2017 Long-Term Care Quality Improvement Program (QIP)

Program Description & Measurement Specifications

Developed by: The QIP Team
QIP@partnershiphp.org

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Updated July 12, 2017
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I. Program Contact Information
Email: LTCQIP@PartnershipHP.org
Fax: (707) 863-4316
Website: Long-Term Care Quality Improvement Program

II. Program Overview and Background
Partnership HealthPlan of California (PHC) has value-based purchasing programs in the areas of primary care, hospital care, specialty care, community pharmacy, and mental health. Beginning January 1, 2016, the Long-Term Care (LTC) Quality Improvement Program (QIP) was established to offer sizeable financial incentives to support and improve the quality of long-term care provided to our members. In collaboration with LTC representatives, a simple, meaningful measurement set has been developed and includes measures in the following areas: Clinical, Functional Status, Resource Use, and Operations.

Eligibility Criteria
LTC facilities must have a PHC contract by December 15, 2016 to be eligible. LTCs must remain contracted through December 31, 2017 to be eligible for payment. Participation will require signing a Letter of Agreement by December 15, 2016 to participate in the 2017 LTC QIP. LTC facilities must be in good standing with state and federal regulators as of the month the payment is to be disbursed. Good standing means that the LTC is open, solvent, not under financial sanctions from the state of California or Centers for Medicare & Medicaid Services. If an LTC appeals a financial sanction and prevails, PHC will entertain a request to change the LTC status to good standing.

Financing Policy
The LTC QIP incentives are separate and distinct from a facility’s usual reimbursement. Each LTC’s potential earning pool is structured as a -bonus, dependent on 1) PHC member volume and 2) an average per diem rate for all facilities (as opposed to a facility-specific amount dependent on a facility’s prevailing rates). The average per diem rate is determined by the Board of Directors. For 2017, the estimate is $4.50 per member per day. This estimate is subject to change based on actual rates and reimbursements in 2017. The bonus will be paid out at the end of the measurement year according to the number of points earned. The withheld funds are specific to each facility and will only be paid out to the extent points are awarded. Unspent funds will be retained by PHC. Year-end payments will be mailed by April 30 following the measurement year.

In the event that an LTC receives a retroactive rate change from DHCS after April 1 following the measurement year, the QIP payment will be based on the rate in effect as of April 1 for the measurement year. All QIP payments will be considered final.
Example:

<table>
<thead>
<tr>
<th>LTC Facility</th>
<th>Number of PHC Custodial Members (assumed the same number for all 365 days)</th>
<th>Annual Payment ($224 per custodial member per day on average)</th>
<th>Potential Earning Pool (Annual payment*2%)</th>
<th>QIP Score (out of 100)</th>
<th>QIP Dollars Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20</td>
<td>$1,635,200</td>
<td>$32,704</td>
<td>45 points</td>
<td>$14,716</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>$817,600</td>
<td>$16,352</td>
<td>90 points</td>
<td>$14,716</td>
</tr>
<tr>
<td>3</td>
<td>50</td>
<td>$4,088,000</td>
<td>$81,760</td>
<td>90 points</td>
<td>$73,584</td>
</tr>
</tbody>
</table>

**Guiding Principles**

The LTC QIP will adhere to the following principles:

1. Where possible, pay for outcomes instead of processes
2. Actionable measures
3. Feasible data collection
4. Collaboration with providers in measure development
5. Simplicity in the number of measures
6. Representation of different domains of care
7. Align measures that are meaningful
8. Stable measures
### III. 2017 Summary of Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Source</th>
<th>Threshold¹</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1. Percent of high-risk residents with pressure ulcers                | NQF 0679    | Lower is better  
Pay for performance based on being better than the average US performance of 5.7% | 10      |
| 2. Percent of residents who lose too much weight                      | NQF 0689    | Lower is better  
Pay for performance based on being better than the average US performance of 7.0% | 5       |
| 3. Percent of residents with diagnosis of dementia with feeding tube in place | None; pay for reporting | None; pay for reporting | 5       |
| **FUNCTIONAL STATUS**                                                 |              |            |        |
| 4. Percent of residents experiencing one or more falls with major injury | NQF 0674    | Lower is better  
Pay for performance based on being better than the average US performance of 3.3% | 10      |
| 5. Percent of residents who have/had a catheter inserted and left in their bladder | NQF 0686    | Lower is better  
Pay for performance based on being better than the average US performance of 2.8% | 10      |
| **RESOURCE USE**                                                      |              |            |        |
| 6. Transfers resulting in admission to hospital as an inpatient        |              | None; pay for reporting | 10      |
| 7. Transfers resulting in ED visit only                                | INTERACT     | None; pay for reporting | 10      |
| **OPERATIONS/ SATISFACTION**                                          |              |            |        |
| 8. CMS Five-Star Quality Rating                                       | CMS Stars rating with 4 and above for full credit, 3 for half credit | CMS Stars rating with 4 and above for full credit, 3 for half credit | 15      |
| 9. Implementation plan for INTERACT 4, Advancing Excellence program, or Project Improvement Plan Charter for QAPI | None, pay for reporting | None, pay for reporting | 10      |
| 10. QI Training by Health Services Advisory Group (HSAG), QAPI Self-Assessment, and NHQCC Participation agreement | None, pay for reporting | None, pay for reporting | 15      |

¹ All clinical and functional measure thresholds are based on data on December 1, 2016 listed on [http://www.medicare.gov/NursingHomeCompare/compare.html#cmprTab=3&cmprID=555227%2C5555694&cmprDist=1.7%2C3.6&loc=94960&lat=37.9885355&lng=122.5655549](http://www.medicare.gov/NursingHomeCompare/compare.html#cmprTab=3&cmprID=555227%2C5555694&cmprDist=1.7%2C3.6&loc=94960&lat=37.9885355&lng=122.5655549)
CLINICAL DOMAIN

Measure 1. Percent of High-Risk Residents with Pressure Ulcers

**Description**
Measures the percentage of long-stay, high-risk residents with Stage II-IV pressure ulcers.


**Threshold**
- Full points: ≤5.7% (National average of NQF Measure 0679)

**Denominator**
All long-stay residents with a selected target assessment who meet the definition of high risk, except those with exclusions. Residents are defined as high-risk if they meet one or more of the following three criteria on the target assessment:

1. Impaired bed mobility or transfer indicated,
2. Comatose,
3. Malnutrition or at risk of malnutrition.

**Numerator**
All long-stay residents with a selected target assessment that meets both of the following conditions:

1. There is a high risk for pressure ulcers, where “high-risk” is defined in the denominator definition.
2. Stage II-IV pressure ulcers are present.

**Exclusions**
Target assessment is an admission assessment or a PPS 5-day or readmission/return assessment.

If the resident is not included in the numerator (the resident did not meet the pressure ulcer conditions for the numerator).

**Reporting Guidelines**
No reporting by the facility is required. PHC will extract summary data on Nursing Home Compare in February 2018.
### Measure 2. Percent of Residents Who Lose Too Much Weight

<table>
<thead>
<tr>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Measures the percentage of long-stay residents who had a weight loss of 5% or more in the last month or 10% or more in the last two quarters who were not on a physician prescribed weight loss regimen.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th><strong>Threshold</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full points: ≤7.0% (National average of NQF Measure 0689)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Denominator</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>All long-stay residents with a selected target assessment except those with exclusions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-stay residents with a selected target assessment which indicates a weight loss of 5% or more in the last month, or 10% or more in the last six months who were not on a physician prescribed weight-loss regimen.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Exclusions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Target assessment is an OBRA admission assessment.</td>
</tr>
<tr>
<td>Weight loss item is missing on target assessment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Reporting Guidelines</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No reporting by the facility is required. PHC will extract summary data on Nursing Home Compare in February 2018.</td>
</tr>
</tbody>
</table>
Measure 3. Dementia with Feeding Tube in Place

**Description**
Measures the percentage of long-stay residents with dementia who have a feeding tube in place.

**Threshold**
- None: up to five points earned through semi-annual reporting

**Denominator**
All long-stay residents, regardless of payer, with a diagnosis of dementia in the last six months.

**Numerator**
Those in the denominator who have a feeding tube in place (NG, PEG, or other).

**Reporting Guidelines**
This measure is based on two reporting periods: January 1, 2017 – June 30, 2017 and July 1, 2017-December 31, 2017. Data should be reported for both PHC members and all other non-PHC members. Please see the table below.

<table>
<thead>
<tr>
<th>Reporting Timeline</th>
<th>Submission Due Date</th>
<th>Submission Template</th>
<th>Points Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2017 – December 31, 2017</td>
<td>February 28, 2018</td>
<td>Submission Template II</td>
<td>2.5</td>
</tr>
</tbody>
</table>
**Measure 4. Falls with Major Injury**

**Description**
Measures the percentage of long-stay residents who have experienced one or more falls with major injury.


**Threshold**
- Full points: ≤3.3% (National average of NQF Measure 0674)

**Denominator**
All long-stay residents with one or more look-back scan assessments except those with exclusions.

**Numerator**
Long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury.

**Exclusions**
Resident is excluded if one of the following is true for all of the look-back scan assessments:

1. The occurrence of falls was not assessed.
   
   OR

2. 0 assessment indicates that a fall occurred AND the number of falls with major injury was not assessed.

**Reporting Guidelines**
No reporting by the facility is required. PHC will extract summary data on Nursing Home Compare in February 2018.
**Measure 5. Catheter Inserted and Left in Bladder**

**Description**

Measures the percentage of long-stay residents who have had an indwelling catheter in the last seven days.


**Threshold**

- Full points: ≤2.8% (National average of NQF Measure 0686)

**Denominator**

All long-stay residents regardless of payer with a selected target assessment, except those with exclusions.

**Numerator**

Long-stay residents with a selected target assessment which indicates the use of indwelling catheters.

**Exclusions**

Target assessment is an admission assessment or a PPS 5-day or readmission/return assessment.

Target assessment indicates that indwelling catheter status is missing.

Target assessment indicates neurogenic bladder or neurogenic bladder status is missing.

Target assessment indicates obstructive uropathy or obstructive uropathy status is missing.

**Reporting Guidelines**

No reporting by the facility is required. PHC will extract summary data on Nursing Home Compare in February 2018.
Measure 6. Inpatient Admissions

Description
Measures the rate of long-stay residents who were transferred and resulted in inpatient admissions in the past six months.

Threshold
- None: up to ten points earned through semi-annual reporting

Denominator
Number of unique long-stay residents regardless of payer in the six-month reporting period.

Numerator
Total number of transfers resulting in admission to hospital as an inpatient.

Note that the rate can potentially be greater than 1. For example, if a site has 30 long-stay residents in the reporting period, and 8 of them each has 4 transfers that meets the measure requirement, the rate is 32/30 = 1.06.

Reporting Guidelines
This measure is based on two reporting periods: January 1, 2017 – June 30, 2017 and July 1, 2017-December 31, 2017. Data should be reported for both PHC members and all other non-PHC members. Please see the table below.

<table>
<thead>
<tr>
<th>Reporting Timeline</th>
<th>Submission Due Date</th>
<th>Submission Template</th>
<th>Points Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2017 – December 31, 2017</td>
<td>February 28, 2018</td>
<td>Submission Template II</td>
<td>5</td>
</tr>
</tbody>
</table>
Measure 7. Emergency Department Visits

**Description**
Measures the rate of long-stay residents who were transferred and resulted in emergency department visits only in the last six months.

**Threshold**
- None: up to ten points earned through semi-annual reporting

**Denominator**
Number of unique long-stay residents regardless of payer in the six-month reporting period.

**Numerator**
Total number of transfers resulting in emergency department visits only (i.e. billing codes for observation stays and inpatient admissions have to be absent).

Note that the rate can potentially be greater than 1. For example, if a site has 30 long-stay residents in the reporting period, and 8 of them each has 4 transfers that meets the measure requirement, the rate is $\frac{32}{30} = 1.06$.

**Reporting Guidelines**
This measure is based on two reporting periods: January 1, 2017 – June 30, 2017 and July 1, 2017-December 31, 2017. Data should be reported for both PHC members and all other non-PHC members. Please see the table below.

<table>
<thead>
<tr>
<th>Reporting Timeline</th>
<th>Submission Due Date</th>
<th>Submission Template</th>
<th>Points Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2017 – December 31, 2017</td>
<td>February 28, 2018</td>
<td>Submission Template II</td>
<td>5</td>
</tr>
</tbody>
</table>
Measures the results of CMS ratings.

<table>
<thead>
<tr>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full Points: CMS Stars rating of 4 or above</td>
</tr>
<tr>
<td>• Partial Points: CMS Stars rating of 3</td>
</tr>
</tbody>
</table>

No reporting by the facility is required. PHC will extract Stars score on Nursing Home Compare in February 2018.

CMS’ Five-Star Nursing Home Quality Rating System is based on the following components:

1. Health inspections
2. Staffing
3. Quality Measures

To find out more about how ratings are calculated, visit https://www.medicare.gov/NursingHomeCompare/About/HowWeCalculate.html.
Measure 9. Quality Improvement Implementation Plan

**Description**
Measures the progress toward implementing either INTERACT 4.0, Advancing Excellence in America’s Nursing Homes, or the Quality Assurance and Performance Improvement program.

**Threshold**
- None: up to ten points earned through semi-annual reporting

**Measure Options**
LTCs can earn up to ten points by reporting on an initial implementation plan and progress towards its goals during the measurement year. There are three eligible resources for improvement programs, of which a site should choose one for the year. LTCs must use the Implementation Plan templates to complete the requirements for the measure.

**Resource 1: INTERACT 4.0**
INTERACT Implementation Checklist

**Resource 2: Advancing Excellence**
Organizational or clinical goal from this list to be accomplished during the measurement year.

**Resource 3: Quality Assurance and Performance Improvement program**
Performance Improvement Plan (PIP) Charter with goals

**Reporting Guidelines**
This measure is based on two plan elements. Please see the table below for reporting timeline templates.

<table>
<thead>
<tr>
<th>Implementation Plan Element</th>
<th>Submission Due Date</th>
<th>Points Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part I</td>
<td>August 31, 2017</td>
<td>5</td>
</tr>
<tr>
<td>Part II</td>
<td>February 28, 2018</td>
<td>5</td>
</tr>
</tbody>
</table>
Measure 10. Quality Improvement Training

**Description**
Measures the attendance of training conducted by the California Quality Improvement Organization contracted with CMS, i.e: Health Services Advisory Group, along with participation in complementary quality programs.

**Threshold**
- Full Points: completion of all three measurement steps
- Partial Points: completion of any combination of one or two of the three different steps

**Measure Steps**
LTCs can earn up to fifteen points by completing the following steps. Documentation for all steps is due by February 28, 2018.

**Step 1: HSAG Training**
Option I: Send two or more staff members to attend PHC-approved training conducted by the Nursing Home Quality Care Collaborative and submit proof of attendance (i.e. certification of attendance). A list of approved trainings and dates will be shared when available. (5 points)

**AND**

**Step 2: Quality Assurance Performance Improvement Self-Assessment**
- Complete and submit a [QAPI Self-Assessment](#) (5 points)

**AND**

**Step 3: Nursing Home Quality Care Collaborative**
- Complete and submit a signed [NHQCC Participation Agreement](#) (5 points)

**Reporting Guidelines**
Documentation for all steps is due to PHC by February 28, 2018.
### Appendix I. Submission Timeline

<table>
<thead>
<tr>
<th>Measure</th>
<th>Submission Required</th>
<th>Submission Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Percent of high-risk residents with pressure ulcers</td>
<td>No; based on Nursing Home Compare data extracted February 2017</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Percent of residents who lose too much weight</td>
<td>No; based on Nursing Home Compare data extracted February 2017</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Percent of residents with diagnosis of dementia with feeding tube in place</td>
<td>Yes; reported semi-annually</td>
<td>August 31, 2017 (Submission Template I) February 28, 2018 (Submission Template II)</td>
</tr>
<tr>
<td><strong>FUNCTIONAL STATUS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Percent of residents experiencing one or more falls with major injury</td>
<td>No; based on Nursing Home Compare data extracted February 2017</td>
<td>N/A</td>
</tr>
<tr>
<td>5. Percent of residents who have/had a catheter inserted and left in their bladder</td>
<td>No; based on Nursing Home Compare data extracted February 2017</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>RESOURCE USE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Transfers resulting in admission to hospital as an inpatient</td>
<td>Yes; reported semi-annually</td>
<td>August 31, 2017 (Submission Template I) February 28, 2018 (Submission Template II)</td>
</tr>
<tr>
<td>7. Transfers resulting in ED visit only</td>
<td>Yes; reported semi-annually</td>
<td>August 31, 2017 (Submission Template I) February 28, 2018 (Submission Template II)</td>
</tr>
<tr>
<td><strong>OPERATIONS/ SATISFACTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. CMS Five-Star Quality Rating</td>
<td>No; based on Nursing Home Compare data extracted February 2017</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Implementation Plan for INTERACT 4.0, or Advancing Excellence, or QAPI</td>
<td>Yes; reported semi-annually</td>
<td>August 31, 2017 (Submission Template III) February 28, 2018 (Submission Template IV)</td>
</tr>
<tr>
<td>10. QI Training</td>
<td>Yes; data due in February 2018</td>
<td>February 28, 2018 (Certificate of Attendance, QAPI Self-Assessment, NHQCC Participation Agreement)</td>
</tr>
</tbody>
</table>
Appendix II.

Submission Template I: Data Due August 31, 2017

Please report data between January 1 and June 30, 2017 for all the measures below. Send your submission via email at LTCQIP@partnershiphp.org or fax at 707-863-4316.

Federal Provider Number: 
Facility Name: 

Measure 3. Dementia with feeding tube in place
Denominator: Number of unique long-stay residents with a diagnosis of dementia in the reporting period. Report both PHC and non-PHC members.
Numerator: Those in the denominator who have a feeding tube in place (NG, PEG, or other)

<table>
<thead>
<tr>
<th>January 1 – June 30</th>
<th>PHC Members</th>
<th>Non-PHC Members</th>
<th>All Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate (numerator/denominator)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Measure 6. Inpatient Admissions
Denominator: Number of all unique long-stay residents in the reporting period. Report both PHC and non-PHC members.
Numerators: Total number of transfers among denominator population resulting in admission to hospital as an inpatient in the reporting period.

<table>
<thead>
<tr>
<th>January 1 – June 30</th>
<th>PHC Members</th>
<th>Non-PHC Members</th>
<th>All Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate (numerator/denominator)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Measure 7. ED Visits
Denominator: Number of all unique long-stay residents in the reporting period. Report both PHC and non-PHC members.
Numerators: Number of transfers among denominator population resulting in ED visit only in the reporting period.

<table>
<thead>
<tr>
<th>January 1 – June 30</th>
<th>PHC Members</th>
<th>Non-PHC Members</th>
<th>All Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate (numerator/denominator)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix III

Submission Template II: Data Due February 28, 2018

Please report data between July 1 and December 31, 2017 for all the measures below. Send your submission via email at LTCQIP@partnershiphp.org or fax at 707-863-4316.

Federal Provider Number: ____________________________
Facility Name: ____________________________

**Measure 3. Dementia with feeding tube in place**
Denominator: Number of unique long-stay residents with a diagnosis of dementia in the reporting period. Report both PHC and non-PHC members.
Numerator: Those in the denominator who have a feeding tube in place (NG, PEG, or other)

<table>
<thead>
<tr>
<th>July 1 – December 31</th>
<th>PHC Members</th>
<th>Non-PHC Members</th>
<th>All Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate (numerator/denominator)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Measure 6. Inpatient Admissions**
Denominator: Number of all unique long-stay residents in the reporting period. Report both PHC and non-PHC members.
Numerators: Total number of transfers among denominator population resulting in admission to hospital as an inpatient in the reporting period.

<table>
<thead>
<tr>
<th>July 1 – December 31</th>
<th>PHC Members</th>
<th>Non-PHC Members</th>
<th>All Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate (numerator/denominator)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Measure 7. ED Visits**
Denominator: Number of all unique long-stay residents in the reporting period. Report both PHC and non-PHC members.
Numerators: Number of transfers among denominator population resulting in ED visit only in the reporting period.

<table>
<thead>
<tr>
<th>July 1 – December 31</th>
<th>PHC Members</th>
<th>Non-PHC Members</th>
<th>All Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate (numerator/denominator)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix IV

Submission Template III: Implementation Plan Part I

Please draft an implementation on either program below and submit by August 31, 2017 via email at LTCQIP@partnershiphp.org or fax at 707-863-4316.

Federal Provider Number: __________________________________________________________

Facility Name: __________________________________________________________

1) Background: Describe the problem you are trying to address.

2) Goals/Objectives: What is your measurable goal? Include baseline data if available.

3) Rational/Steps/Tools: What is the strategies/tools you will use to make improvement?

4) Timeline/Staff: Describe your project timeline and team.

Points Allocation (5 points): 1 point for submission, and 1 point for completing each of these four steps.
Appendix V

Submission Template IV: Implementation Plan Part II

Please draft an implementation on either program below and submit by February 28, 2018 via email at LTCQIP@partnershiphp.org or fax at 707-863-4316. The program described should be an update to what was submitted in August for Part I.

Federal Provider Number: ________________________________

Facility Name: _______________________________________

1) What is the result/score of your improvement plan? Have you reached, or are you on target to reach, your goal described in Part 1?

2) If yes, what was the key for success? If no, what lessons did you learn and what next steps will you take?

Points Allocation (5 points): 1 point for submission, and 2 points for completing each of these two steps.