VieCare Armstrong, LLC.

Annual Quality Improvement Report

July 1, 2022 thru June 30, 2023

LIFE ARMSTRONG FY 2020 ANNUAL QI REPORT
(July 1, 2022 – June 30, 2023)

CMS Required Quality Measures							
Quality Indicator	***Quality Objective/Rationale***	***Goal Benchmark***	***1st Qtr***	***2nd Qtr***	***3rd Qtr***	***4th Qtr***	***Goal Met/ Not Met***
Enrollments	Identify patterns or trends of effectiveness of marketing strategies to maintain expected census.	Enrollment of 9 participants/quarter	7	8	6	7	**Not Met** 7 avg. for yr.
		Net enrollment of 3 participants/quarter	2	3	-1	-1	**Not Met** 1 avg. for yr.
	LIFE Armstrong County enrolled 28 participants during FY2023. The number of enrollments did not meet the target goal for all 4 quarters and the program's goal to increase 1 participant in net enrollment was met 2 of the 4 quarters. The Marketing and Enrollment department continues to work on growing the LIFE Armstrong County census with events at various locations in order to get information about the LIFE Program out into the community. This monitor will continue in FY2024.						
	Achieve census at end of quarter that meets or exceeds program's budget benchmark.	Meet or preferably exceed budget of 90-94 census	89	90	94	93	**Met** Average 92 for the year
	The benchmark for maintaining or increasing the current census levels by offsetting new enrollments with voluntary disenrollments and deaths each quarter was met for 3 of 4 quarters during FY2023. This monitor will continue in FY2024.						
Disenrollments Voluntary	Review voluntary disenrollments determine effectiveness of strategies to reduce # of disenrollments	Voluntary disenrollments will not exceed 3% of annual census (excluding deaths)	0%	0.4%	1%	0.4%	**Met** Average 0.5% for the year
	There were 5 disenrollments during FY23 with 0 due to dissatisfaction with the program and the benchmark was achieved for all 4 quarters. Reason for disenrollments: Moved out of service plan area – 1 Chose SNF placement – 1 Chose Personal Care Home – 1 No longer financially eligible – 1 Family wanted to be paid caregiver – 1 LIFE Armstrong will continue to monitor this indicator during FY2024 to identify contributing factors prompting a participant request to disenroll and assess the need to implement clinical and/or operational improvement(s) that may avert the participant's disenrollment.						

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Deaths – End-of-Life Wishes	Participant end-of-life wishes are carried out according to advance directive. Participant death occurred according to participant wishes.	100%	100%	100%	100%	100%	**Met** Average 100% for year
	There were fifteen (15) deaths that occurred during fiscal year FY2023: • 53% (8) occurred in the participant's home • 53% (8) in the hospital • 6% (1) in a SNF. LIFE through with each participant's end-of-life wishes and the benchmark was achieved for all 4 quarters. LIFE Armstrong County will continue to monitor this indicator during FY2024.						
Hospitalizations	LIFE staff will utilize information to identify participants who demonstrate high utilization of acute care services	Not to exceed 99 days per quarter	125	107	155	99	**Not Met** 122 days avg. for year
	LIFE Armstrong achieved the target goal in 1 of the 4 quarters during FY2023. Significant participant comorbidities and high acuity levels of care, along with COVID-19 restrictions which made placement in SNF/ECF more difficult to achieve during the 3rd and 4th quarters contributed to increased hospital stays. During weekly Case Management meetings, interdisciplinary team members completed an intensive review of all hospitalizations and acted upon identified opportunities to promote and/or enhance early care interventions to prevent hospitalizations. The FY2024 target for this measure will remain the same.						

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<table>
<tr><th>Quality Indicator</th><th>Quality Objective/Rationale</th><th>Goal Benchmark</th><th>1st Qtr</th><th>2nd Qtr</th><th>3rd Qtr</th><th>4th Qtr</th><th>Goal Met/ Not Met</th></tr>
<tr><td rowspan="3">Readmissions within 30 Days</td><td rowspan="2">Identify improvement opportunities of treatment plan to prevent readmissions within 30 days of discharge.</td><td>Quarterly hospital readmission rate ≤ 15%</td><td>19%</td><td>14%</td><td>16%</td><td>10%</td><td>Met
Avg Qtr
15%</td></tr>
<tr><td>Rolling 12-month hospital readmission rate ≤ 15%</td><td>21%</td><td>21%</td><td>21%</td><td>16%</td><td>Not Met
Avg
20%</td></tr>
<tr><td colspan="7">Eleven (11) hospital readmissions occurred within 30 days of participant’s original admission during FY2023, which is 9 less than the previous fiscal year. None (0) of the diagnoses for the readmissions was the same or related to the initial diagnosis.
LIFE Armstrong did not achieve the quarterly benchmark for 2 of the 4 quarters during FY2023, but the overall average readmission rate of 15% did meet the target goal. The 12-month rolling readmission goal was not achieved for all 4 quarters and the average rolling rate was above the benchmark at 20%. However the 4th quarter did drop 5% and was just above the target goal. Significant participant comorbidities and high acuity levels due to decline in health status and COVID-19 infections contributed to not meeting readmission rate benchmarks. The FY2024 target for this measure will remain the same.</td></tr>
<tr><td rowspan="2">Emergency Room Visits</td><td>Participants presenting to ER for services & are treated &released following evaluation / treatment</td><td>Outpatient ER visits/ 1000/Annum: 350</td><td>263</td><td>254</td><td>293</td><td>149</td><td>Met
240 avg. for year</td></tr>
<tr><td colspan="7">LIFE Armstrong County participants utilized hospital emergency room services 140 times between July 1, 2022 and June 30, 2023, which is 10 less than the previous fiscal year. The ER visit rate remained below the target goal all four quarters; with an average rate of 240 for the fiscal year. The internal goal of 30% or less of the ER visits deemed non-emergent/emergent-avoidable by the LIFE physician/clinical staff was met for 2 of the 4 quarters with an average of 34%, which is above the 30% benchmark. No patterns or trends noted.
The majority of visits occurred during M-F and during the hours of 8am-5pm. The top three diagnoses are listed below.
The FY2024 target for this measure will remain the same.
<table>
<tr><th colspan="2">ER Visits</th><th colspan="3">Average for FY2023</th></tr>
<tr><td rowspan="2">Day of Week</td><td>M-F</td><td>69%</td><td rowspan="5">Top 3 Diagnoses</td><td rowspan="5">Falls 19%
Neurological 17%
Respiratory 16%</td></tr>
<tr><td>Sa-Su</td><td>33%</td></tr>
<tr><td rowspan="3">Time of Day</td><td>8a-5p</td><td>57%</td></tr>
<tr><td>5p-12a</td><td>28%</td></tr>
<tr><td>12a-8a</td><td>12%</td></tr>
</table>
</td></tr>
</table>

LIFE ARMSTRONG FY 2020 ANNUAL QI REPORT
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CMS Required Quality Measures

Quality Indicator	*Quality Objective/Rationale*	*Goal Benchmark*	*1st Qtr*	*2nd Qtr*	*3rd Qtr*	*4th Qtr*	*Goal Met/ Not Met*
Nosocomial Pressure Wound Rate	Stage I-IV pressure ulcers will be considered nosocomial if acquired in any setting.	Less than 5 nosocomial pressure wounds per 1000 participant days.	2.0	2.4	3.4	5.9	**Met** Average 3.4 for year
	Life Armstrong County's nosocomial pressure wound rate was below the target threshold for 3 or the 4 quarters during FY2023. The FY2024 target for this measure will remain the same.						
Infection Control	Review all treated infections for trends and/or patterns.	***Number of Infections***	***1st Qtr***	***2nd Qtr***	***3rd Qtr***	***4th Qtr***	***Total # Infections***
		Reporting purposes only	12	25	42	27	106
	There were 141 infections reported and treated during FY2023 with the top infections as follows: 1. Urinary tract infections (UTI): 38 (27%) 2. EENT: 26 (18%) 3. Skin/Wound: 24 (17%) Influenza/COVID-19: 24 (17%) UTI infection data was collected during the fiscal year to identify areas of improvement to assist with reducing the number or recurrence of these infections. Of the 38 UTI infections: • 84% were cultured • 2% were recurrent • 2% were med resistant • 2% required an ER/Hospital visit. • 0 (0%) were related to a catheter Medical conditions and hygiene practices were the most common reasons for recurrent and new UTI infections during the fiscal year. This quality indicator will be included in the FY2024 QI Plan.						

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<table>
<tr><th colspan="8">CMS Required Quality Measures</th></tr>
<tr><th>Quality Indicator</th><th>Quality Objective/Rationale</th><th>Goal Benchmark</th><th>1st Qtr</th><th>2nd Qtr</th><th>3rd Qtr</th><th>4th Qtr</th><th>Goal Met/ Not Met</th></tr>
<tr><td rowspan="2">Routine Immunizations Pneumococcal</td><td>Number of participants receiving pneumococcal vaccine compared to number of eligible participants accepting offer to be vaccinated.</td><td>80% CMS</td><td>81%</td><td>79%</td><td>85%</td><td>83%</td><td>Met
Average 82% for year</td></tr>
<tr><td colspan="7">The CMS benchmark of 80% for this indicator was achieved in 3 of the 4 quarters throughout FY2023. Quarterly measurements ranged from a low of 79% to a high of 85% with an overall immunization rate of 82%; which exceeds the benchmark by 2%.
19 eligible LIFE Armstrong participants refused the vaccine despite receiving additional education & physician and nurse counseling during each 6-month reassessment and 30 participants did not have immunization status documented during the fiscal year. Clinic processes are were revised during the first two quarters, which resulted in a 6% improvement during the 3rd quarter.
The FY2024 target for this measure will remain the same.</td></tr>
<tr><td rowspan="4">Routine Immunizations Influenza</td><td rowspan="2">Promote participant well-being & reduce risk of infectious influenza outbreak among participants.</td><td rowspan="2">CMS Benchmark 80%</td><td>2020-2021</td><td>2021-2022</td><td>2022-2023</td><td colspan="2">Goal Met/ Not Met</td></tr>
<tr><td>71%</td><td>80%</td><td>90%</td><td colspan="2">Met
90% for FY23</td></tr>
<tr><td colspan="7">At the conclusion of the 2022-2023 influenza vaccination campaign; LIFE Armstrong County achieved a 90% immunization rate; which exceeds the 80% CMS benchmark.
LIFE Armstrong County clinic and nursing staff will continue to educate participants on the importance of being vaccinated and encourage their participation during the 2023-2024 campaign.</td></tr>
</table>

CMS Required Quality Measures

Quality Indicator	*Quality Objective/Rationale*	*Goal Benchmark*	*1st Qtr*	*2nd Qtr*	*3rd Qtr*	*4th Qtr*	*Goal Met/ Not Met*
Falls – Number of Participant Falls	Track incidence of participant falls to develop strategies to promote reduction in the incidence of falls and injuries incurred from falls.	2.74-5.48 falls per 1,000 participant days	8.2	6.4	8.0	5.4	**Not Met** Average 7.0 for year
	LIFE Armstrong participant falls numbered 232 for FY2023; which was 76 more than the previous fiscal year. The majority of falls occurred within the participants' home and while ambulating. The fall rate was within or below the benchmark parameters for 1 of the 4 quarters with an average fall rate of 7.0 falls/1000 participant days falls; which exceeds the highest benchmark parameter. Deconditioning due to COVID-19 restrictions contributed to not meeting the target goal. Weekly falls committee meetings continue to be conducted to determine and act upon significant contributing factors, as well as, review individual participant falls and implement appropriate interventions as quickly as possible. The FY2024 target for this measure will remain the same.						
Falls - Resulting in Participant Injury	Number of participant falls resulting in Level III, IV or V injury compared to number of reported participant falls during report period.	Total participant falls resulting in Level III, IV or V severity will not exceed 8%	3%	2%	3%	7%	**Met** Average 4% for year
	Of the 232 falls that occurred during the fiscal year: • 164 (71%) resulted in "No Injury" • 60 (26%) resulted in a "Minor" Injury • 8 (5%) were classified as a Level III, IV and V injury • No participant deaths were reported as a result of a fall Overall for FY2023, the combined Level III, IV and V severity of injury classifications were 4%; which is below the benchmark for this indicator and the target rate was achieved for all 4 quarters throughout the fiscal year. This quality indicator will be included in the FY2024 QI Plan.						

CMS Required Quality Measures

Quality Indicator	*Quality Objective/Rationale*	*Goal Benchmark*	*1st Qtr*	*2nd Qtr*	*3rd Qtr*	*4th Qtr*	*Goal Met/ Not Met*
Grievances & Appeals	The grievance and appeals process is carried out according to regulatory requirements.	100% resolution within 5 business days	100%	100%	100%	100%	**Met** 100%
	During FY2023, LIFE Armstrong County received 12 grievances from participants and/or caregivers of which all or 100% were resolved to the participant/caregiver satisfaction. Additional participant education was conducted to ensure participants understood the process and also to encourage them to voice any concerns or issues. Communication was the largest area of concern but no patterns or trends were identified. There were no appeals received by LIFE Armstrong during this fiscal year reporting period. The FY2024 target for this measure will remain the same.						
Customer Satisfaction **Participant and Family/ Caregiver**	Utilize participant and family/caregiver satisfaction responses to improve operations in each LIFE service and care area, as well as general operations.	75% or greater *Strongly agree* or *agree* overall rating	Participant		78%		**Met**
			Family/ Caregiver		83%		**Not Met**
		75% or greater *Would Recommend*	Participant		75%		**Met**
			Family/ Caregiver		83%		**Not Met**
	Results of the satisfaction surveys for the LIFE Armstrong County program identify the participant's and level of satisfaction relevant to specific care areas, as well as the program in general. The benchmark for participant and family/caregiver satisfaction was achieved for fiscal year 2023. The ADHC Director, department managers and staff will develop and implement plans of action to address any identified areas of concern. Implemented actions will be measured and plans modified as indicated to promote total satisfaction. The FY2024 target for this measure will remain the same.						

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DEPARTMENTAL QUALITY MEASURES							
Quality Indicator	***Quality Objective/Rationale***	***Goal Benchmark***	***1st Qtr***	***2nd Qtr***	***3rd Qtr***	***4th Qtr***	***Goal Met/ Not Met***
Nutritional Services Participant Weights	Monitor until weight status has been maintained or improved for 6 months.	50%	88%	100%	83%	94%	**Met** 92% avg. for year
	The number of LIFE Armstrong County participants who maintained or gained weight during each quarterly review period exceeded the 50% target for all 4 quarters during FY2023. Due the significant importance of this indicator, the monitor will continue to be included in the FY2024 Quality Improvement Plan.						
Recreation – LIFE in Motion	Participants will exercise 30 minutes each day while at the Center to promote optimal physical fitness and well-being.	90%	92%	92%	94%	88%	**Met** Average was 92% for year
	The target goal was achieved in 3 of the 4 quarters monitored during FY2023 with an overall 92% average; which exceeds the target benchmark. This monitor will continue in FY2024.						
Human Resources Relias Training	All Relias trainings will be completed by LIFE Armstrong staff by the end of the month due.	100%	85%	92%	87%	92%	**Not Met** Average 89% for year
	LIFE Armstrong County's average performance rate for FY2023 was 89%, which was below the monitor's 100% target goal, but was an improvement of 10% from the previous fiscal year. The Human Resources Department continues to notify Department Managers of staff compliance each month in completing assigned Relias training modules for follow-up with staff. This monitor will continue during FY2024.						

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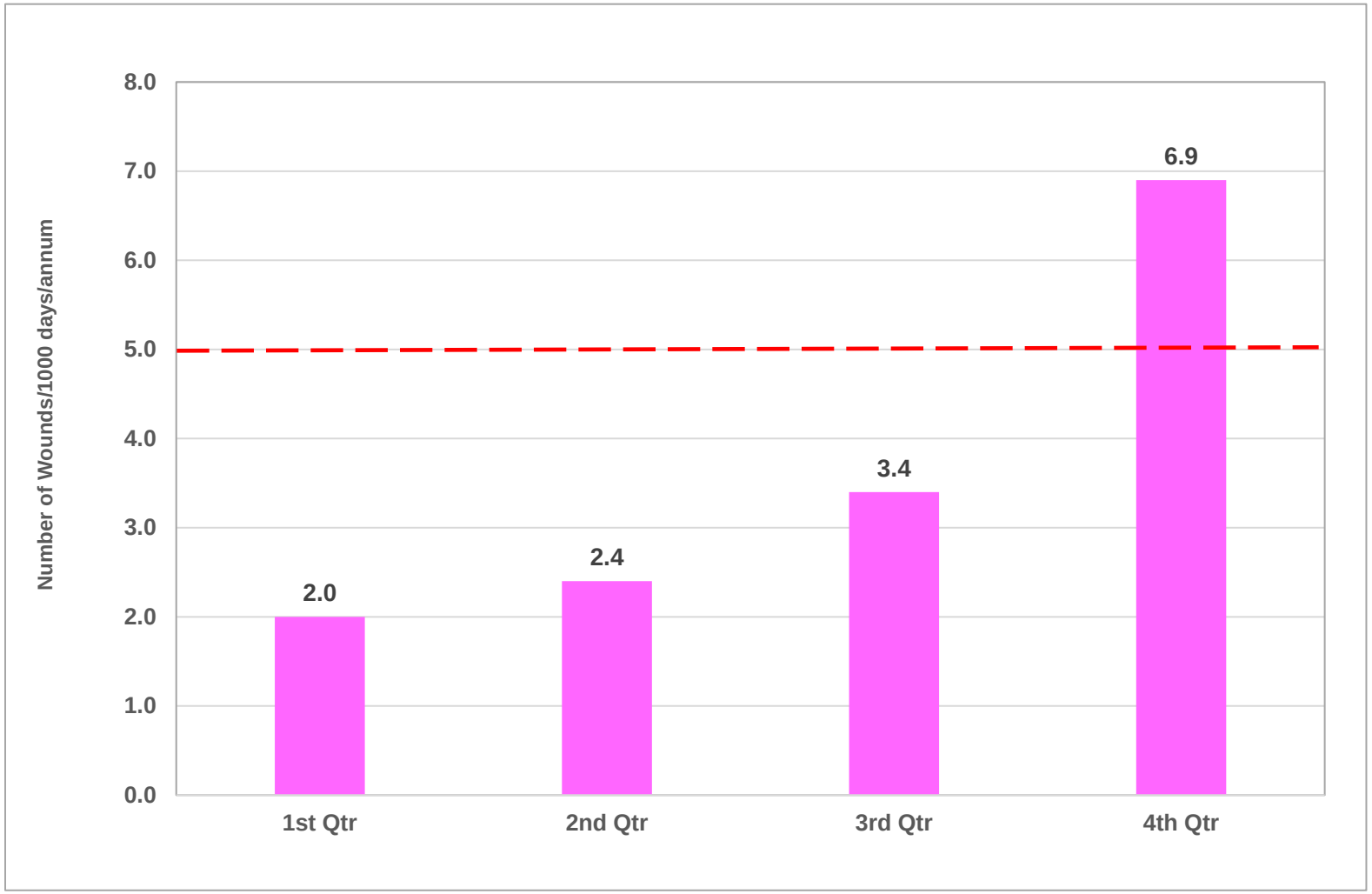
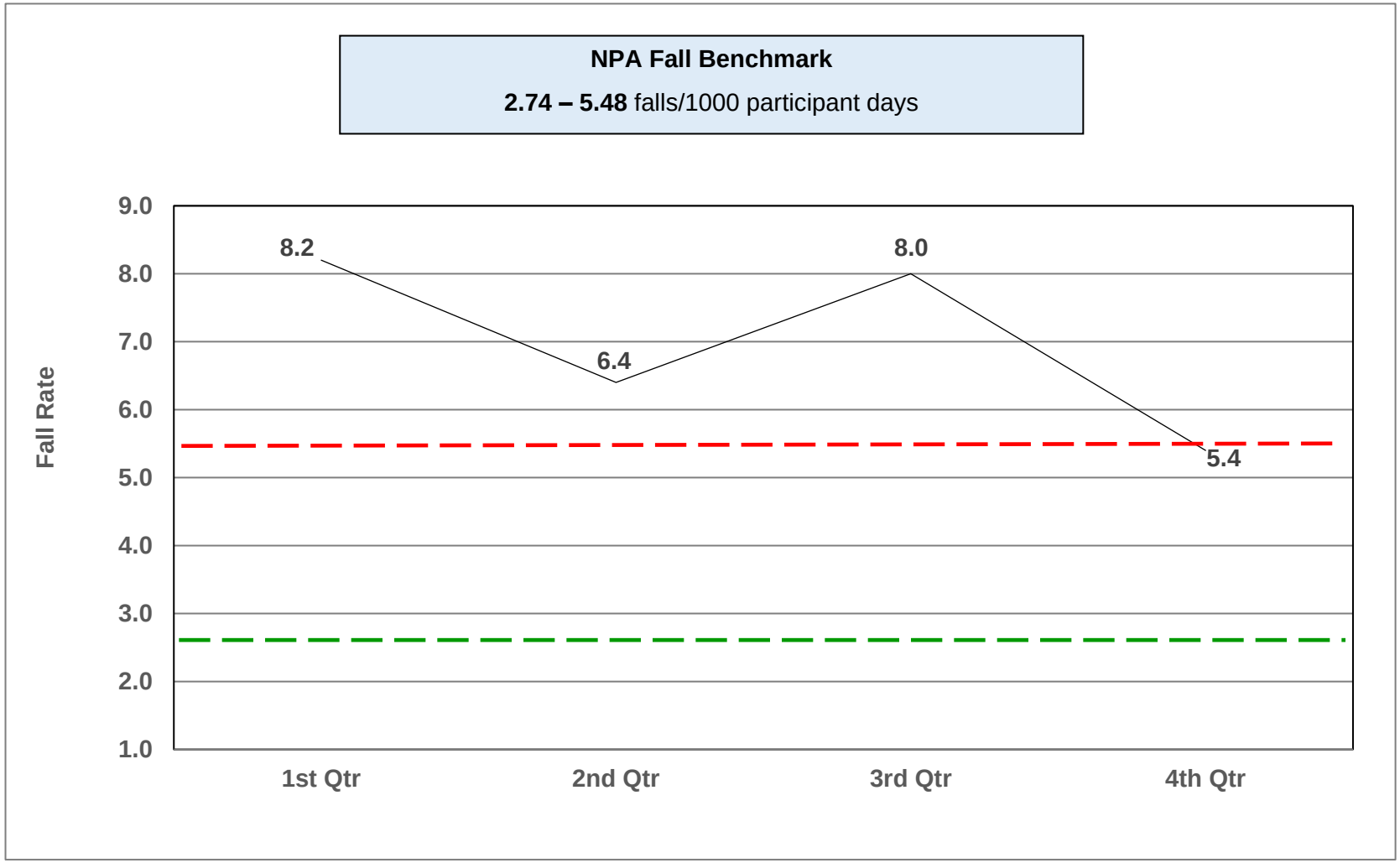
DEPARTMENTAL QUALITY MEASURES							
Quality Indicator	***Quality Objective/Rationale***	***Goal Benchmark***	***1st Qtr***	***2nd Qtr***	***3rd Qtr***	***4th Qtr***	***Goal Met/ Not Met***
Social Services Depression Screening (PHQ-9)	**Enrollment:** Participants will be assessed for depression by day 30 after enrollment.	100%	100%	100%	100%	100%	**Met** 100%
	Annual: Participants will be assessed for depression within 12 months of enrollment.	100%	100%	100%	100%	100%	**Met** 100%
	LIFE Armstrong social workers achieved and sustained 100% compliance for screening each new participant upon enrollment in the LIFE program and current participants annually. This monitor was revised during the 4th quarter and for FY2024 the PHQ-9 scores will be tracked with the goal of 100% of those scoring 10 or more (indicating high depression) have appropriate services in place.						

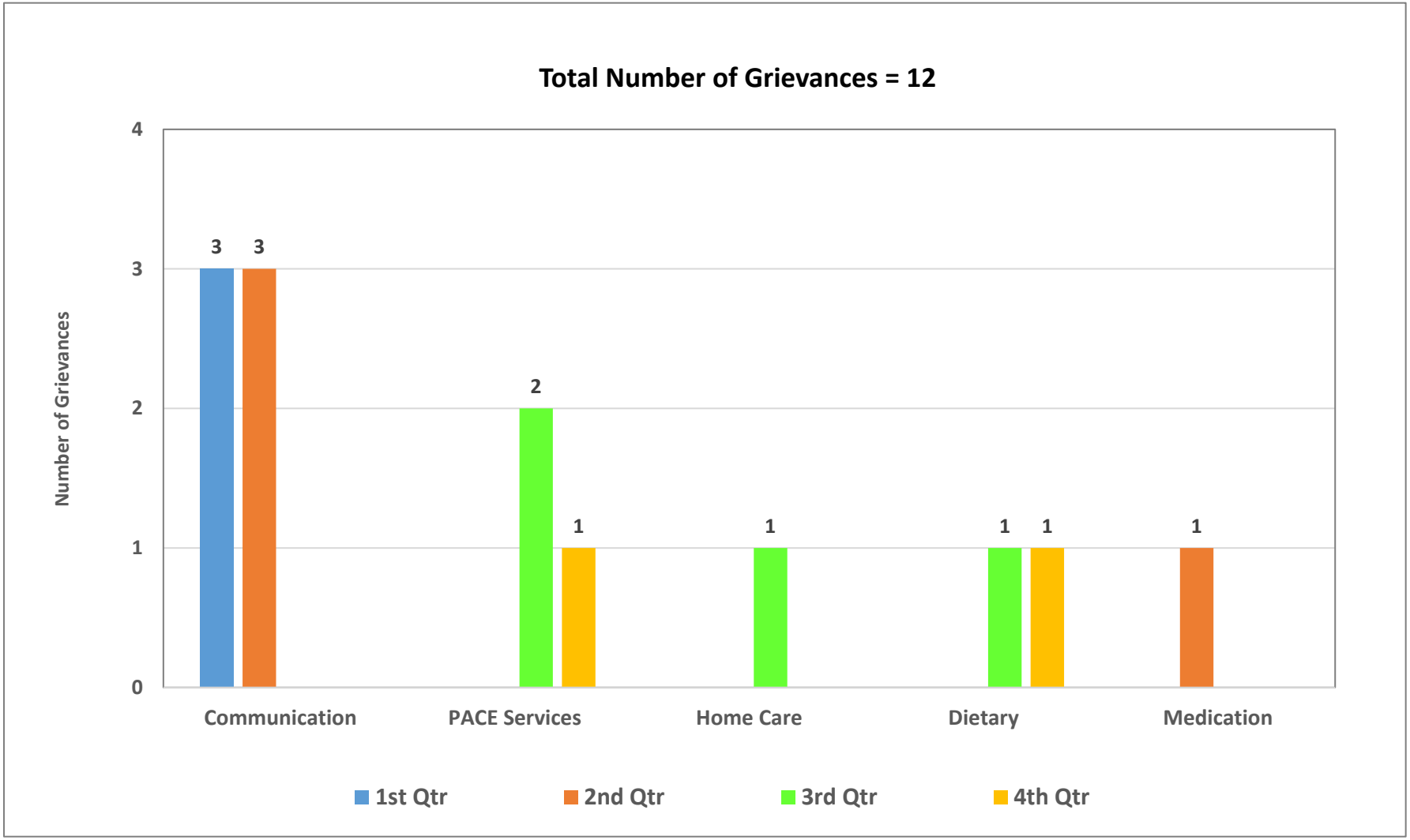
PRESSURE WOUNDS-NOSOCOMIAL



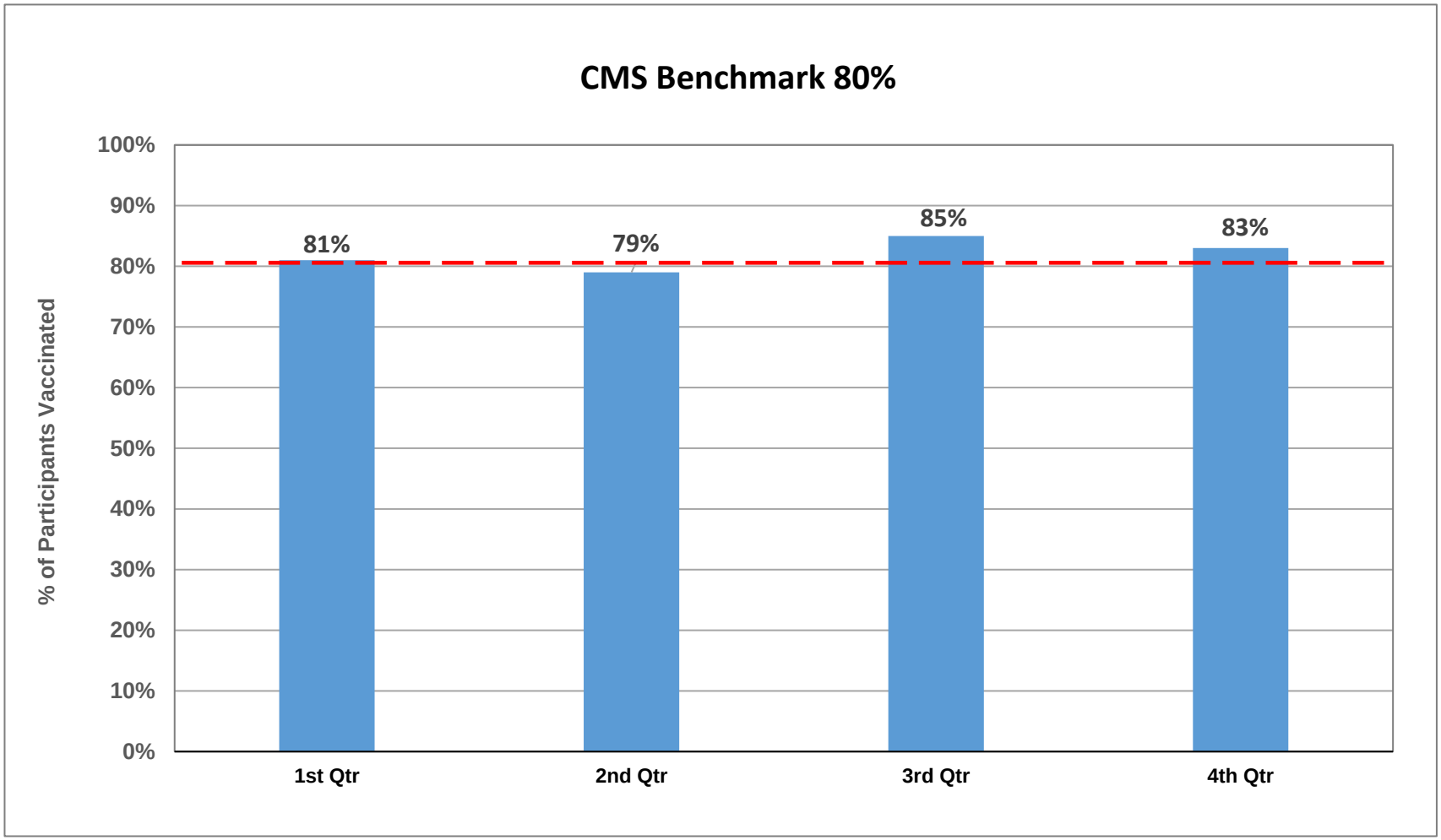
FALL RATE


NPA Fall Benchmark
2.74 – 5.48 falls/1000 participant days
Fall Rate
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
8.2
6.4
8.0
5.4
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr

GRIEVANCES


Total Number of Grievances = 12
Number of Grievances
4
3
2
1
0
3
3
2
1
1
1
1
1
Communication
PACE Services
Home Care
Dietary
Medication
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr

PNEUMOCCAL ADMINISTRATION



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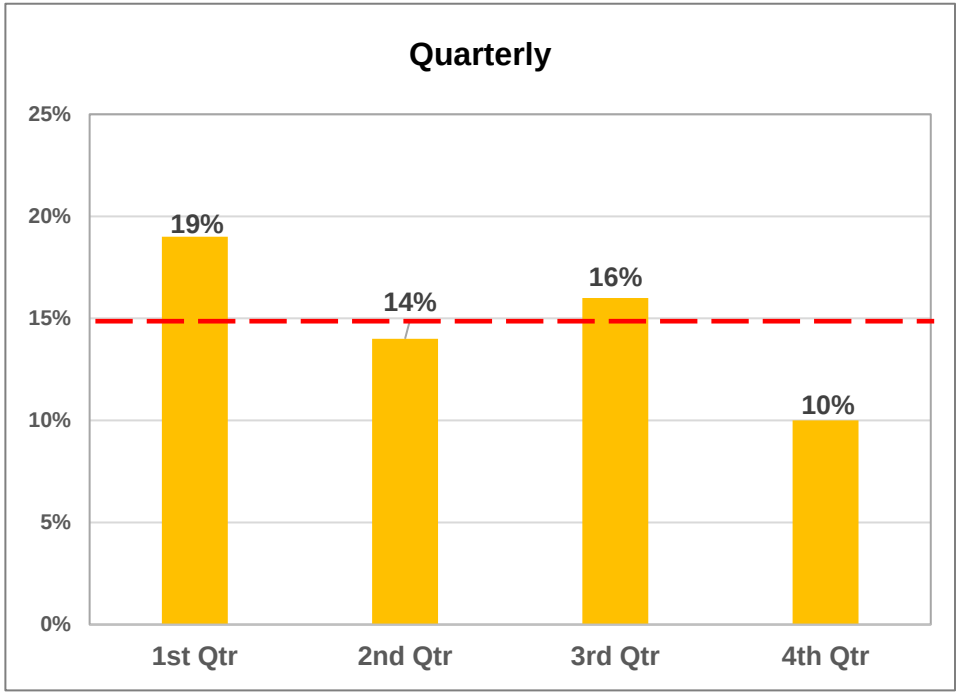
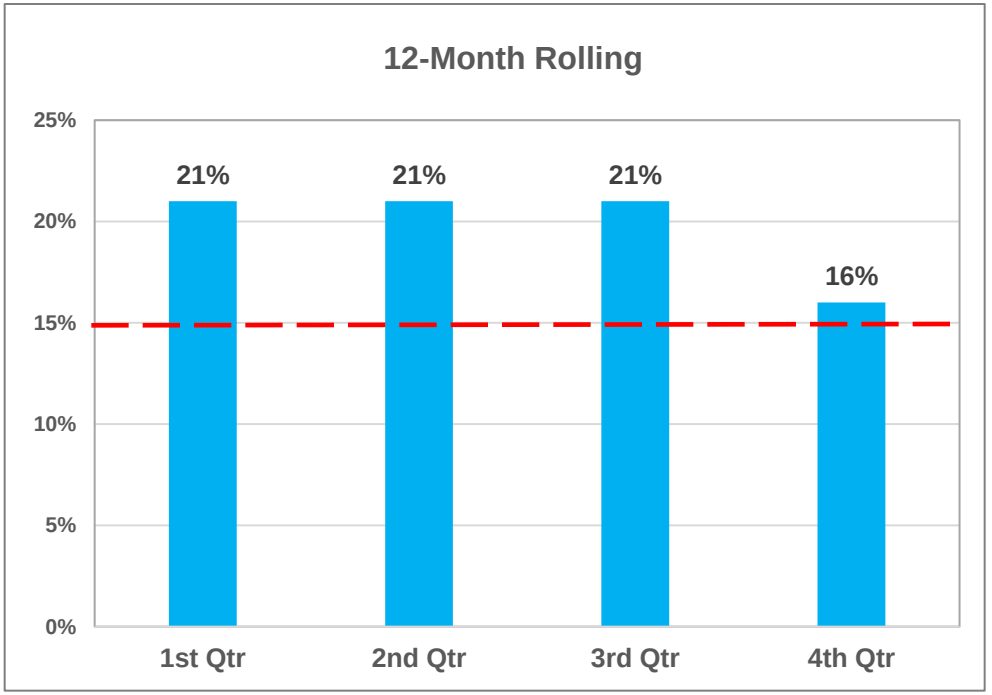
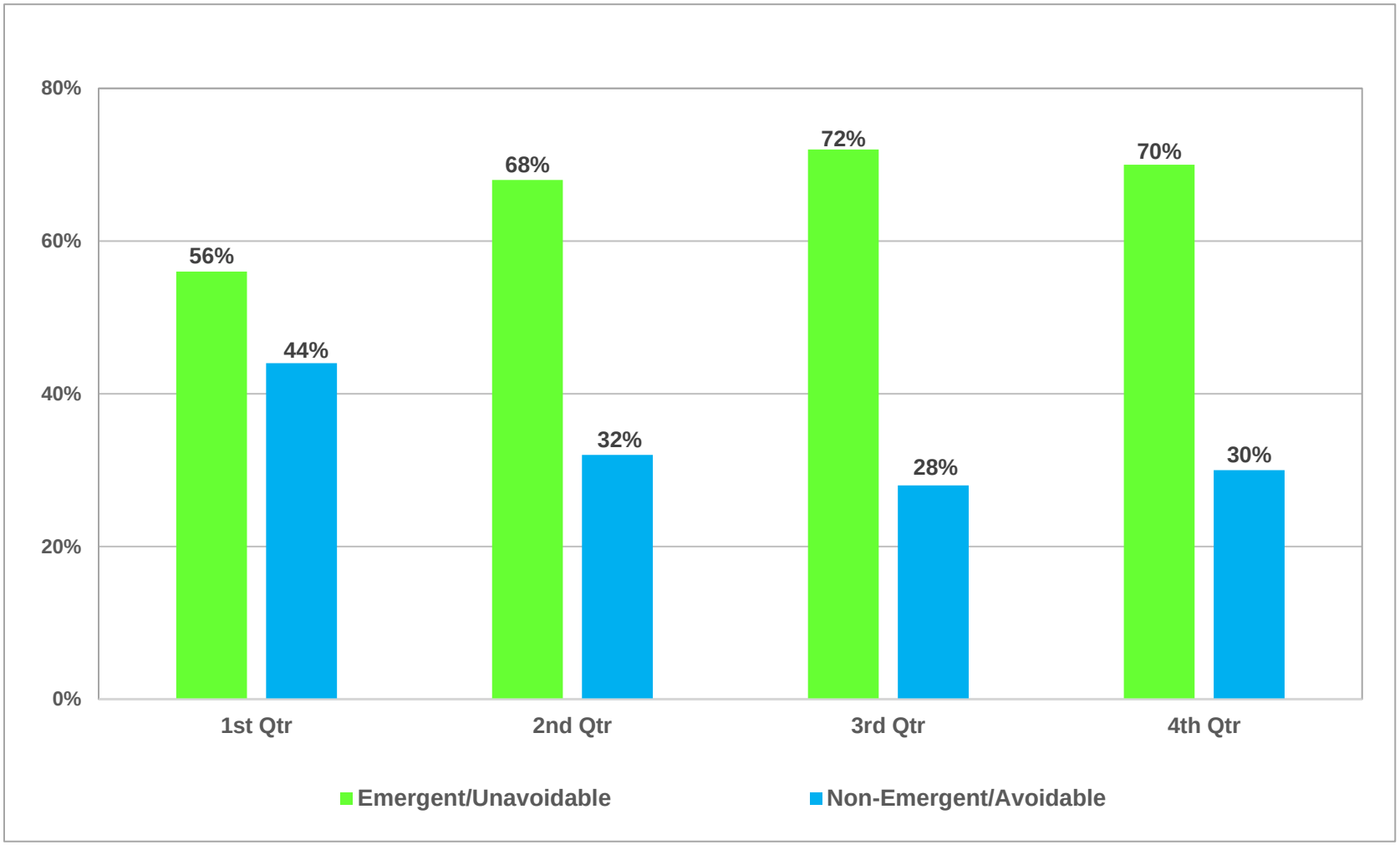
HOSPITAL READMISSIONS

BENCHMARK = 15%





ER VISITS – Non-Emergent/Avoidable vs Emergent/Unavoidable



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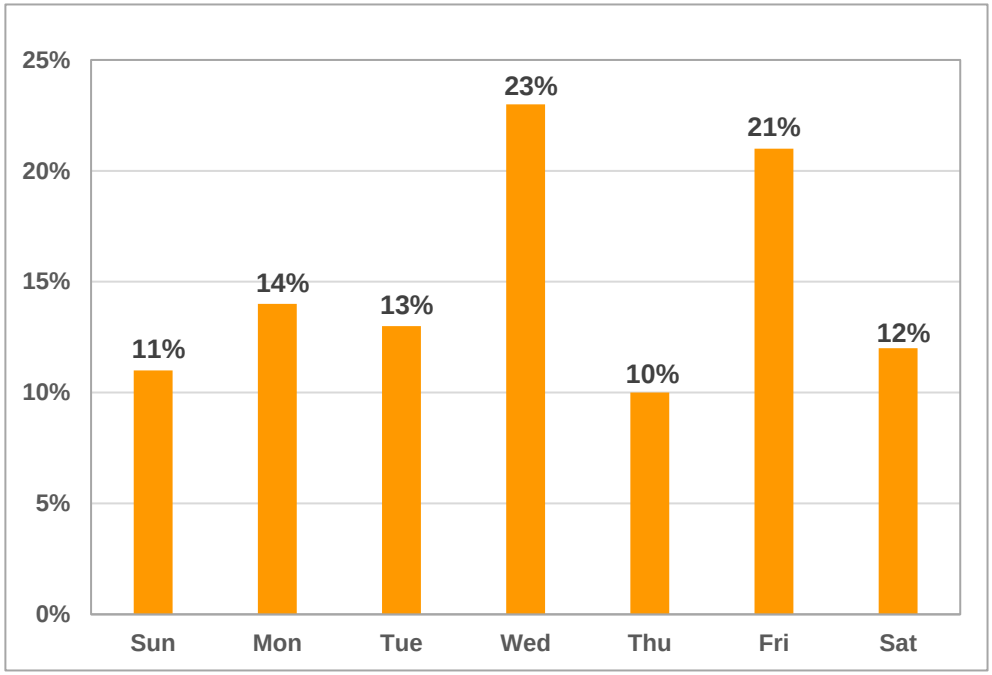
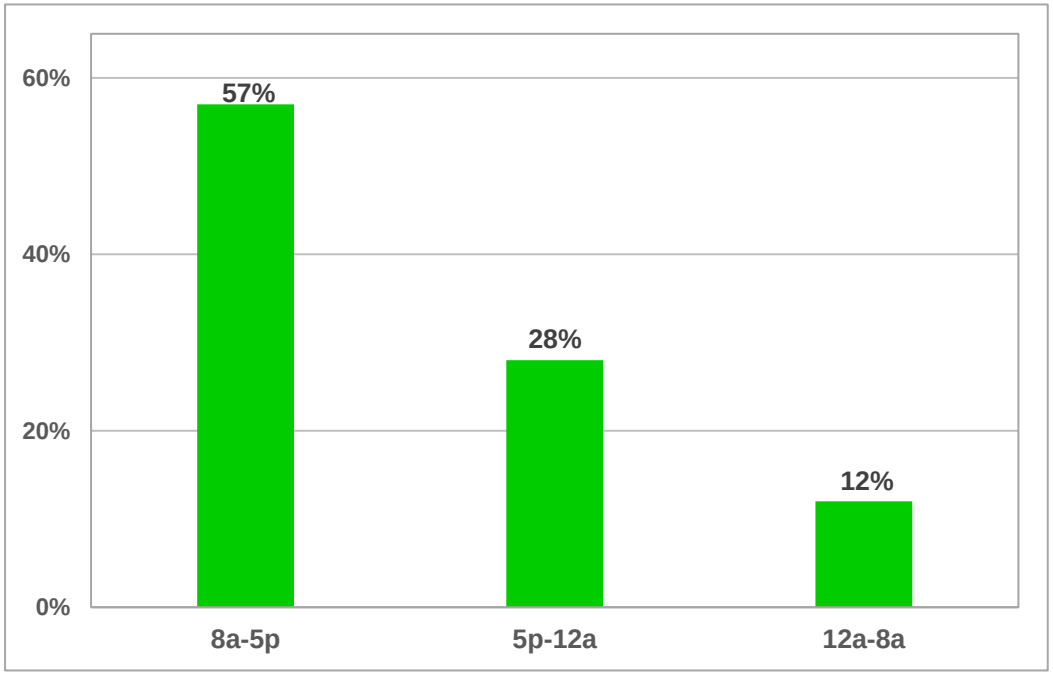
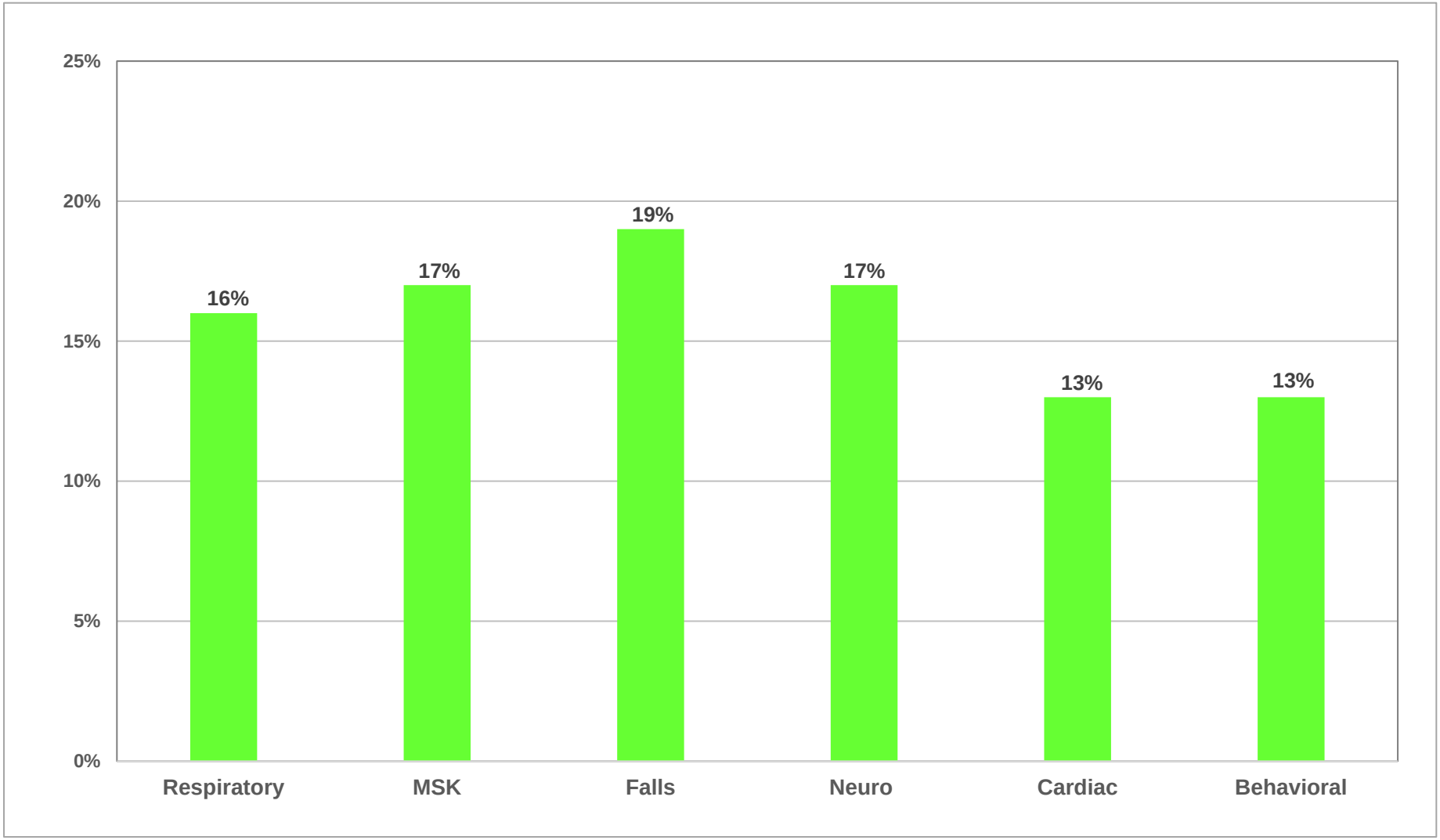
ER VISITS – DAY OF WEEK



ER VISITS – TIME OF DAY



ER VISITS – TOP ER DIAGNOSES



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SUMMARY

In conclusion, this report discloses the LIFE Armstrong County outcome measurements for the quality monitors identified in the FY2023 Quality Improvement Plan. Where indicated, there is mention of contributing factors that impacted the outcome and actions taken or strategies developed to promote improved performance in providing care and services to LIFE participants.

The following QI Initiatives were met or exceeded the target goal during FY2023 and it is anticipated these performance measures will continue to increase or be sustained throughout the upcoming fiscal year monitoring period:

- Deaths
- Enrollments (Quarterly)
- Voluntary Disenrollments
- Hospital Readmissions
- Pressure Ulcer Prevention
- Emergency Room Visits
- Fall Injury Prevention
- Pneumococcal & Influenza Vaccinations
- Grievance Resolution
- Participant Weights
- Participant Fitness Programming
- Depression Screening – Enrollment & Annual

The following QI Initiatives did not meet the target goal during FY2023 and reveal opportunities for improvement in the upcoming fiscal year monitoring period:

- Enrollments (Net)
- Fall Prevention
- Hospitalizations
- Relias Training

With regard to Program Satisfaction, further assessment will be carried out to determine opportunities for improvement; which may lead to the development or modification of work processes that when implemented emphasizes the program's desire to increase participant satisfaction.

Respectfully submitted,
Laura Hankey, RN, BSN, Director of Quality Assurance and Education