2018 Long-Term Care Quality Improvement Program (QIP)

Program Description & Measurement Specifications

Developed by: The QIP Team

QIP@partnershiphp.org

Released February 15, 2018
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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, 2017 to be eligible. LTCs must remain contracted through December 31, 2018 to be eligible for payment. Participation will require signing a Letter of Agreement by December 15, 2017 to participate in the 2018 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 2018, the estimate is $4.50 per member per day. This estimate is subject to change based on actual rates and reimbursements in 2018. 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 1</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>20</td>
<td>$1,635,200</td>
<td>$32,704</td>
<td>45 points</td>
<td>$14,716</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>$817,600</td>
<td>$16,352</td>
<td>90 points</td>
<td>$14,716</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>$4,088,000</td>
<td>$81,760</td>
<td>90 points</td>
<td>$73,584</td>
<td></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. 2018 Summary of Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Source</th>
<th>Threshold</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GATEWAY MEASURE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS Five-Star Quality Rating</td>
<td>CMS</td>
<td>Facilities must receive at least two stars in the CMS Five-Star Quality Rating in order to be eligible for the other measures in the program. Facilities receiving one star will not be eligible.</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>CLINICAL DOMAIN</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Percent of high-risk residents with pressure ulcers</td>
<td>CMS</td>
<td>Points for being at or below the average US performance of 5.6%.</td>
<td>10</td>
</tr>
<tr>
<td>2. Percent of residents who lose too much weight</td>
<td>CMS</td>
<td>Points for being at or below the average US performance of 7.1%.</td>
<td>10</td>
</tr>
<tr>
<td>3. Percent of long-stay residents who needed and got a flu shot</td>
<td>CMS</td>
<td>Points for being at or above the average US performance of 94.9%</td>
<td>5</td>
</tr>
<tr>
<td>4. Percent of long-stay residents who got a vaccine to prevent pneumonia</td>
<td>CMS</td>
<td>Points for being at or above the average US performance of 94.1%</td>
<td>5</td>
</tr>
<tr>
<td><strong>FUNCTIONAL STATUS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Percent of residents experiencing one or more falls with major injury</td>
<td>CMS</td>
<td>Points for being at or below the average US performance of 3.4%</td>
<td>10</td>
</tr>
<tr>
<td>6. Percent of residents who have/had a catheter inserted and left in their bladder</td>
<td>CMS</td>
<td>Points for being at or below the average US performance of 1.9%</td>
<td>10</td>
</tr>
<tr>
<td><strong>RESOURCE USE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Hospital Admissions</td>
<td>PHC</td>
<td>Points for being at or below the average PHC rate (TBD)</td>
<td>10</td>
</tr>
<tr>
<td><strong>OPERATIONS/SATISFACTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Health Inspection Rating</td>
<td>CMS</td>
<td>CMS Stars rating with 4 and above for full credit, 3 for half credit</td>
<td>10</td>
</tr>
<tr>
<td>9. Staffing Rating</td>
<td>CMS</td>
<td>CMS Stars rating with 4 and above for full credit, 3 for half credit</td>
<td>10</td>
</tr>
<tr>
<td>10. Implementation Plan</td>
<td>Submission</td>
<td>None, pay for reporting</td>
<td>10</td>
</tr>
<tr>
<td>11. QI Training and QAPI Self-Assessment</td>
<td>Submission</td>
<td>None, pay for reporting</td>
<td>10</td>
</tr>
</tbody>
</table>

1 All clinical and functional measure thresholds are based on data on February 1, 2018 listed on [http://www.medicare.gov/NursingHomeCompare/compare.html#cmprTab=3&cmprID=555227%2C5555694&cmprDist=1.7%2C3.6&loc=94960&lng=37.9885355&lng=-122.5655549](http://www.medicare.gov/NursingHomeCompare/compare.html#cmprTab=3&cmprID=555227%2C5555694&cmprDist=1.7%2C3.6&loc=94960&lng=37.9885355&lng=-122.5655549)
**Gateway Measure**

**CMS Five-Star Quality Rating**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities must receive at least two stars in the CMS Five-Star Quality Rating in order to be eligible for the other measures in the program. Facilities receiving one star will not be eligible. This eligibility measure is designed to ensure the QIP is rewarding high quality care. According to CMS, facilities with 1 star are considered to have quality much below average.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reporting by the facility is required. PHC will extract summary data on Nursing Home Compare in February 2019.</td>
</tr>
</tbody>
</table>
Measure 1. Percent of Residents with Pressure Ulcers

**Description**

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

Pressure ulcers can cause severe discomfort. Patients with advanced pressure ulcers often have decreased mobility and independent function. As part of the Five-Star Rating System, this measure is an important piece of understanding quality outcomes of Long-Term Care facilities.¹


**Threshold**

- Full points: ≤5.6% (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 2019.
**Measure 2. Percent of Residents Who Lose Too Much Weight**

**Description**
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.

Unmanaged or unintended weight loss in nursing home residents can further complicate existing health conditions. Weight loss complications include frailty, bone fractures, and compromised immune systems. This measure evaluates the rate of residents seeing unintended weight loss.


**Threshold**
- Full points: ≤7.1% (National average of NQF Measure 0689)

**Denominator**
All long-stay residents with a selected target assessment except those with exclusions.

**Numerator**
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.

**Exclusions**
Target assessment is an OBRA admission assessment.

Weight loss item is missing on target assessment.

**Reporting Guidelines**
No reporting by the facility is required. PHC will extract summary data on Nursing Home Compare in February 2019.
Measure 3. Flu Shot for Current Flu Season

Description
Measures the percentage of long-stay residents who are given, appropriately, the influenza vaccination during the current or most recent influenza season.

The CDC considers residents of long term care facilities to be at greater risk for seasonal influenza. Therefore, preventing the flu from occurring and spreading should be a priority for health care residences.


Threshold
- Full points: ≥94.9% (National average of NQF Measure 0681)

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

Numerator
Residents meeting any of the following criteria on the selected target assessment:
1. Resident received the influenza vaccine during the current or most recent influenza season, either in the facility (O0250A = [1]) or outside the facility (O0250C = [2]); or
2. Resident was offered and declined the influenza vaccine (O0250C = [4]); or
3. Resident was ineligible due to contraindication(s) (O0250C = [3]) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, bone marrow transplant within the past 6 months).

Exclusions
Resident was not in facility during the current or most recent influenza season.

Reporting Guidelines
No reporting by the facility is required. PHC will extract summary data on Nursing Home Compare in February 2019.
### Measure 4. Residents Receiving a Pneumonia Vaccine

**Description**

Measures the percentage of long-stay residents whose pneumococcal polysaccharide vaccine status is up to date.

Pneumonia is a common disease in many long-term care facilities and causes increases in morbidity and mortality. This measure is proposed as new to measurement set in order to evaluate adequate preventive opportunities being available to members.


**Threshold**

- Full points: ≥94.1% (National average of NQF Measure 0683)

**Denominator**

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

**Numerator**

Residents meeting any of the following criteria on the selected target assessment:

1. Have an up to date pneumococcal vaccine status (O0300A = [1]); or
2. Were offered and declined the vaccine (O0300B = [2]); or
3. Were ineligible due to medical contraindication(s) (e.g., anaphylactic hypersensitivity to components of the vaccine; bone marrow transplant within the past 12 months; or receiving a course of chemotherapy within the past two weeks) (O0300B = [1]).

**Reporting Guidelines**

No reporting by the facility is required. PHC will extract summary data on Nursing Home Compare in February 2019.
Measure 5. Falls with Major Injury

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measures the percentage of long-stay residents who have experienced one or more falls with major injury. A common safety concern in many nursing homes, injuries due to falls can severely impact a resident’s quality of life. Additionally, residents may in turn lose motivation or confidence in independent mobility after a fall.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full points: ≤3.4% (National average of NQF Measure 0674)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>All long-stay residents with one or more look-back scan assessments except those with exclusions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident is excluded if one of the following is true for all of the look-back scan assessments:</td>
</tr>
<tr>
<td>1. The occurrence of falls was not assessed.</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>2. 0 assessment indicates that a fall occurred AND the number of falls with major injury was not assessed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reporting by the facility is required. PHC will extract summary data on Nursing Home Compare in February 2019.</td>
</tr>
</tbody>
</table>
Measures the percentage of long-stay residents who have had an indwelling catheter in the last seven days. Extended use of catheters are associated with urinary tract infections and prolonged hospital or inpatient stays. This measure evaluates the frequency of catheter use in low-risk residents without preexisting conditions. vi


Full points: ≤1.9% (National average of NQF Measure 0686)

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

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

Target assessment is an admission assessment of 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.

No reporting by the facility is required. PHC will extract summary data on Nursing Home Compare in February 2019.
Measure 7. Inpatient Admissions/100 Resident Days

Description
Measures the rate of long-stay residents with one or more hospital admission during the review period.

Hospitalizations for long-term care facility residents can disrupt their continuity of care and lead to costly complications.\textsuperscript{vii} This measure evaluates facilities’ hospitalization rates across the PHC network.

Threshold
Full points: TBD

Denominator
Number of resident days accumulated by PHC members in the reporting period.

Numerator
Number of admissions to an inpatient setting during the review period by PHC members

Steps to identify the numerator:
Step 1: Identify all acute inpatient stays in an acute facility during the measurement year. To capture all admissions, include service location in inpatient hospital, inpatient rehab, and inpatient psychiatry.
Step 2: Acute-to-acute transfers: An acute-to-acute transfer counts as one stay.

Codes Used
Codes to identify service location as acute facility: SVC_Location Codes 3, 21, 61, and 51

Codes to identify acute-to-acute transfers: See table below.

<table>
<thead>
<tr>
<th>Code Field</th>
<th>Code</th>
<th>Code Field</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSCODE</td>
<td>00</td>
<td>DSCODE</td>
<td>84</td>
</tr>
<tr>
<td>DSCODE</td>
<td>02</td>
<td>DSCODE</td>
<td>85</td>
</tr>
<tr>
<td>DSCODE</td>
<td>04</td>
<td>DSCODE</td>
<td>86</td>
</tr>
<tr>
<td>DSCODE</td>
<td>08</td>
<td>DSCODE</td>
<td>87</td>
</tr>
<tr>
<td>DSCODE</td>
<td>30</td>
<td>DSCODE</td>
<td>88</td>
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<tr>
<td>DSCODE</td>
<td>31</td>
<td>DSCODE</td>
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<tr>
<td>DSCODE</td>
<td>66</td>
<td>DSCODE</td>
<td>90</td>
</tr>
<tr>
<td>DSCODE</td>
<td>82</td>
<td>DSCODE</td>
<td>91</td>
</tr>
</tbody>
</table>

Codes used to identify resident days: LT01, LT02, LT03

Exclusions
Exclude hospital stays for the following reasons:
- A principal diagnosis of pregnancy
- A principal diagnosis of a condition originating in the perinatal period

Reporting Guidelines
No reporting by the facility is required. PHC will calculate rate using claims and inpatient data.
Measure 8. Health Inspection Rating

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measures the inspections conducted by federal surveyors to ensure safe and clean conditions for long term care residents.</td>
</tr>
<tr>
<td>Because CMS requires most nursing homes to partake in these onsite inspections, this measure ensures that facilities are evaluated through a standardized process and compared objectively against a large number of facilities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Full Points: Health Inspection rating of 4 or above</td>
</tr>
<tr>
<td>- Partial Points: Health Inspection rating of 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reporting by the facility is required. PHC will extract Health Inspection stars score on Nursing Home Compare in February 2019.</td>
</tr>
<tr>
<td>To find out more about how ratings are calculated, visit <a href="https://www.medicare.gov/NursingHomeCompare/About/HowWeCalculate.html">https://www.medicare.gov/NursingHomeCompare/About/HowWeCalculate.html</a></td>
</tr>
</tbody>
</table>
Measure 9. Staffing Rating

**Description**

Measures the ratio of staffing hours per resident day for long term care residents.

Higher staff to resident ratios are generally associated with greater care quality. CMS uses a standard scale to rate staffing ratios across the state. This measure is proposed as new to the measurement set as a means to ensure sufficient care staff levels for members.

**Threshold**

- Full Points: Health Inspection rating of 4 or above
- Partial Points: Health Inspection rating of 3

**Reporting Guidelines**

No reporting by the facility is required. PHC will extract Staffing stars score on Nursing Home Compare in February 2019.

To find out more about how ratings are calculated, visit [https://www.medicare.gov/NursingHomeCompare/About/HowWeCalculate.html](https://www.medicare.gov/NursingHomeCompare/About/HowWeCalculate.html)
Measure 10. Quality Improvement Implementation Plan

**Description**

Measures the progress toward implementing either INTERACT 4.0, or the Quality Assurance and Performance Improvement program.

Quality Improvement is the foundation of the QIP. Taking time to assess progress towards goals leads to improved outcomes. This measure encourages facilities to set goals and develop plans for achieving them.

**Threshold**

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

**Measure Options**

LTC facilities can earn up to ten points by reporting on an initial implementation plan and progress towards its goals during the measurement year. There are two 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. Improvement plans are subject to review and audit by the PHC Quality Department.

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

- **Resource 2: 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, 2018</td>
<td>5</td>
</tr>
<tr>
<td>Part II</td>
<td>February 28, 2019</td>
<td>5</td>
</tr>
</tbody>
</table>
Measure 11. QI Training and QAPI Self-Assessment

**Description**

Measures the attendance of training focusing on quality improvement methods and practices.

Quality Improvement is the foundation of the QIP. The program encourages regular education in quality improvement methods and continuing education of clinical guidelines.

**Threshold**

- Full points: completion of both measurement steps
- Partial points: completion of either one of the two measurement steps

**Measure Steps**

LTCs can earn up to ten points by completing the following steps. Documentation for all steps is due by February 28, 2019.

**Step 1: Quality Improvement Training**

Send two or more staff members to attend PHC-approved training focusing on quality improvement, 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).
# 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>Gateway Measure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS Five-Star Rating</td>
<td>No; based on Nursing Home Compare data extracted February 2019</td>
<td>N/A</td>
</tr>
<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 2019</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 2019</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Long-stay residents who needed and got a flu shot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Long-stay residents who got a vaccine to prevent pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Functional Status Domain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Percent of residents experiencing one or more falls with major injury</td>
<td>No; based on Nursing Home Compare data extracted February 2019</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Percent of residents who have/had a catheter inserted and left in their bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resource Use Domain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Inpatient Admissions/1000 Resident Days</td>
<td>No; calculated using PHC data</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Operations/Satisfaction Domain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Health Inspection Rating</td>
<td>No; based on Nursing Home Compare data extracted February 2019</td>
<td>N/A</td>
</tr>
<tr>
<td>10. Implementation Plan</td>
<td>Yes; reported annually</td>
<td>February 28, 2019: Certificate of Attendance, QAPI Self-Assessment</td>
</tr>
<tr>
<td>11. QI Training and QAPI Self-Assessment</td>
<td>Yes; reported annually</td>
<td></td>
</tr>
</tbody>
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Appendix II
Submission Template I: Implementation Plan Part I

Please draft an implementation on either program below and submit by August 31, 2018 via email to 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 IV: Works Cited for Measure Rationale

Appendix III
Submission Template II: Implementation Plan Part II

Please draft an implementation on either program below and submit by February 28, 2019 via email to 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.
Appendix IV: Works Cited for Measure Rationale


