Meeting Notes

Resident Quality of Care Outcomes and Improvements Task Force

Date: Monday, January 4, 2021
Time: 2:00 pm – 4:00 pm

Attendees

Task Force members: Oluwatosin Adejuwon (Ms. T), Kari Thurlow (representing Julie Apold), Patricia Cullen, Aisha Elmquist, Rachel Jokela, Brent Knodle, Elizabeth McMullen, Jane Pederson, Kristine Sundberg, Penelope Viggiano, Lores Vlaminck
MDH: Lindsey Krueger
Public: Many attendees via WebEx

Agenda

- Welcome
- Goals for Meeting
- Background & Vision
- Member Introductions
- Charter Review, Refinement and Approval
- Next Steps
- Conclusion

Welcome

Lindsey Krueger began the meeting by welcoming everyone and congratulating the task force members on their appointments. Lindsey shared her positions with MDH (Director for Office of Health Facility Complaints and Interim Program Manager for Home Care and Assisted Living, Program Manager for Assisted Living Licensure) and her experience (RN, OHFC Investigator and Supervisor).

Meeting Logistics

Task Force members were promoted to co-hosts on WebEx and were allowed to unmute themselves and asked to speak freely.

All others (public attendees) remained muted but were encouraged to submit any comments or questions via the Chat Feature on WebEx. Questions were responded to via the chat or during the course of the meeting.

Goals for the Meeting

Lindsey reviewed the goals for the meeting, beginning with an orientation to both the work and the members of the task force. Primary focus was the Charter and ended with establishing a meeting schedule/cadence. Lindsey hoped to begin the discussion on safety best practices but unfortunately, ran out of time.

Background

Lindsey explained that the creation of the task force was recommended from the *Improving Quality and Safety in Long Term Care Settings Work Group*. This work group was convened by Marie Dotseth and was one of six informal working groups that came together at the invitation of Commissioner Malcolm in the fall of 2018 (prior to Assisted Living Licensure passing). The quality work group was part of the deployment of 144G and aimed to create a system to improve quality and safety in Long Term Care in Minnesota. They wanted to discuss a system which fosters a culture of learning and improvement through data transparency, sharing of successes and challenges state-wide, is person-centered and optimizes both resident choice and safety concurrently. The workgroup aimed to move from general exploration of broader topics to specific improvement projects.

Task Force Deliverables per 144G.9999

Examine and make recommendations on an ongoing basis, on how to apply proven safety and quality improvement practices and infrastructures to settings and providers that provide long-term services and supports.

Subdivision 3. Recommendations

The task force shall periodically provide recommendations to the commissioner and the legislature on changes needed to promote safety and quality improvement practices in long-term care settings and with long-term care providers. The task force shall meet no fewer than four times per year.

Vision

The focus of the task force is to identify best practices rather than minimum standards.

The Improving Quality and Safety in Long-Term Care Settings Work Group identified broad draft recommendations:

- Data availability and use
- Tools and guidance to enable accurate and comprehensive reporting
- Advancing a culture of safety

The work group also developed a shared set of characteristics for the ideal system for long-term care in Minnesota:

- Quality and patient safety information is transparent and easy to understand for residents, families and providers
- Is person centered/person-directed
- Is fair/just and promotes accountability across all settings
- Focused on learning where data is available for improvement
- A sufficient and well-trained workforce
- The regulatory system supports and promotes improvement in patient safety and quality
- Standards for safety data and measurement

Member Introductions

Oluwatosin Adejuwon (Ms. T) - Direct Care Provider or Representative – 15 years in the healthcare industry (PCA, administrator)

Julie Apold - Organization representing Long-Term Care Providers and Home Care Providers – VP of Quality & Performance Excellence at Leading Age of MN and manages Performance Excellence in Aging Services program. 10 years as the Senior Director of Patient Safety and Quality at the Minnesota Hospital Association.

Patricia (Patti) Cullen - Organization representing Long-Term Care Providers and Home Care Providers – President/CEO Care Providers of MN and Board Chair of the Minnesota Alliance for Patient Safety.

Aisha Elmquist - Ombudsman for Long-Term Care (or designee) – Deputy Ombudsman

Rachel Jokela - MDH staff with expertise in issues related to safety and adverse health events – 10 years in patient safety and quality (9 with MDH)

Brent Knodle - Public Member (family member in an assisted living setting) – St. Paul Firefighter (14 years)

Lindsey Krueger - Health Regulation Division (Task Force chair)

Elizabeth (Beth) McMullen - Consumer Organization Representative – VP of Government Affairs at Alzheimer's Association of MN/ND

Jane Pederson - Nonprofit Organization Representative – Chief Medical Quality Officer, Stratis Health, Geriatrician (20 years)

Pamela Peters - Public Member (is or has been a resident in an assisted living setting)

Kristine (Kris) Sundberg - Consumer Organization Representative – Executive Director at Elder Voice Family Advocates

Penelope (Pennie) Viggiano - Direct Care Provider or Representative – VP Housing with Services Benedictine Health System, healthcare (33 years), healthcare leader (26 years)

Lores Vlaminck - Expert in the safety and quality improvement field – RN (45 years), consultant and trainer on palliative and end-of-life care

Charter Discussion

Kris Sundberg started the discussion wondering if we needed to define "proven". Rachel Jokela agreed and thought it could be problematic without a definition. Kari Thurlow informed the group that the terms "evidence based" were deliberately left out of statute because it could become too restrictive and allowed further definition by the task force. Pennie Viggiano added that data for assisted living is not as robust. Lores Vlamninck referenced the Bill of Rights and the use of "accepted" medical standards.

Patti Cullen shifted the conversation to the reference of "long term care settings" being confusing. She wondered if the task force was focused on all long-term care or just assisted living. Beth McMullen added that "resident" can apply across multiple settings. Kris believed post-acute care or nursing facilities were not intended to be included.

Jane Pederson wanted to address minimum standards and think about practices or key features instead. Practices that could be put into place in different organizations and key nuggets they can implement in their own complex system. Beth stated that the same standards won't apply similarly for all settings and recommendations could specify which setting they are appropriate for. Pennie added that there is a huge difference between minimum standards and best practices. What level of action is the expectation? Kari thought that was ours to figure out. Legislation was passed with minimum standards. Beyond that, there is a lot we can do collectively to encourage constant quality improvement. Not sure if the end result is more regulation/legislation vs. lifting up best practices for the field as a whole. Beth concurred this was intended to be not about regulating but about how we lift everyone up. Maybe policy recommendations to help enable that – changes as we learn new things. Might not want it written in stone (legislation). Kris thought it was important to keep all options open and not go into it with bias that there won't be any regulatory recommendations made. Oluwatosin Adejuwon (Ms. T) pointed out that recommendations should be implementable across a spectrum of facility sizes. Kari added the key is not saying it is a perfect process that has to be done the same way every time. Look at what the key elements are and enable each organization to put them into their environment. This sets us apart from minimum standards and settles on an approach for how this industry expects progress, quality and safety to be achieved. Kris states she sees a wide range of what is considered "quality" which doesn't fit with "resident-centered" care. Need guideposts for those that don't understand quality. Patti stated it's hard to do the research and provide recommendations and suggested they work in collaboration with others that have already done the research.

Lindsey shifted the conversation to the "Goals" section of the Charter. Kris asked if she was referring to the current legislative session. Lindsey thought it could be a possibility or the next session depending on the task force. Beth suggested that they look to a future session, that the current session doesn't seem feasible and Kris agrees. Beth indicated it would be good to include a goal that encompasses health equity and think about health disparities that we know exist in direct care systems. Want to make sure they're not making it more difficult for certain populations. Ms. T suggested using "diverse, fair and just". Quality of care is continuous

improvement due to a constantly changing world. Pennie agreed but wondered if it is achievable and accessible (to the community and the provider). Aisha Elmquist added to work on what data we might have or need to have to see how quality of care looks like in the state. Jane was looking for ways to promote or encourage the accessibility of useful data that can be accessed in real time to assess how well they are doing. Lores agrees that providers think they are doing a good job and get excited about measuring the quality. Providers want data but it's tough with day-to-day tasks. They ask to be pointed to data they can use. Jane suggests finding good examples of ways you can collect data that doesn't take an army of analysts and is useful to look at. Brent Knodle brought it back to the scope – what data is good for whom? Patti is a member of the *Report Card Group* and wonders if there will be a purposeful intersection between the report card work and the task force.

Next, the group questioned how would they measure success? Pennie wanted to know what measures will determine if the recommendation has improved safety. She was also nervous that testing could cause undue burden on the facility. Since recommendations are for best practices and not forced implementation, they could be hard to measure accurately. Wondering if it could be as simple as general acceptance? Patti added that we don't want to capture a snapshot in time. It's more about establishing a process so providers could change and adapt as the population changes. Lores questioned what was reasonable given the short time frame (potential). Ms. T suggested they first identify the areas that need improvement, based on data, then success would be easier to identify. Pennie added that maybe the best opportunities for improvement aren't represented in the data set.

Pennie also wondered if they were overcomplicating things if the task force was only meeting for six months. Jane agreed that in six months, they won't be able to address everything, nor have the bandwidth to get down to specific details. Aisha thought the task force wasn't initially conceived as short term and hopes to extend. Beth thought the task force would struggle with what they could accomplish if it only assembles through July 31, 2021. Lindsey stated that statute defines two years. She agrees that if the task force is to be successful and bring well-thought out recommendations, it will take more than four meetings. Current conversation is taking time and we're not dealing with in-and-out type topics.

The group moved on to what should be considered "in-scope" for the task force. Patti wanted to know the origin of what was currently listed as "in-scope" in the charter (long-term care settings include assisted living and dementia, memory care, and nursing care settings) and Lindsey let everyone know that it was just a starting point. Patti wanted to know if the focus was the senior population with Kris adding that long-term care covers adults and not just seniors. Beth thought residential settings (not home care). Patti gave push-back on nursing facilities (due to extensive regulations already in place). Lores agrees that it would be too much for nursing facilities and the task force should focus on assisted living. Adding, if we focus on this and do super work in this realm, then we could potentially expand. Aisha referenced subdivision 3 that states long term care settings and long term care providers. Under statutory language nursing care is both of those. Statute describes the scope so we shouldn't eliminate any settings. Ultimately, the task force agreed that the focus would be on assisted living but

won't ultimately exclude other facility types if recommendations are appropriate for them as well. Ms. T asked the group to make sure dementia care was included with assisted living. There was a consensus that when referring to "assisted living" it would include assisted living with dementia care. The group also agreed to remove "out of scope" items from the charter.

Next Steps

Lores was not opposed to monthly meetings for now and Patti agreed. No objections from the task force. Lindsey will send out a Doodle Poll to narrow down dates for a February meeting.

Lindsey confirmed she will continue to work on the Charter and send it out via email for review and feedback.

Focus for next meeting:

- What data already exists?
- Presentations by Patti Cullen (Nursing Home aspect), Marie Dotseth and Rachel Jokela

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