full Bowel Incontinence Without a Toileting Plan	3.4 (.8)	3.6 (.8)	2.9 (1.2)	3 (1.2)
Prevalence of Indwelling Catheters	4.1 (.7)	3.7 (.5)	4 (.6)	3.6 (.8)
Prevalence of Urinary Tract Infections	4.1 (.7)	4 (.8)	3.4 (.5)	4.1 (.7)
Prevalence of Infections	4.6 (.5)	4 (.8)	3.9 (.9)	4.3 (.8)
Prevalence of Falls with Major Injury	3.9 (1.4)	2.3 (1.1)	2.1 (1.2)	3.1 (1.2)
Prevalence of Unexplained Weight Loss	4.1 (.7)	3.4 (.5)	3.3 (.5)	3.9 (.7)

	1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly Agree			
	Importance	Validity	Responsiveness	Usability
Prevalence of Pressure Sores in High-Risk Residents	4.1 (.9)	3.9 (.9)	3.6 (.8)	3.9 (.9)
Prevalence of Antipsychotics Without a Diagnosis of Psychosis	4.3 (.5)	3.3 (1.1)	3.1 (1.1)	3.4 (1.3)
Worsening or Serious Functional Dependence	4.1 (1.1)	3.2 (.8)	2.6 (.5)	3.6 (1.0)
Walking as Well or Better than Previous Assessment	4.1 (1.2)	3.3 (.8)	3 (.8)	3.4 (1.3)
Worsening or Serious Mobility Dependence	4 (1.2)	2.9 (.9)	3.3 (1.1)	4.1 (1.2)
Worsening or Serious Range of Motion Limitation	4.1 (1.2)	3.1 (.9)	2.7 (.8)	3.3 (1.0)
Prevalence of Residents who Report Moderate to Severe Pain	4 (1.2)	3.1 (1.2)	2.7 (.8)	3.4 (1.3)
Long-stay Resident Quality of Life Ratings	4 (.8)	2.9 (1.2)	2.3 (1.1)	3.3 (1.3)
Family Satisfaction Ratings	4.1 (.9)	2.7 (1.1)	2.7 (1.1)	3.4 (1.1)
State Inspection Results	3.9 (1.2)	2.6 (.5)	2.6 (.5)	3.3 (1.0)

- **Short-stay Quality Measures**

Average responses for each short-stay quality measures are visualized in Table 11.

Overall, all short-stay quality measures were considered as important, valid, responsive and useful in decision making. Again, it should be noted that the small size is very small and the standard deviations for some quality indicators are fairly wide.

Table 11. Short-stay quality measures (n=7)

	1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly Agree			
	Importance	Validity	Responsiveness	Usability
Short-stay Quality Indicators	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Percent of Hospitalizations	4.1 (.7)	3.6 (1.0)	3.1 (1.2)	3.7 (1.1)
Prevalence of New or Worsening Pressure Sores	4.4 (.8)	4.1 (.7)	3.3 (.8)	4.3 (.8)
Prevalence of Residents who Report Moderate to Severe Pain	4 (.8)	3.3 (1.0)	2.9 (.9)	3.3 (1.4)
Percent of Community Discharges	4 (.6)	2.9 (1.2)	2.7 (.8)	2.9 (1.1)
Short-stay Resident Experience Ratings	4 (1.2)	3.3 (.8)	2.6 (.5)	3.6 (1.0)
State Inspection Results	3.6 (1.0)	2.9 (.4)	2.9 (1.1)	3.4 (.8)

Structural Quality Measures

The “Proportion of Beds in Single Rooms” was flagged across four criteria as the least rated structural quality measure. The responsiveness of “Direct Care Staff Retention” and “Temporary Staff Agency Use” had relatively low rates. Average responses for each structural quality measure are visualized in Table 12.

Table 12. Structural quality measures (n=7)

	1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly Agree			
	Importance	Validity	Responsiveness	Usability
Direct Care Staff Hours per Resident Day	4.4 (.5)	3.7 (1.0)	2.9 (1.5)	3.6 (1.0)

	1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly Agree			
	Importance	Validity	Responsiveness	Usability
Direct Care Staff Retention	4.3 (.5)	3.9 (.7)	2.3 (1.0)	3.7 (.8)
Temporary Staff Agency Use	4.3 (.5)	4 (.6)	2.3 (1.1)	3.7 (.5)
Proportion of Beds in Single Rooms	2.7 (1.0)	2.4 (1.0)	2 (1)	2.4 (1.0)

Recommended Actions

A number of themes are intertwined throughout the four data sources for this report, and the provided recommended actions are based upon commonalities within the integrated findings from the qualitative component of the VBR evaluation. Findings from the quantitative portion of the evaluation are considered within these recommendations as well. It must be acknowledged that the small sample size, likely to do the Covid-19 pandemic response efforts, significantly limits the generalizability of these findings. Similarly, it is likely that those who volunteered to participate in the study, given the low response rate, do not fully represent the population of MN nursing home providers in regards to knowledge and expertise. The survey findings indicate that respondents perceived a very high level of knowledge regarding QI measurement, the MN quality report card, and VBR, and quality council discussions as well as the expert panel survey were specifically aimed at those with a high level of understanding. However, despite these limitations the reported findings are informative given the expertise of the respondents, and can be viewed as the perspectives of experts with in the population of MN nursing home providers.

Recommended Action: Reduce the number of QI’s

Participants in the quality council discussion groups and focus group interviews described QI’s that they felt were not useful, unnecessary and/or did not reflect care quality. This is consistent with the findings of the quantitative component of the VBR evaluation, which noted ceiling effects (inability to achieve improvements in score due to current high performance), lack of variability between some measures such that the measures do not discriminate between facilities in regards to quality, and groups of measures that may be measuring the same underlying construct and therefore could be eliminated to reduce complexity. The findings from the qualitative component indicate a need to examine the recommendations from the quantitative analyses and reduce the number of QI’s where possible.

Recommended Action: Focus on QI’s that are responsive to improvements in the care provided

Respondents from both interviews and surveys reported that QI’s may accurately measure a reported outcome, but the outcome measured may not be reflective of care provided and/or may not be able to be influenced by caregiving staff. They voiced frustration and concern that their care efforts were not acknowledged by some outcomes, and that risk adjustment helped with the

process but was often unclear or inadequate. Specific QI's noted as likely unresponsive include: incontinence (some incontinence is normal with aging and not a reflection of assistance provided with toileting); falls with injury (the amount of injury incurred is more an effect of resident frailty than staff supervision); pain (difficult to achieve no pain despite nursing efforts); behaviors (often occur despite staff intervention); and functional decline (may be unavoidable given the resident population). It is recommended that the QI's which providers perceive as unresponsive to their efforts be re-evaluated in light of the findings from the quantitative portion of the evaluation.

Recommended Action: Work toward a more comprehensive measure of quality

Providers described a vision of quality within their facilities that went beyond individual QI's, and discussed feeling frustrated that the areas they used to guide their view of how well their facility is performing were not included in the quality measures. Providers described relationships within the facility and with family members, lack of complaints, staff who appear happy at work, efficient daily operations, and general demeanor of residents as examples. There was a perception voiced in interviews that the reliance upon MDS measures and thresholds did not reflect the current focus of those in the industry who are forward thinking, and were based on the old, punitive way of thinking. Concerns regarding the QOL measure reflected some of the desire to measure quality of resident care more comprehensively. Additionally, the state-wide survey noted wide variance among respondents on whether QI's were person-centered, and interview findings noted a perception that the resident voice may be missing in some of the QI measures such as incontinence and mobility, contributing to the perception that a more comprehensive view of quality is needed. Although challenging, it is recommended to work toward a measurement process that captures a more global view of quality.

Recommended Action: Nursing facility staff would benefit from more knowledge and information regarding the inter-relationship between quality, spending, and VBR.

Consistent with the findings of the quantitative component of the evaluation, the relationship between costs, quality, VBR and spending decisions is unclear. Respondents were clear that there was a relationship, but survey responses reflected high variability in the perceived nature of this relationship and interview findings supported the lack of clarity in this relationship. Interview respondents described spending decisions as driven by leadership, yet heavily influenced by clinical staff who function within quality committees at the facility level, often with little understanding of how clinical decisions influence spending, or vice versa. It was recommended by respondents to provide quality committees with additional information regarding the use of purpose of QI data, the revenue implications of quality measurement and VBR, and particularly reasons for the time lags in state data. The state-wide survey noted a perceived strength in using data for decision making, so providing a wider group of nursing home staff with information to better understand the universe of factors which influence spending and quality decisions would build upon a current strength and further engage direct care staff as experts in resident care.

Recommended Action: The VBR threshold must be tightened to be meaningful to high functioning facilities

Consistent with the findings from the quantitative component of the evaluation, the current VBR threshold does not appear to provide meaningful direction to facilities who are currently meeting the quality standard. Interview respondents reported feeling positively about the VBR program in terms of revenue, but not in terms of using VBR performance to guide decisions. This finding is supported by the state-wide survey, where respondents were almost evenly divided in their view of the usefulness of VBR for decision making.

Appendix A

Statewide Survey: Other feedback

1. What feedback do you have regarding quality measures and the MN quality report card?

- Taking action for the appearance of action is inefficient.
- Some things are flagged for too long such as a fall with major injury and certain medications.
- Antipsychotic domain should be adjusted for behavioral health facilities
- I don't see the value in having state-specific quality measures and report card when we have the federal equivalent at Nursing Home Compare.
- Assigning value to questions asked by interviewers who lead residents to answer negatively is wrong. Putting weight on the answers by residents who are cognitively impaired and unable to give a rational answer is wrong.
- Being evaluated by the answers of families who have never set foot in the facility and have no idea what we do to care for the residents is wrong.
- Encouraging hospitals to send us unstable admissions that we end up needing to send back for the higher level of care they need and then spinning that in a way that penalizes us in the name of quality is wrong.
- The nursing home report card has limitations. Some items are inappropriately listed - such as private rooms - for us, private rooms are a factor of government reimbursement limitations - not intent. Also, the use of Temp Agency staffing is related to economic/unemployment conditions in a geographic space - and not necessarily reflective of quality.
- When the MN QI data goes back a full year, all information is not up to date. i feel the Federal Quality Measures that are received for each month/quarter are more relevant to the current situation.

- MN QI Reports are received >6 weeks after the report date so is hard to determine accurate data in a timely manner for our Quality meetings and for the PIP grants.
- It is important to keep the technical guide current. Sometimes it is difficult to know what residents have affected the score. Would be nice to see a way to drill down to that resident - much like the Casper report.
- Continue to have a quality resource available to assist facilities in interpreting their reports and also provide a resource for known best practices in improving a quality score - that will eliminate each facility trying to re-invent the wheel
- It has been a very difficult time for LTC facilities due to the Covid-19 pandemic. Quality measures and focus has been difficult due to the need to constantly be aware of and create policy for Covid-19. Quality improvement is very important but has been challenging during this time. It would be good if the data was more current.
- More timely reports would improve the use of the MN Quality Measures
- I don't receive anything from MN about quality measures and the MN Quality report cards.
- Measures that require programs to be put in place should not be a part of quality since most facilities cannot meet them i.e. Bladder incontinence without a toileting plan. The toileting plan is not attainable as required by this measure. Same thing with Restorative Nursing.
- Additional responsibilities that SNFs now have as a result of COVID are going to greatly affect quality measures as staff time has at times been shifted to focus on screening and testing of staff and residents for example, per the new CMS and state requirements. SNFs are experiencing staff challenges the way it is and to place additional burden on them is unfortunate not only for the staff, but primarily for the residents receiving the care.

2. What feedback do you have regarding MN VBR policy?

- Basing reimbursement on the level of quality will hurt facilities that need more resources to improve quality. I would be similar to reducing classroom time for students that test poorly.
- Short Stay should not be included in VBR, not all facilities serve short stay residents.
- I have no feedback on MN VBR policy at this time
- VBR policy has been extremely beneficial and pulled many facilities back from the brink of closure in 2016. We are still working to wisely spend toward quality as our rates slowly catch up because of the 18-month lag. With cash flow issues, it takes time to get to where we want to go (like finding and paying for talent in the QA area).

- Another issue, the MN legislature never has addressed the property payment portion of our rates and so replacing buildings and fixed assets is still very much limited.
- A BIG fear is that we will go backwards towards the abyss if MN reneges on their VBR promise, now that MN has spent \$Billions on COVID. It is imperative that they do not change the formula, tempted by other government spending and leave staff and residents holding the bag, again."
- I have been clinically focused, and although I know it is important, have not focused on the financial side. I do not allow the dollar be the reason not to provide quality care - although at times, Administration/finance have needed to meet with me. Sometimes it is not beneficial to a facility to decrease spending because the facility gets penalized in the next budget. This does not make sense to me, if it is not needed, then don't spend it, but if it is needed for a reason (new regulation, rapid turnover of staff due to???, or other) than I believe the dollars should be there for those emergencies and unusual circumstances.
- I think these are important areas and need to be tracked. Resident satisfaction and family satisfaction can be one area that is difficult for facilities who are older as this can drive the score down but does not reflect quality of care. Also, it can be dependent on how some of the questions are asked, questions could be misinterpreted by the residents.
- Please keep this program-it does allow us to provide the care needed and continue to address any staff wage increases needed to increase staffing.
- Many of us would not still exist without the state having gone to VBR. It is the best reimbursement we have had.
- Explaining what it is and sending it to facility administrators.
- Requiring facilities to jump through hoops to be reimbursed is not a solid plan. It is just as punitive as the survey process and really doesn't improve the care given. Just makes a facility look bad.
- The VBR policy has been tremendous for our facility as it pays you for your quality! This is what payment should be driven by. The Metro facilities do not like the VBR system as some of the facilities in that area do not provide the quality and have seen a decrease in payment. This is a fair system to all facilities. We should be paid for quality vs location. We are all providing the same care. It takes leadership to promote quality.
- More focus should be placed on quality of life for residents. This will allow facilities to truly create a more "home-like environment" for the residents that's resident directed without all of the restrictions/regulations to work around. Quality of care is important; however, quality of life should exceed if that is what the resident chooses.

3. Having experienced the COVID-19 pandemic, what advice would you give others in your role to prepare for future infectious disease outbreaks?

- Emergency planning and supply stockpile should be on everyone's radar.
- Better federal and state coordination and not to constantly contradict and then the enormous amount of fines that started with this unclear protocols and guidance which was constantly changing.
- Have back up staff.
- Remain calm, take it day by day, and focus on one thing at a time.
- 1. Buy PPE now and have some stored. 2. Stay calm - everyone who has a computer in government will tell you what to do, but it is your job locally to do what's best. 3. Be there for your staff.
- Personally, I have completed additional training for emergency preparedness (professional series FEMA) - so I was able to assist facilities in preparedness. Having said that, the greatest of plans could not have identified all the factors involved with this pandemic. I am seeing staff and leaders losing energy, becoming fatigued. I feel that the inability for CMS and STATE to be on the same page, and to direct providers in a clear manner would help. There have been many unknown characteristics of COVID 19 (and still are). The learning from this pandemic along with a recovery plan will be very important to be ready for the next! There are very limited resources for those roles, especially in small facilities - perhaps consider that in regulation and re-imbursement strategies?
- Have facilities designed to respond to these events and policies that prepare for testing, surveillance, and visitation.
- Plan for the worse, review policies and systems for identifying, managing, and minimizing infections.
- This has been the most challenging time in my career and has pulled me in many different directions. As far as future infections, if we know what we are dealing with, it is fairly easy to implement what we need to. The unknown with Covid-19 and how it has been politicized has made this unlike anything we have ever had to deal with. Understanding and following basic infection control practices is always key to slowing outbreaks. Unfortunately, we have had to implement frequent changes in guidance from the state and feds (some we have agreed with, some we have not). The number of changes has made it incredibly difficult to keep staff educated while continuing to provide excellent person-centered care to our residents. In this time, the focus shifted so much to Infection Control, it made it impossible to maintain all other levels of quality that are so important to keeping our residents happy and healthy. I do not have much advice for handling future pandemics and I hope this is the only one I ever experience. Having audits for IC in place prior to an event is very important to controlling the spread

and having a great incident command team that works well together is very important for initially implementing protocols.

- Plan for the worst-case scenario. Do not plan to receive direct, clear guidance as this is something we didn't receive during the COVID-19 pandemic. There's a lot of time wasted to try and interpret some of the guidance directed by CMS and the state agency, especially when they don't align. It would be helpful if state or federal agencies could provide sample policy, procedure templates for facilities to be able to tweak per facility discretion/needs.
- Have more influence on lawmakers to lessen the severity of financial penalties assessed to facilities during this time and have survey become less of a threat, rather support sites during times of crisis. Staff are tired, working short and working with COVID residents creates fear. The heavy survey penalties lessen the facilities ability to focus in the right areas, esp. during staffing shortages etc.
- There are government programs that appears to be helpful, i.e.: FEMA nurses to provide backup assist when sites are experiencing severe COVID outbreaks. The irony, FEMA nurses will not work with COVID residents, which is generally when you need FEMA nurses.
- Develop your infection control program like it is a program on steroids. Be prepared to convert staff into other roles as able and have drills with staff working different positions. Because in an outbreak, everyone is going to be doing everything.
- Have an established communication system with families of residents and have drills to ensure this is working well.