UTAH MEDICAID ICF/ID FACILITY
State Fiscal Year 2016
QUALITY IMPROVEMENT INCENTIVE APPLICATION
Rule R414-504-5

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2016

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

☐ This facility received no violations that are at the "immediate jeopardy" level, as determined by the Department, at the most recent re-certification survey and during the incentive period. Qualifying Requirement

☐ This facility received no more than one condition level deficiency during the incentive period. If the facility received a deficiency during the incentive period, it will be eligible for only 50% of the possible reimbursement. Qualifying Requirement

☐ This Facility has implemented a meaningful Quality Improvement plan which includes the involvement of residents and family. *(A brief description of our Quality Improvement Plan is attached.)* 50% weighting

- ☐ This facility has a demonstrated process by which our Quality Improvement plan is assessed and measured. *(A brief report describing this process including an example demonstrating how the facility assessed, responded to and re-evaluated a quality concern, is attached.)*

☐ This facility had **customer** satisfaction surveys conducted by an independent third-party entity in each quarter of the incentive period. The following information is attached: 25% weighting

- ☐ Name and brief description of the third-party entity performing the quarterly survey.
- ☐ Brief description of
  - the survey questions,
  - who is surveyed,
  - when the surveys are done, and
  - how this facility uses the survey results to improve operations / customer satisfaction.
- ☐ Four Quarterly survey results summaries with the final quarter ending March 31st of the incentive period (e.g., a graph, etc.)
- ☐ An action plan to address survey items rated below average for the year. *(A list of the areas identified as below-average during any part of the year and each corresponding plan to improve the area is attached. Below average means a rating below the industry average. If that is not available, choose the area that your facility consistently receives the lowest rating.)*

☐ This facility has implemented an employee satisfaction program. (*A brief description of our employee satisfaction program is attached including a brief example of how employees have benefited from the program*.) 25% weighting

Please ensure that the attached documents do not exceed a total of 10 pages.

By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify.

Fax to: 801-323-1597 <or> Mail instructions: http://health.utah.gov/medicaid/stplan/longtermcare.htm