



2009
AHCA/NCAL National Quality Award
A Benchmark of Distinction

Step I Application & Criteria



ahca[®]
American Health Care Association

ncal[®]
National Center For Assisted Living



2009 AHCA / NCAL National Quality Award

Step I Applicant Information

SUBMISSION: Applications will be accepted beginning February 1, 2009. Please visit http://www.ahcancal.org/quality_improvement/quality_award/Pages/default.aspx for application submission and payment instructions.

DEADLINE: Applications must be posted electronically prior to **11:59 PM EST**, (10:59 PM CST, 9:59 PM MST, 8:59 PM PST) **February 27, 2009**.

FORMAT: This is an on-line application process. You will be required to enter the information gathered on the following two pages prior to uploading your application into our database. Please print this form and complete it prior to initiating the on-line application process so that you have the necessary information to be able to complete your submission. **Create a separate Microsoft Word document to address all Step I Criteria found on pages 5-6 of this document.**

ORGANIZATION: For the purposes of the application and criteria, *organization* means the single facility or center that is applying for the award, not a multi-facility organization.

AUTHORIZATION - Prior to submitting your application, you will be asked to agree with the following statements:

- > Submission of this document certifies that the attached application is an accurate and true reflection of the application of the AHCA/NCAL award criteria to this organization (facility). The contact person identified above certifies that the content of this application is original to this organization and was not supplied by others, including the corporate office or parent company or external consultants (mission and related statements exempt). Furthermore, the contact person identified above understands that if this application is deemed by AHCA/NCAL not to meet these requirements, it will be disqualified and the application fee will be forfeited. Applications will be compared against other current and previous applications to screen for originality.
- > By submitting this application, I certify that I have reviewed the Step II criteria and am familiar with the core values and concepts of quality, as they are essential to consistency and alignment of organizational processes and results.
- > By submitting this application, I also understand that in the interest of improving the quality of care provided to all long term care residents nationwide, I may be called upon by AHCA/NCAL to share success stories, lessons learned, or practices identified and/or implemented that have led to improved quality. I also may be asked to serve as an examiner, or as an informal mentor to other Quality Award applicants. I understand that I am not obligated to serve in any of these capacities, but that in the spirit of the mission of the AHCA/NCAL Quality Award Program, I will assist to the best of my ability in advancing quality improvement in long term care.

1. CONTACT INFORMATION

Important — Please specify the name of your organization *exactly as you would like it to appear on your award* and in written form. If you are part of a multi-facility organization, please verify whether your parent company's name should be included. The name provided at the time of application cannot be changed once your application has been submitted. **All fields are required.**

Name of Organization: _____			
Six-Digit Federal Medicare/Medicaid Provider Number ¹ (if none, write n/a): _____			
Name of Administrator: _____	Email: _____		
Contact Person: _____	Email: _____		
Address: _____			
City: _____	State: _____	Zip: _____	Phone: _____

2. DEMOGRAPHICS

Is your organization independently owned <i>or</i> part of a regional or national company? (Please check only one)
<input type="checkbox"/> Independently Owned
<input type="checkbox"/> Regional/National (Name of Parent Company: _____)

Put an "X" next to the <i>primary</i> service(s) your organization provides that will be the focus of your responses to the criteria:	
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Assisted Living
<input type="checkbox"/> Nursing Facility/Assisted Living	<input type="checkbox"/> Residential Care for MR/DD

Please specify the scope of your application. Does your application cover a distinct part of your organization, or the entire organization?	
<input type="checkbox"/> I am applying for my entire organization	
<input type="checkbox"/> I am applying for a distinct part of my organization (<i>please indicate below</i>)	
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Assisted Living
<input type="checkbox"/> Nursing Facility/Assisted Living	<input type="checkbox"/> Residential Care for MR/DD

¹ Your six-digit federal provider number - often referred to as the "Medicare Number" - can be found on the top right corner of any recent CMS-Form-2567 (the statement of deficiencies). It can also be found on any recent OSCAR 3 & 4 Report.

<p>Has your organization previously applied for a Step I Award? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please list the year(s) in which you previously applied: _____</p>
--

3. PUBLICITY RELEASE

<p>AHCA/NCAL publicizes names of award recipients in printed materials and at events. Do we have your permission to publicize your organization’s name, as indicated in Item 1 above, if you are an award recipient? Yes <input type="checkbox"/> No <input type="checkbox"/></p>

4. ELIGIBILITY — If applicable, you must answer “Yes” to these three questions to be eligible for an award.

<p>Is your facility a member in good standing of AHCA/NCAL? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is your facility pledged to <i>Quality First: A Covenant for Healthy, Affordable and Ethical Long Term Care</i>? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is your organization participating in the <i>Advancing Excellence in America’s Nursing Homes Campaign</i>?² Yes <input type="checkbox"/> No <input type="checkbox"/></p>
--

5. SURVEY AND TURNOVER RESULTS

<p>Has your organization been cited for Substandard Quality of Care or Immediate Jeopardy level on <u>any</u> type of survey (see Chapter 3 of General Information & Instructions) in any of the last 3 calendar years or in 2009 prior to submission of this application?³</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

<p>Please report your organization’s staff turnover rate for the last 3 calendar years, using the formula in Chapter 2 of the General Information & Instructions.</p> <p style="text-align: center;"> _____ _____ _____ 2006 2007 2008 </p>
--

² Not applicable for ALFs and developmental disability (DD) residential services providers.
³ Not applicable for ALFs and developmental disability (DD) residential services providers. For all others, you are still eligible to apply and receive a feedback report if you answer “Yes,” but you will NOT be eligible to receive a Quality Award.

STEP I CRITERIA – ORGANIZATION OVERVIEW

The Step I application is an overview of the applicant’s organization. For the purposes of these criteria, *organization* refers to the single facility or center that is applying for the award, not a multi-facility organization. The intent of the criteria is for the applicant to address what is most important to the organization and the key factors that influence how the organization operates. The Step I application provides the foundation on which the more complex and in-depth Step II and Step III applications may be written and submitted in subsequent years.

1. BASIC DESCRIPTION OF THE ORGANIZATION

This section should provide information on:

- a. The organization’s environment: urban, suburban, rural, etc.
- b. The applicant’s major health care services (e.g., skilled nursing, subacute, assisted living, etc.).
- c. The organization’s mission/vision statement (verbatim) and the specific methods used to communicate it across the organization.
- d. The organization’s workforce. Identify your key workforce groups by position (e.g., professional nurse, nursing assistant, cook, dietary aid, housekeeper), the desired number in each position, and a general description of the education level and/or professional requirements for each position. Consider using a table to provide your response.
- e. Major equipment and technologies used (e.g. computers, transfer equipment, automated dispensers, alarm devices, etc.).
- f. The regulatory environment within which the organization operates relating to health care delivery, occupational health and safety, physical plant, payment and reimbursement, etc.

2. STAKEHOLDER REQUIREMENTS

Principal stakeholders consist of customers and other groups that are most affected by the organization's services, actions, and success. In addition to residents, identify three other principal stakeholders in the first column of the table below. In the second column, identify the important requirements that each of these principal stakeholder groups has of the organization. In the third column, identify the processes that your organization uses to learn of these important stakeholder requirements. Your responses should be complete and clear.

Four Principal Stakeholder Groups	Requirements this Group has of the Organization	How the Organization Learned of these Requirements
1. Residents	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

3. SUPPLIER AND PARTNERING RELATIONSHIPS

This section should provide information on:

- a. Types of suppliers of goods and services, including other health care providers.
- b. From the above, the most important types of suppliers of goods and services.
- c. Any limitations, special business relationships, or special requirements that may exist with some or all suppliers and partners.
- d. The organizational structure and key management links to the parent company if the applicant organization is owned by a parent organization. Respond “NA” if the applicant is not owned by a parent organization.

4. COMPETITIVE ENVIRONMENT

This section should provide information on:

- a. The organization’s position (relative size) within the local market environment. Include numbers and types of competitors.
- b. Principal factors that determine competitive success in the local market.

5. ORGANIZATIONAL OPPORTUNITIES AND CHALLENGES

This section should provide information on:

- a. At least two major strategic opportunities or challenges for the organization (e.g., entry into new markets or segments, human resource recruitment and retention, new alliances with suppliers, physicians, or other partners, introduction of new technologies, changes in the health care environment that impact the organization’s delivery of services, changes in strategy, or other opportunities or challenges).
- b. An explanation of why it is important for the organization to address these opportunities or challenges.

6. MEASURES

This section should provide information on:

- a. Key organization performance measures.
- b. Report briefly on improvement across one clinical quality indicator. The indicator should be clearly clinical in nature, not merely a process measure that impacts a clinical indicator. Describe the process by which this indicator was improved, including what specific changes were made. Include data illustrating the improvement. *IFC/MR facilities only: Given the largely non-clinical nature of IFC/MR services, these facilities may report on improvement of a non-clinical indicator in response to criteria 6b.*
- c. **Assisted Living Facilities (ALFs) and developmental disability (DD) residential services providers only:** Because you are unable to report survey data, please report briefly on a *second* quality improvement effort. This effort need not necessarily be clinical in nature. Describe the process by which improvement was attained, including what specific changes were made. Include data illustrating the improvement.
- d. Describe actions that top leaders take to drive excellence and continuous improvement.