Assisted Living Report Card Advisory Group Meeting

Date: 09/28/2020
Location: WebEx virtual meeting hosted by Department of Human Services

Attendance

Advisory Group Attendee	Organization
Susan Mezzenga	Minnesota Board on Aging
Ann Thole	Minnesota Board on Aging
Kari Thurlow	LeadingAge Minnesota
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)
Adam Suomala	Minnesota Leadership Council on Aging & Diverse Elders Coalition
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
David Hill	Department of Human Services
Tetyana Shippee	University of Minnesota
Tricia Skarphol	University of Minnesota

Observer	Organization
Jean Peters	Elder Voice Family Advocates

Agenda

- Introductions
- Background and updates on the project
- Pursuing the project in the context of COVID and AL license implementation
- Discuss data source beyond the resident and family survey that might support quality measures
- Discuss the frequency of future meetings

Background and updates on the project

- Phases 1 & 2 (summaries discussed below under U of MN presentation) were completed prior to Covid-19.
- Phase 3: started to develop and refine resident and family surveys. In March, pilot testing of these surveys was paused due to Covid-19.
- Phases 4 & 5: Currently delayed due to Covid-19. (Phase 4: Develop and test resident and family surveys, measurement development, and plan website; Phase 5: Finalize surveys and develop website).

Pursuing the project in the context of COVID and AL license implementation

- Pilot testing of the survey tools was delayed due to COVID-19. The start of the Advisory Group was also postponed. As we slowly re-engage in aspects of the Report Card project, we realize that COVID-19 is in no way behind us. We will need to find the right pace of engagement, to allow stakeholders to attend first and foremost to COVID-19, while also moving forward on report card activities where possible.
- The DHS AL Report Card project team has stayed engaged in the AL licensure implementation efforts because there are some ways these projects connect. For example, data collected through AL license could support quality measures on the AL report card and basic provider information for the AL Report Card website.

University of Minnesota presentation

- Phase 1 Findings: literature review identified 9 assisted living quality domains
    - 1) Resident quality of life; 2) Resident and family satisfaction; 3) Safety; 4) Resident health outcomes; 5) Staff; 6) Physical and social environment; 7) Service availability; 8) Core values and philosophy; and 9) Care services and integration
- Phase 2 Findings: stakeholder feedback
    - Top 3 quality domains across stakeholder groups: 1) Quality of life; 2) Staff quality; and 3) Resident safety (choice and autonomy considerations)
    - Lowest rated domains: 1) Physical environment; and 2) Social environment
    - Gaps identified: 1) Culturally appropriate care in AL; 2) Staff safety; 3) Dementia care specific domain/subdomains; and 4) End of life care

Quality domains and data sources to discuss at future meetings

Advisory Group members were polled on which domains, from the 9 identified in the literature review, the group should spend time discussing at future meetings. Appendix A provides members' responses in full. The results for quality domains were as follows:

1) Staff (10 votes)
2) Resident Health & Outcomes (8 votes)
3) Safety AND Physical and Social Environment (tied with 6 votes each)
4) Care Services & Integration (5 votes)
5) Service Availability (3 votes)
6) Core Values and Philosophy (1 vote)

Summary of reasons for focusing on these domains include the items chosen capture the most important aspects of quality. Many mentioned that various domain areas like staffing, health outcomes and services can all affect resident safety. Covid-19 was mentioned as a reason for focusing on the social and physical environment. Items to remember to consider are resident choice, variability of services across AL settings, increasing complexity of care for some AL residents (multiple chronic health conditions), and providing clear information for payers (many AL facilities may or may not take waivers).

Groups members were also polled on what data sources we should look into to support these quality domains. Suggestions were:

- Licensing orders issued to the provider for this topic area
- Geriatrics Workforce Enhancement Program resource center
- Long term services and support research
- Surveys
- Department of Employment and Economic Development data
- Department of Labor & Industry data
- State data
- Currently no good resources for this
- Staffing details (credential of staff in numbers), staffing ratios
- Provider reported data

Summary of comments and questions raised at the meeting

- Some group members wondered if Covid-19 might impact the literature on quality and quality measurement in assisted living. Some members also wondered if people would have a different view of what matters most to assisted living quality given Covid-19
    - The U of MN will review the literature and update the Advisory Group on any changes they observed since the review was conducted in the spring of 2019.

- DHS is also working with Vital Research to pilot test the resident quality of life and family satisfaction surveys. Vital Research will make some observations through the pilot of how Covid-19 might be affecting peoples' perceptions of assisted living quality.

- A group member wondered if the reason some people did not rate social and physical environment as top areas that affect quality was because living in a facility for many years changes their expectations of what their life could be.
  - The U of MN commented that there is some research to support that living in a nursing home, not necessarily an assisted living facility, might change expectations, however people surveyed still said that the physical and social environment was important, just not as important as other quality measures listed.
  - The group member then commented that maybe what we are hearing is that people first need to feel safe and have those basic needs met before they can focus on their social and physical environmental needs.

- A group member asked about how the timing of the new assisted license and Covid-19 will affect the assisted living report card.
  - DHS said that the assisted living licensure is still set to take effect on August 21, 2021.
  - Right now, it is not possible to go into the assisted living facilities to conduct resident and family surveys and DHS will monitor what is possible for conducting these surveys in the future. It is possible that the first statewide round of resident and family surveys will take place prior to the assisted living license. However, in future years the surveys will occur when the assisted living license is in effect.

- A group member asked if DHS and the U of MN have talked about holding 1 or 2 virtual focus groups for residents or family members to see if they would rate the measures of quality differently due to Covid-19.
  - The U of MN will look at updates to the literature, but also commented that there have been many policy pieces, editorials and letters to the editor about this issue.
  - DHS commented that Vital Research has begun some pilot testing of resident and family surveys by phone and by mail. There have been comments suggesting those surveyed view items differently during Covid-19. There should be some anecdotal findings from pilot testing of what people are saying pre-Covid-19 and post-Covid-19.
  - A group member commented that we should be cautious about using observations to make permanent changes and was unsure if people's wants and needs during a pandemic will be the same going forward.

- A group member wondered if the U of MN and DHS will look closer at how different groups rated quality measures. For example, do residents have different safety concerns than family members or policy-makers or do people from different social classes or with different incomes rate items differently.
  - The U of MN commented that stakeholders (residents, family members, assisted living providers, policymakers, advocates and so on) cared about all 9 measures of quality, but it was a

matter of choosing the 3 most important to them. The U of MN said it did look at differences among groups and only saw differences in a few areas. Assisted living residents thought the physical and social environment was more important than other groups. But overall there was agreement across all groups surveyed on which quality measures were the most important. The U of MN can share this full report with advisory group members or follow-up with more details at a later meeting.

Frequency of meetings

Most agreed that the group should begin its work by meeting every 6-8 weeks.

Appendix A: Advisory Group member responses to three discussion questions

What quality domain(s) do you think we should spend time discussing in future meetings?	Why do you think we should focus on this/these quality domain(s)?	What data sources should we look into to support this/these quality domain(s)?
Safety; Resident health outcomes; Staff	I think all three of these need to be looked at in the context of resident choice, and could be impacted by resident refusing services or residents using outside providers for some services.	I am not sure
Care services and integration	In Assisted living there is a variety of service levels needed and a variety of individuals who may come together to provide them	
Safety; Staff	Resident safety is critically important, as well as staff training, qualifications and number of staff 24/7	
Resident health outcomes; Staff; Physical and social environment	Safety is also important but residents have the right to refuse services/treatments and make their own health choices. Residents have little control over staff and the physical environment but they make a huge difference in quality of life.	not sure what is best
Safety; Physical and social environment	I think safety is of paramount concern to all involved but especially to members living in the assisted living and their families. I also think social environment is of utmost importance currently in lieu of COVID and the impacts of isolation.	
Safety; Staff; Service availability	We need to ensure resident needs are able to be addressed.	Licensing orders issued to the provider for this topic area.
Resident health outcomes; Staff	I think all the domains above are important and great to see they are being looked at.	

What quality domain(s) do you think we should spend time discussing in future meetings?	Why do you think we should focus on this/these quality domain(s)?	What data sources should we look into to support this/these quality domain(s)?
Resident health outcomes; Staff; Physical and social environment	I think these capture the most important aspects of quality, and some aspects of the others could be included in these domains.	This is the really hard question. Data is not as available as in the NH world. Maybe start with a measure in each domain and a plan of how to get it, most likely having to use provider reported data with some aspect of auditing to determine it is valid.
Physical and social environment; Service availability; Care services and integration	This group seems to have the chops to work on the higher-level systems questions involved with these domains - leaving some of the others to more "boots on the ground" leaders at the community level.	new GWEP resource center? PHI? Center for LTSS Research,
Safety; Staff; Physical and social environment; Core values and philosophy	In light of COVID-19, residents are isolated and staff are overwhelmed. I have experience with providers who are requiring that residents with dementia stay in their apartments, with little to no socialization. Also-different AL's have different values regarding informing families of COVID notification.	Focus groups would be important or other published experiences
Resident health outcomes; Staff; Service availability; Care services and integration	These are areas that would benefit from greater levels of discussion due to: great variability in services requested/purchased, areas where there are geographic "deserts" where there are gaps, and more details needed.	surveys, DEED data, DOLI data

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Resident health outcomes; Staff; Physical and social environment	The diagnostic process has been developed in acute care and outpatient care but not in the LTC setting. Guidelines do not address complexity and the combination of multiple chronic conditions - we need to understand what is needed before we can measure outcomes. Staff are critical to success. Also, I am not sure residents and families understand the impact of social isolation and other factors.	I wish I had a good answer
Staff; Care services and integration		I think we need to consider looking at details of staffing ratios. Of course a ratio does not tell the whole story, but it is an incredibly important number with impacts on quality of care and resident safety and the laws around disclosing this info for the public are not great. We could collect from the providers themselves - and include details like credentials of staff in the numbers (i.e. how many residents per nurse)
Safety; Resident health outcomes; Staff; Care services and integration	There are 1700 AL facilities that may or may not take waivers - those individuals and their families who are paying dearly for care deserve to have the best information possible as they sign on for services.	surveys, state data
Resident health outcomes	The health needs of AL clients have increased. This is one area that the provider may directly impact. A couple of the other domains, arguably, like staffing and service availability, are *inputs* to health outcomes.	There are not any good sources. The MDH survey data is unreliable.