

UTAH MEDICAID ICF/MR FACILITY
State Fiscal Year 2012
QUALITY IMPROVEMENT INCENTIVE APPLICATION
Rule R414-504-5

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2012

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 has implemented a meaningful Quality Improvement plan which includes the involvement of residents and family. 50% weighting
(A brief description of our Quality Improvement Plan is attached.)
- This facility has a demonstrated process by which our Quality Improvement plan is assessed and measured. 25% weighting
(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.
 - July, August or September 2011 survey results summary (e.g., a graph, etc.)
 - October, November or December 2011 survey results summary (e.g., a graph, etc.)
 - January, February or March 2012 survey results summary (e.g., a graph, etc.)
 - April, May or June 2012 survey results summary (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: 801-323-1595

<or>

Mail instructions: <http://health.utah.gov/medicaid/stplan/longtermcare.htm>