Pittsburgh Care Partnership, Inc.
Community LIFE
Quality Management Report
2025

Mission:

Community LIFE is a Program of All-Inclusive Care for the Elderly, empowering older adults to remain at home while preserving their dignity, independence, and quality of life.

Background:

Community LIFE is a not-for-profit, integrated, full-risk, social-managed care plan. It provides a full range of health care services for participants eligible under Medicare, Medicaid or both. Community LIFE provides services from the eight health centers located in Homestead, McKeesport, Tarentum, Lower Burrell, Bedford, Rostraver, Somerset and Wilkinsburg. In addition to comprehensive medical coverage and prescription services, Community LIFE provides preventive, social and support services with a goal to enhance the ability of participants to manage their health and stay independent.

The care of the participant is managed daily by a team of professionals, including primary care providers, registered and licensed practical nurses, social workers, dietitians, recreational and rehabilitation therapists, nursing aides and other support staff, such as drivers. The team, along with the participant and his/her loved one, develops a plan of care supporting the participant's wishes and goals of remaining at home with access to needed services.

Quality Management:

Community LIFE strives to create a culture that embraces quality and process improvement as opportunities for growth, achievement, collaboration, innovation and ownership.
The most notable accomplishments of 2025 are:

- Implemented a Falls reduction best practice at all centers.
- Continued analysis of Emergency Department Best Practice.
- Complete Office of Long Term Living (OLTL) survey audit.
- Developed a standardized process to capture and address omitted medications resulting in a reduction of medication errors.

The following report provides a detailed explanation of 2025 quality initiatives.

Census:

Goals

- Achieve budgeted census of 869.

Outcomes

- The overall census for Community LIFE grew by 2%, from 861 in 2024 to 874 in 2025.
- In 2025, Community LIFE had a total of 205 enrollments, or approximately 51 enrollments per quarter, and a continued net census of 13. In 2025, there were 123 deaths at annual rate of 11.54% as compared to 10.98% in the previous year. Disenrollments increased from 63 (6.07%) to 69 (6.47%).

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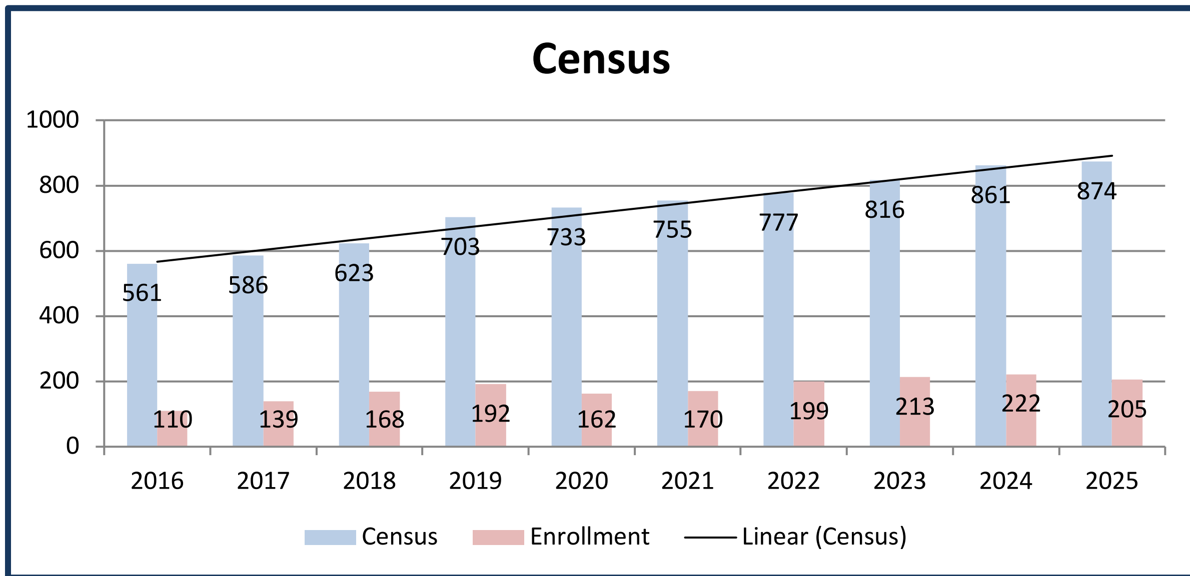
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Census	561	586	623	703	733	755	777	816	861	874
Enrollment	110	139	168	192	162	170	199	213	222	205



Satisfaction:

Goals

- Voluntary disenrollment not to exceed internal benchmark of 1.25% per quarter or 5% annually.
- Track and trend grievances and identify opportunities for improvement.
- Assure all grievances are addressed to the satisfaction of the participant in the required timeline.

Outcomes

- In 2025, annual voluntary disenrollment was 6.47% as compared to 6.07% in 2024.
- In 2025, the total number of disenrollments were 69. Of those, 14 moved out of the service area, 5 were unhappy with the LIFE provider or program, 10 preferred their own provider, 11 were admitted to an in network or out of network skilled nursing facility, 5 avoided the financial cost share, 2 were unwilling to comply with treatment plan and 22 disenrolled to join other programs such as CHC and or waiver.
- Total number of grievances in 2025 was 183, which is down from 365 in the previous year. Of the total, 13.1% were Home Care related, 21.9% were related to communication, 9.8% were dissatisfied with medical care, 16.4% had concerns with transportation and 21.3% were concerned with outside providers and contractors. The remainder were for various other reasons. Overall contractor grievances have decreased from 66 in 2024 to 39.

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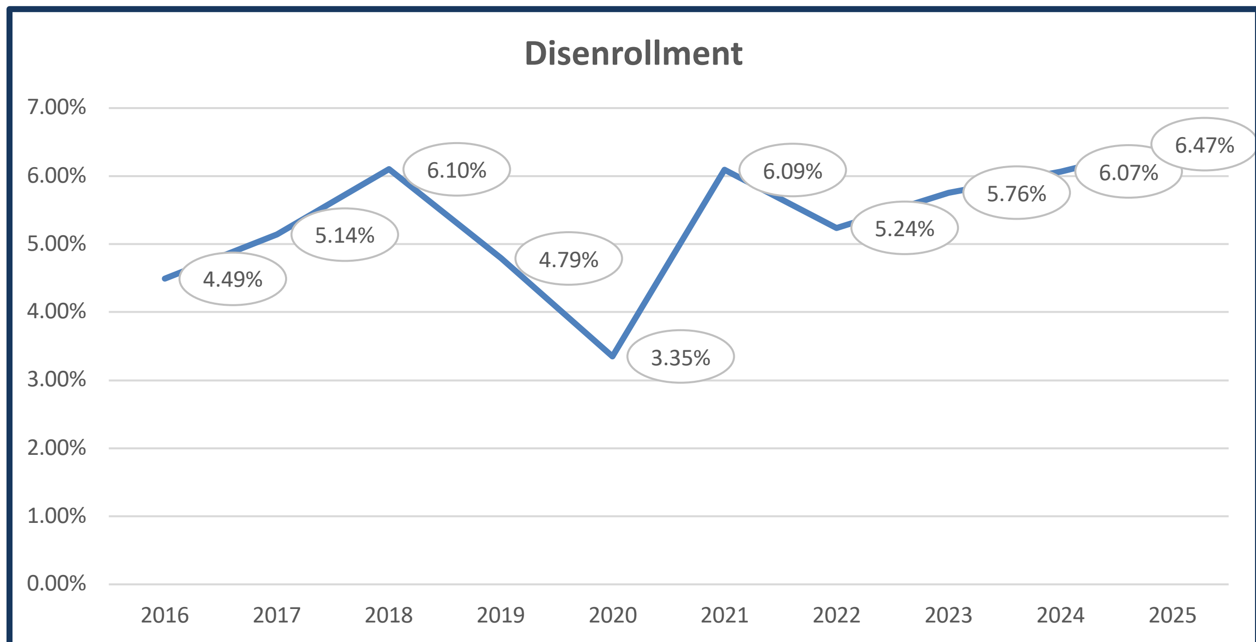
Disenrollment	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Internal Benchmark	PA Benchmark
Rate	4.49%	5.14%	6.10%	4.79%	3.35%	6.09%	5.24%	5.76%	6.07%	6.47%	3.20%	8.80%



Disenrollment Reasons	2017	2018	2019	2020	2021	2022	2023	2024	2025
Out of Network/Moved Out of Service Area	11	20	16	17	33	33	15	9	14
Dissatisfied/Unhappy with LIFE provider and or program	1	4	6	5	2	2	10	12	5
Preferred their own Provider	0	2	1	1	2	3	11	5	10
Other	10	13	10	6	18	12	21	37	40
No longer meets eligibility	7	6	6	0	0	0	0	0	0
Total	**29**	**45**	**39**	**29**	**55**	**50**	**57**	**63**	**69**

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Utilization Management:

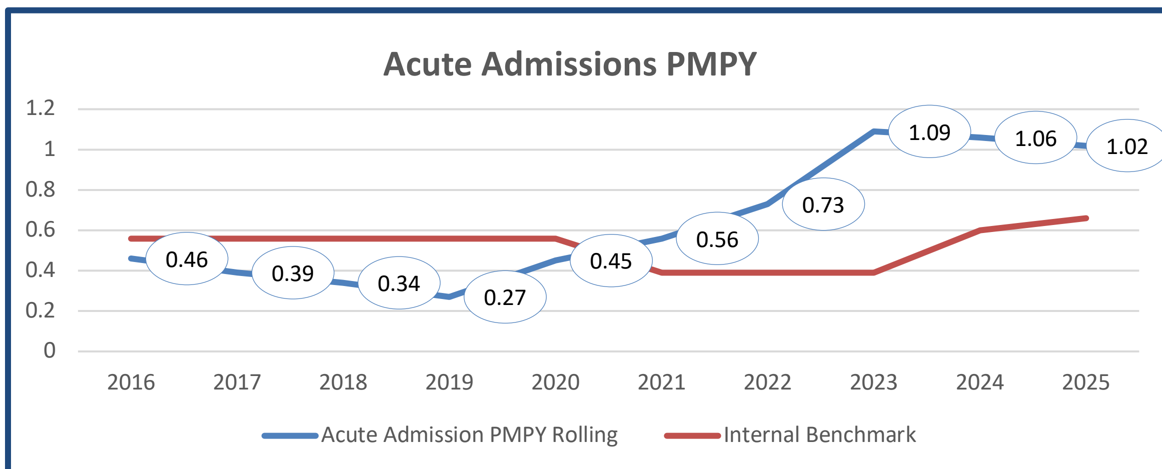
Goals

- To assure participants receive appropriate level of care as determined by the Interdisciplinary Team and to bring effective and efficient care to our participants.
- Achieve hospital days per 1000 members per year to ≤ 3,200.
- Achieve admissions per member per year ≤ 0.66.
- Achieve ER visits (rolling) per member per month ≤ 1.1.

Outcomes

- Acute admission decreased by 3.8%, from 1.06 in 2024 to 1.02 in 2025. This is above Community LIFE's internal benchmark of 0.66.
- 2025 rolling hospital days per 1000 members increased by 0.8% to 4,491 as compared to 4,454 in 2024. This is above the 3,200 internal Community LIFE benchmark.
- Readmission rates for any reason increased by 9.8% from 24.1% in 2024 to 27.1% in 2025.
- Nursing home days per 1000 decreased by 12.1%, from 29,771 in 2024 to 26,180 in 2025. In the same period, nursing home days as a percent of total also decreased from 8% to 7%.

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	% Change
Acute Admission PMPY	0.46	0.39	0.34	0.27	0.45	0.56	0.73	1.09	1.06	1.02	-3.8%
Rolling Acute Days /1000	2732	2382	1662	1319	2205	3587	4167	4671	4454	4491	0.8%
Acute ALOS	5.5	5.9	5.1	4.9	5.9	6.7	5.7	4.4	3.8	4.7	23.7%



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Clinical Outcomes:

Goals

- 80% of eligible participants will be vaccinated for influenza.
- 80% of eligible participants will be vaccinated for pneumonia.

Outcomes

- In the 2025 influenza season, 82% of the eligible participants were vaccinated. This is a decrease compared to 85% in 2024.
- The pneumonia vaccination rate for the fourth quarter of 2025 for eligible participants was 95% as compared to 89% in the same period of 2024.

Safety:

Goals

- Falls with serious injury not to exceed 6.4% annually.
- Reduce total Fall rate per 100 member months to 40%.

Outcomes

- Percent of falls with serious injury increased by 8.48% from 8.02% to 8.70%.
- Total number of falls per member increased by 10.03%, from 51% to 56%.

	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**1 Year Change %**
Fall w. Serious Injuries	7.80%	6.90%	6.10%	6.90%	9.74%	13.27%	12.01%	10.46%	8.02%	8.70%	8.48%
Falls per Member	1.94	1.8	1.88	1.72	1.8	1.74	1.98	2.13	2.05	2.25	9.88%
Falls per 100 member months	49%	45%	47%	43%	45%	43%	49%	53%	51%	56%	10.03%

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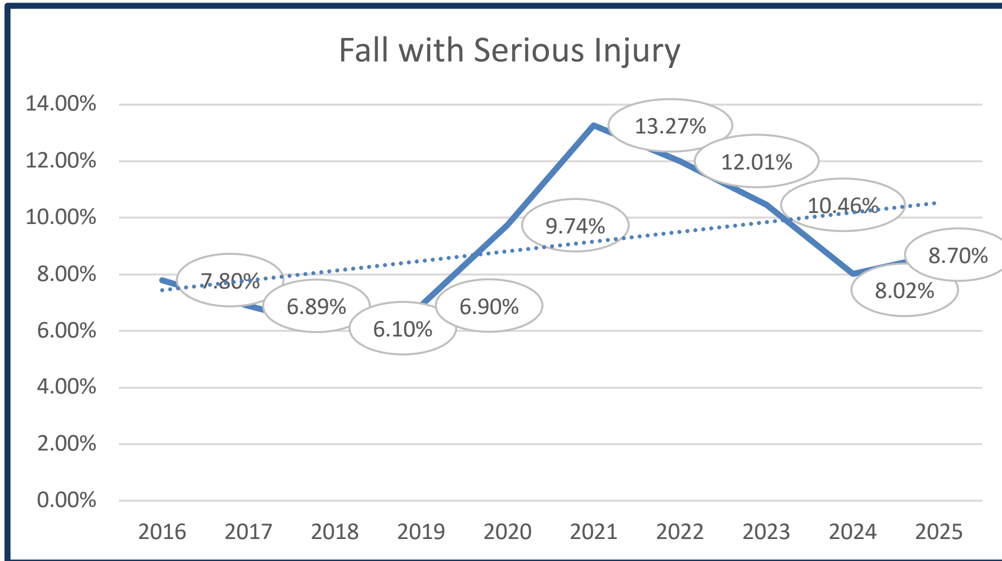

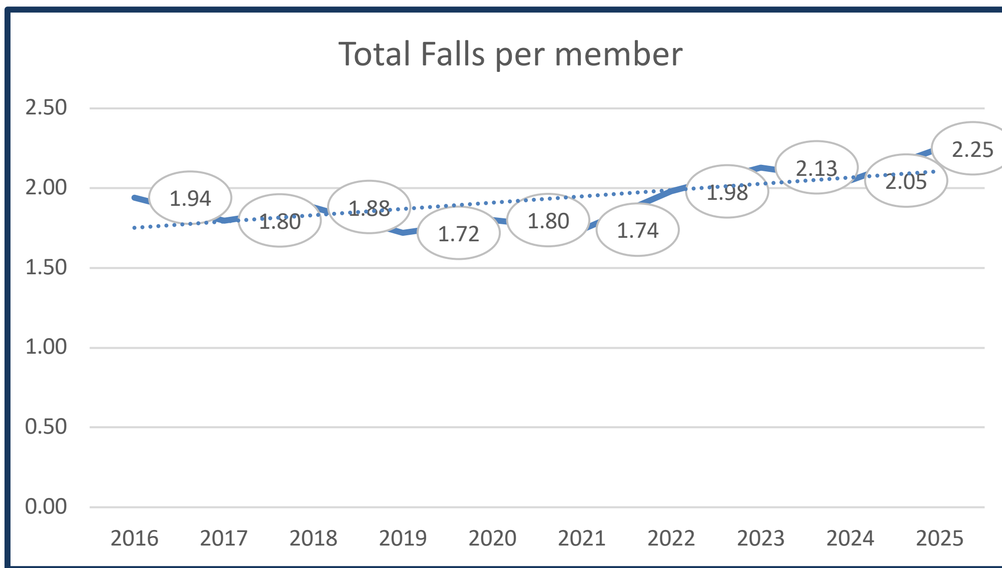

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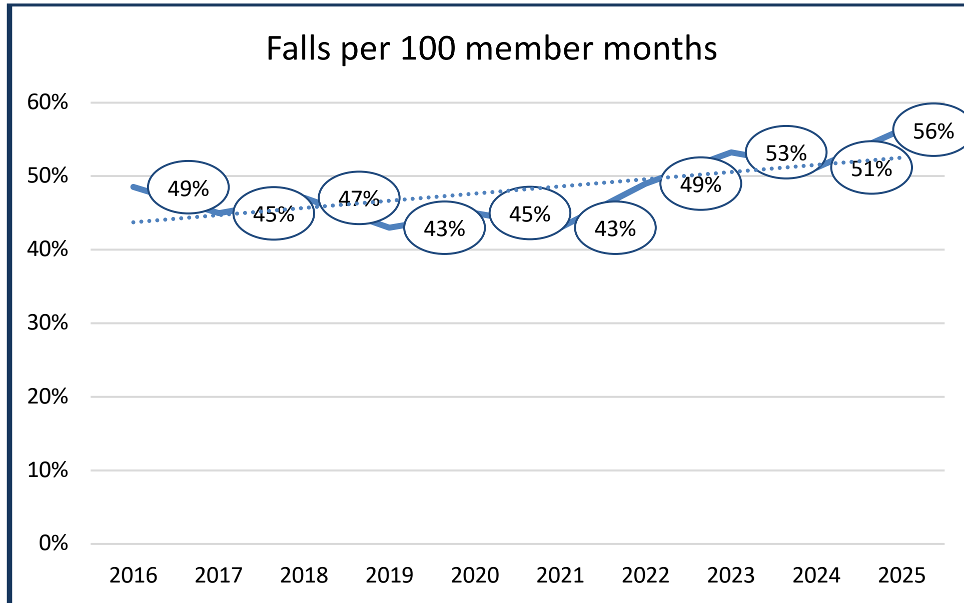


Quality Initiatives Completed in 2025:

- Quality Aim: To develop day center programing to address participants' behavioral health needs.
- Quality Aim: To develop standardized process(es) to correctly capture and address omitted medications.

Quality Initiatives in 2026:

2026 QUALITY AIM #1. To achieve a rate of emergency department visits of less than 1.1 PMPY at end of year

Background: Emergency Department (ED) Utilization

Emergency department utilization is the primary driver of healthcare utilization (HCU). HCU increased in 2021 and has remained high:

Table 2. Health Care Utilization (HCU) Community LIFE 2014-2024

YEAR	ED PMPY*	AA PMPY*	Hospital days/1000 participants PY*	LOS*	Readmission rate %
2015	1.1	0.43	2300	5.25	12
2016	1.2	0.5	2600	5	18
2017	0.82	0.4	2250	6	12
2018	1.1	0.33	2000	5	14
2019	1.1	0.27	1500	5	10
2020	1.14	0.44	1600	5	14
2021	1.51	0.56	3500	6.3	20
2022	1.5	0.75	4000	5.7	23
2023	1.5	1.1	4600	4.3	22
2024	1.7	1.1	4400	4.2	23

2025 (YTD)	1.96	1.1	4200	4	22

*ED (Emergency Department), AA (Acute Admissions), PMPY (Per Member per Year), PY (Per Year), LOS (average Length of Stay)

In response, CLIFE implemented in 2024 an Emergency Department (ED) log (an Excel spreadsheet with information about each ED visit including but not limited to: 1. Reason for visit; 2. Time of visit; 3. Whether the participant called Community LIFE; 4. IDT interventions before and after visit). The ED log is maintained daily. The medical director reviews every ED visit to determine if the visit was preventable.

An ED visit is classified as not preventable if: 1. The participant did not call CLIFE, 2. The participant went after hours and our on call staff were unable to intervene, or 3. The participant went for an ACSC that was already being treated by CLIFE. In addition, the electronic medical records of participants are reviewed for each visit to determine if CLIFE could have prevented the visit.

Key findings include that approximately:

1. Seventy-five percent of individuals presenting to the emergency department do not contact Community LIFE (CLIFE) beforehand.
2. Sixty percent go the ED after hours
3. Twenty-five percent go with ambulatory care-sensitive conditions (ACSC), a percentage consistent with the national averages. Of those participants, 60% were treated by CLIFE for the ACSC prior to the ED visit.
4. Approximately ninety to ninety-five percent of ED visits are thought to be not preventable given current processes.

As a result, the following initiatives were implemented or refined using the PDSA cycle in 2025:

1. Restructured morning meeting to place greater emphasis on anticipation of clinical needs
    a. Rationale: after hours ED visits may reflect unanticipated needs
    b. **Summary**: this intervention continues.

2. Weekly clinical calls to participants who have gone to ED three or more times in six months
    a. Rationale: calls by Nurse/Provider may anticipate participants' needs
    b. **Summary**: this intervention was discontinued as it was thought to be ineffective and replaced by a more detailed review of the ED log (see initiative 7 below)

3. Patients discharged from ED or hospital are seen 48 hours and seven days after discharge by the Provider
    a. Rationale: increased frequency of Provider visits may avert readmissions and demonstrate to participants that CLIFE teams can support their needs
    b. **Summary**: we stopped this intervention in March 2025 after we found a direct correlation between Provider visits and ED visits. Our findings were consistent with the most recent research.[1]

4. Routine nutritional supplementation post ED for two weeks
    a. Rationale: routine supplementation has been associated with fewer readmissions.

[1] Boggan, Joel C., et al. "Effectiveness of Synchronous Postdischarge Contacts on Health Care Use and Patient Satisfaction: A Systematic Review and Meta-analysis." *Annals of Internal Medicine* 178.2 (2025): 229-240.

   b. **Summary**: 17% of participants received supplements in Q1 2025. Audit and coaching increased that number to 45% in Q2 2025. We are continuing this intervention.

5. Review ERS (emergency response system) use in participants.
   a. Rationale: An ERS is meant to be used for participants at high risk for falls. Many participants with an ERS activate the ERS without alerting Community LIFE. Because the ERS dispatches 911, the Community LIFE On Call Nurse does not have an opportunity to intervene.
      i. Participants who had an ERS but were able to use the phone and were not at elevated risk had the ERS removed.
   b. **Summary**: we will continue to review all participants for appropriate ERS use.

6. ERS was changed to a live monitoring system wherein, when an ERS is pressed, a dispatcher will call the Community LIFE Nurse On Call to triage the participant.
   a. Rationale: Community LIFE staff are unable to assess participants after ERS was pressed.
   b. **Summary**: August YTD indicate that three-way calling was able to divert approximately 20% of EMS dispatches. We will continue to review this data.

7. IDT review of ED log
   a. Rationale: IDT reviewed participant-specific interventions that may be needed to avert low-value ED visits
   b. **Summary**: The ED log has been maintained daily since February 2024. Beginning in July 2025, the process was modified. The Medical Director noted potential actionable points for each visit. These points are now reviewed with the Utilization Management Team, the Directors of Operations and Nursing, and the Center Administrators, Nurse Managers, and Providers at each center weekly during the 11:30 am utilization call.

8. Development of standardized behavioral health (BH) processes (Figure 3).
   a. Rationale: CLIFE participants have a high behavioral health burden which may impact ED utilization
   b. Summary: We stopped this intervention as the IDTs had difficulty with the processes. This intervention has been replaced by **2026 QUALITY AIM #2.**

Year 2026 Quality Intervention: Emergency Department Visits

The following initiatives will be implemented and refined using the PDSA cycle in 2026:

1. The Medical Director will continue to complete the ED log daily and review team specific findings with the Center Administrators, Nurse Managers, and Providers weekly (step #7 above). Teams will be asked to discuss and develop participant level interventions targeting low-value ED utilization.

2. CLIFE will implement Intus Care (Home - IntusCare) population health and utilization software (see Figures 1 and 2). Participant-specific ED risk data from Intus will be reviewed daily and incorporated into IDT daily huddles, care planning, and utilization review. Piloting of Intus will occur November 2025 through January 2026 with implementation organizationally in 2026.

Figure 1. Intus Emergency Department/Hospital Dashboard, Organizational Data

INTUS provides daily organizational-wide data on ED visits and admissions. Data include the number of ED visits, admissions and length of stay. This data can be reviewed for outliers and trends.

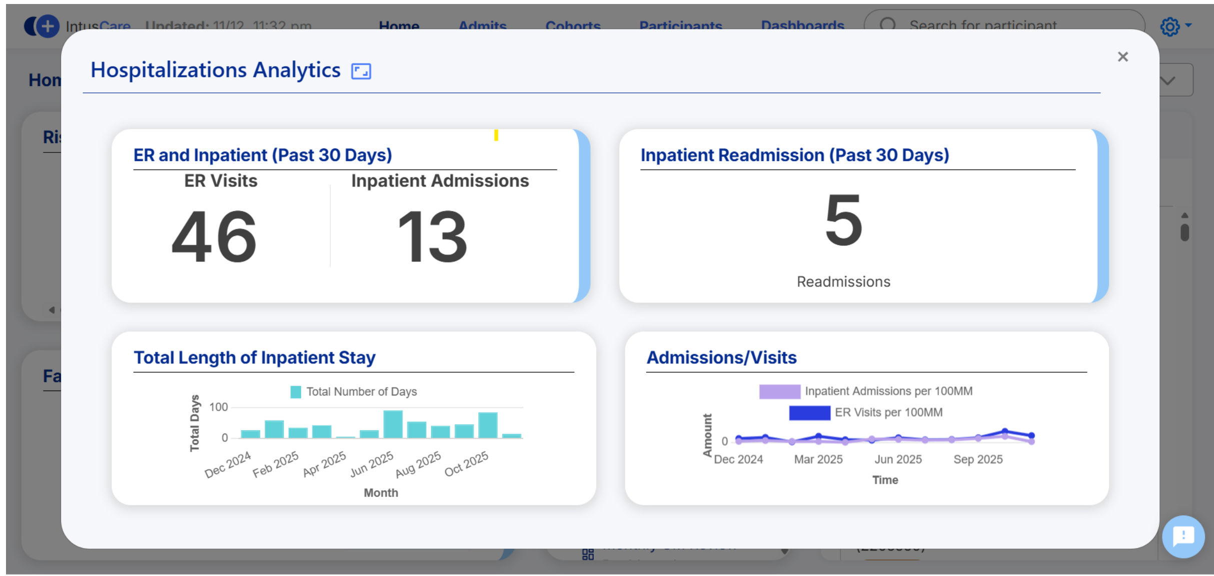
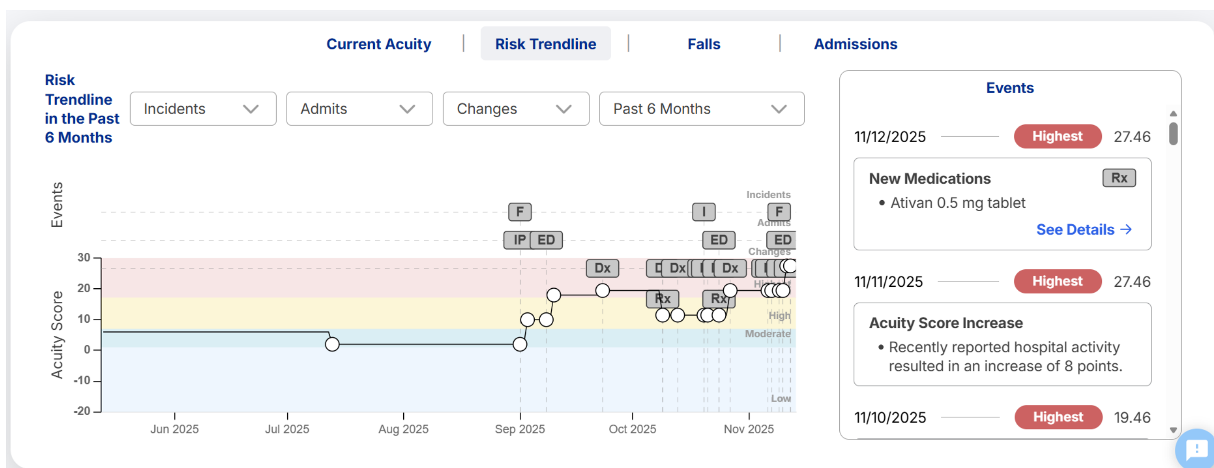


Figure 2. Intus Emergency Department/Hospital Dashboard, Team-Specific Data

Data is also available at the IDT and individual level. Individual data includes information about risk acuity, falls (F), inpatient admission (IP), emergency department visits (ED), new diagnosis (Dx) and medications (Rx) that the teams can review to determine how best to intervene.



Novemer and December 2025 will be spent piloting INTUS at the Tarentum center prior to organizational-wide rollout 2026.

2026 QUALITY AIM #2. By the end of 2026, develop and implement a comprehensive Motivational Interviewing Program

Background: Behavioral Health

The NPA Clinical and Operational Data Analysis Committee (CODAC) conducted a behavioral health analysis of PACE participants in 2023. The main finding was that the prevalence of any mental illness is higher in PACE (approximately 80% of participants) than in the general population of older adults (approximately 15% in adults over 50 years old). More specifically, the presence of dementia (60% in PACE vs. 8% in the community dwelling elderly) and psychosis/schizophrenia/bipolar and related disorders (10% in PACE vs. 2% in the community dwelling elderly) is markedly higher in PACE.

Community LIFE has a Behavioral Health team of experts to help care for these participants. The needs of our participants, however, are more than can be provided solely by the Community LIFE Behavioral Health Team. As such, our Behavioral Health Team will lead a motivational interviewing (MI) training program at CLIFE.

Motivational interviewing (Understanding Motivational Interviewing | Motivational Interviewing Network of Trainers [MINT]) is a goal-oriented communication style geared to empowering participants with their health choices so as to provide care most congruent with their goals, values, and expectations.

MI is effective for management and treatment of behavioral health disorder, substance abuse disorders and in helping to elicit healthy changes in participants.[2] [3]

All IDT members will undergo four hours of training by end of year 2025.

Year 2026 Quality Intervention: Behavioral Health

1. CLIFE Supportive Care Manager and Coordinator, both of whom are MI certified, will each attend one IDT meeting a week to audit and guide teams.

2. All IDT members will undergo another four-hour training in Spring 2026.

3. CLIFE Supportive Care Manager and Coordinator, both of whom are MI certified, will each attend one IDT meeting a week to reinforce MI techniques in summer 2026.

4. The Supportive Care Manager and Coordinator will regroup in Fall 2026 with key operations and clinical team members to determine lessons learned and to plan on how best to adapt/continue this initiative. This will likely include a train-the-trainer program enabling IDT members to help facilitate MI.
5. We will measure the success of this intervention by assessing staff satisfaction (#4 above), participant satisfaction (end of year 2026 survey), and by reviewing and comparing communication-related grievances from 2025 through 2026.

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[2] Romano, Mia, and Lorna Peters. "Evaluating the mechanisms of change in motivational interviewing in the treatment of mental health problems: A review and meta-analysis." *Clinical Psychology Review* 38 (2015): 1-12.
[3] Hall, Kate, Tania Gibbie, and Dan I. Lubman. "Motivational interviewing techniques: Facilitating behaviour change in the general practice setting." *Australian family physician* 41, no. 9 (2012): 660-667.

2026 QUALITY AIM #3: To achieve a falls rate of 45% per member per month for three quarters.

Background: Falls

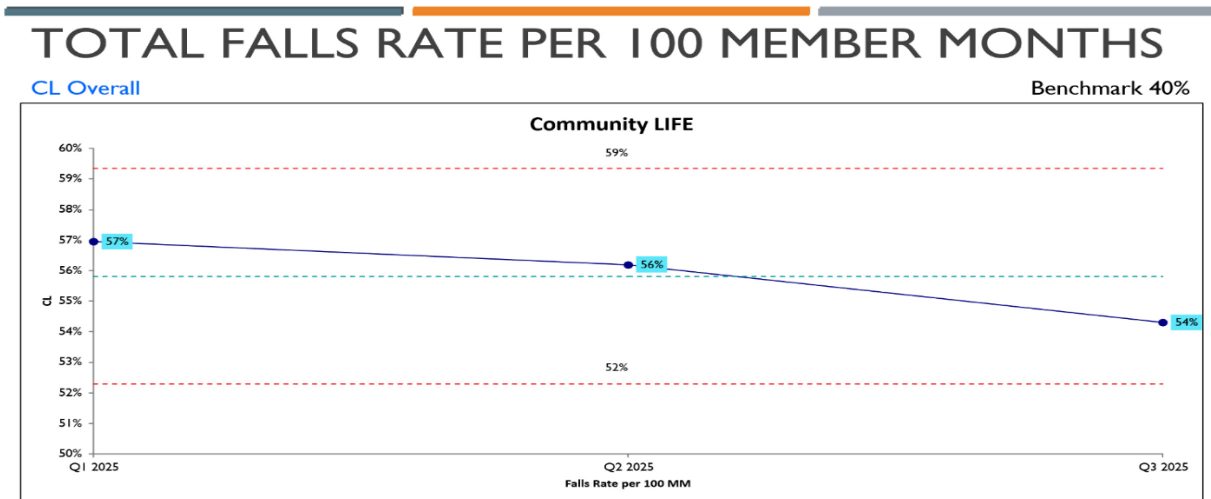
Community LIFE has a historical fall rate (total falls/100-member month) of 40-45%. Since the covid pandemic, our fall rate has remained elevated at approximately 50-55%. In response, CLIFE has implemented multiple falls-related initiatives including:

2025 Summary Falls:

1. Pharmacist-led medication reviews focusing on psychotropic medications and other medications associated with a particularly high fall risk with a pharmacist-recommended taper.
2. Collaboration between rehabilitation, activities, and day center staff to increase physical activity of participants who attend the day center.
3. Screening all participants at 6-month intervals for malnutrition. Supplements are offered to all with a Mini Nutritional Assessment (MNA) score less than 7.
4. Implementation of the Otago program. Otago is a standardized, validated set of strength and balance exercises demonstrated to reduce falls in the community-dwelling elderly.

Unfortunately, the fall rate remained elevated at approximately 55% in 2025

Figure 3.

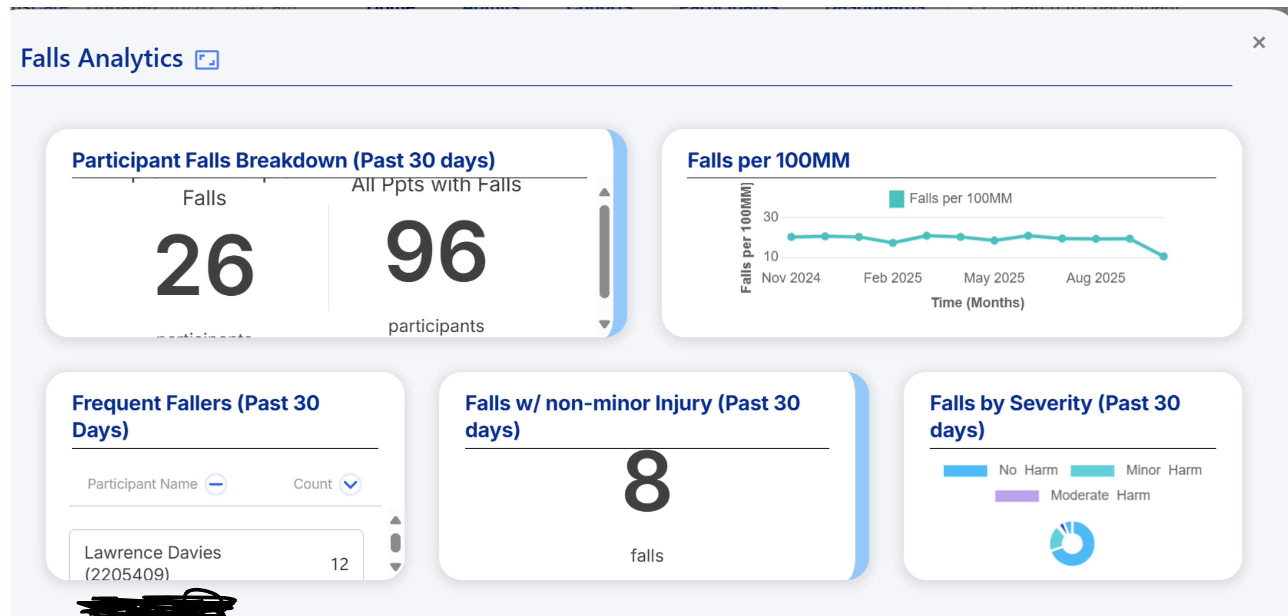


Year 2026 Quality Intervention: Falls

1. Intus Care will be used to analyze fall-related data. Piloting of Intus will occur November 2025 through January 2026 with implementation organization wide in 2026. This data will be incorporated into falls rounds.

Figure 4. Intus Falls Dashboard, Organizational Data

INTUS provides daily organizational-wide data on falls. Data include the number and severity of falls and falls rate. This data can be reviewed for outliers and trends.

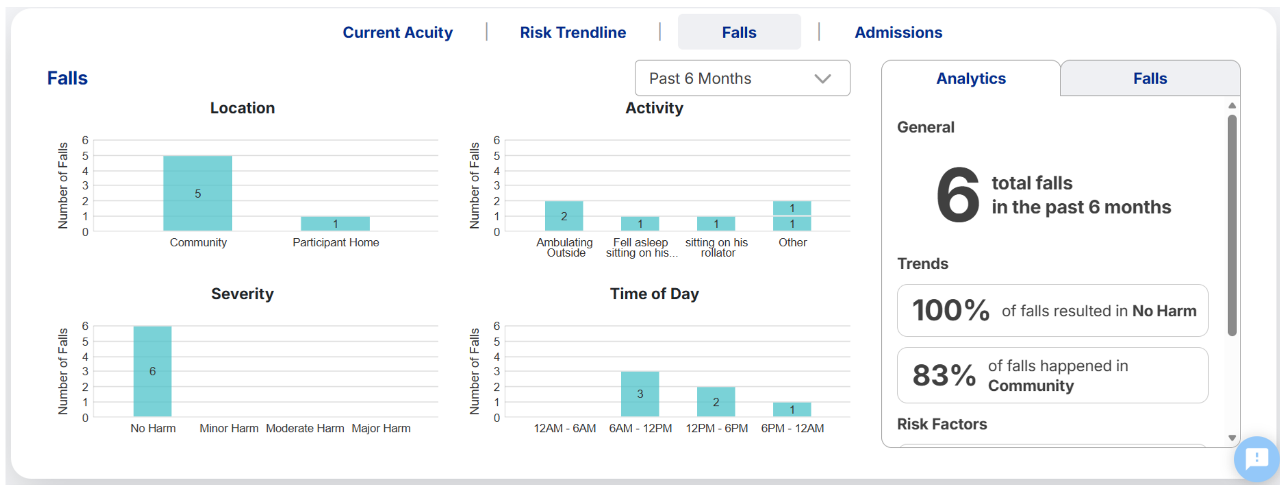


2. We will incorporate organizational-wide falls-related best practices based on pilots conducted at the Somerset and Tarentum centers September through December 2025. These include:
   a. Standardizing our falls-related nomenclature and processes
   b. A new standardized falls assessment (Somerset) and falls rounds (Tarentum)
   c. Developing two therapy programs:
      i. Restorative Therapy: offered to all participants to maintain functional level. This includes offering therapy to all participants upon enrollment.
      ii. Skilled Therapy: offered to participants post hospital and skilled nursing facility (SNF), a change in condition or fall, or with the need for new durable medical equipment (DME)
   d. Participants who refuse therapy will be reevaluated twice a month after any refusal and re-offered therapy as indicated.
3. Provider progress notes have a new prompt to discuss falls (implemented August 2025).
4. All participants are screened for osteoporosis with the Osteoporosis Screening Tool (OST) biyearly. Participants at high risk are identified for osteoporosis treatment.
5. The National PACE organization (NPA) recently conducted a data analysis of risk factors for falls in PACE participants. Antidepressants and antipsychotic agents were heavily associated with

falls. As a result, we will be working with our pharmacy vendor to focus on best practice deprescribing patterns for these agents. Participants will be assessed for these medications every six months.

Figure 5. Intus Falls Dashboard, Team-Specific Data

Falls data is also available at the IDT and individual level. Data includes place and time of fall and risk factors (especially medications) related to falls. Teams can review to determine how best to intervene.



2026 QUALITY AIM #4. Achieve 90% compliance with key clinical care measures:

Background: Compliance

The following initiatives were implemented or refined in 2025 using the PDSA cycle:

Regulatory agencies expect Community LIFE to follow all provider orders without delay. This includes, but is not limited to, orders for medications, treatments, labs, testing, consults, etc. This is an area in which Community LIFE has struggled. Prior to April 2024, every chart audited had a finding (i.e., a provider order was not followed as written) in this area resulting in score of 0%. The following processes were modified or newly implemented in 2025:

- The Clinical Specialist at each center runs a weekly report in the Orders Tracking section of the electronic medical records to review the status (e.g., ordered, scheduled, or pending) of each order.

- These reports are then sent to the Director of Nursing, Assistant Director of Nursing, Nurse Manager, Medical Scheduler, and Medical Records to make sure all orders are consistent with what the Provider ordered.

- Chart audit findings were sent to the Nurse Managers and Center Administrators and audited weekly by the Director of Nursing and the Director of Operations/Regional Director of Operations to address findings.

Background: Wound Documentation

The following initiatives were implemented in 2025 using the PDSA cycle:

1. Nurse Managers audited wound documentation weekly and facilitated weekly wound rounds with the IDT utilizing a standardized checklist.

2. Community LIFE contracted with *The Wound Company* The Wound Company: Value-Based Wound Care to assist in the assessment of wounds, identifying wound types, assisting in wound treatment recommendations, and suggesting wound prevention measures.

3. Quality Coaches audited random charts across all eight centers and will send the findings weekly to the IDT.

4. Chart audit findings were sent to the Nurse Managers and Center Administrators and audited weekly by the Director of Nursing and the Director of Operations/Regional Director of Operations to address findings.

Though improvement was made in failure to provide all required services and wound documentation, we are not at goal (90% accurate docmentation).

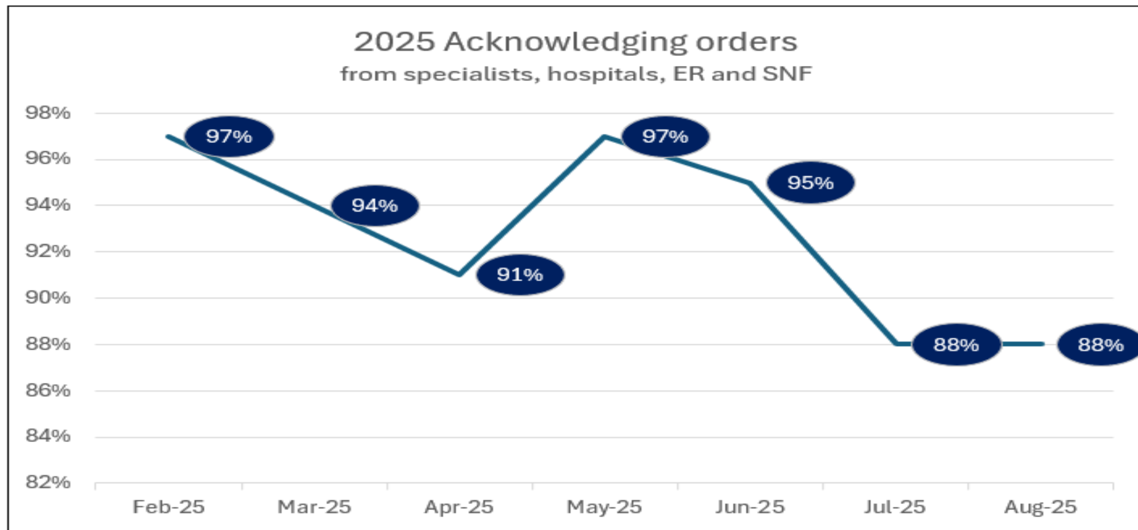
Q3	CL	BDF	EAS	HOM	LGF	MCK	MVL	SOM	TAR
	78%	81%	83%	40%	78%	95%	NA	76%	97%
Q2	**CL**	**BDF**	**EAS**	**HOM**	**LGF**	**MCK**	**MVL**	**SOM**	**TAR**
	78%	92%	75%	74%	81%	70%	NA	70%	84%
Q1	**CL**	**BDF**	**EAS**	**HOM**	**LGF**	**MCK**	**MVL**	**SOM**	**TAR**
	80%	90%	83%	42%	100%	94%	51%	75%	100%

Top Deficiencies:
1. Blanks on the flowsheets
2. Missing wound round notes
3. Missing Care Plans
4. Wound orders not cosigned by the PCP

We will continue the above processes while reviewing and revising the following in 2026.

Quality Aim 4a. Acknowledging orders from specialists and hospitals, emergency departments and skilled nursing facilities within the regulatory time frame.

Figure 6. Acknowledging orders from Specialists, Hospitals, Emergency Deaprtment and Skilled Nursing (Goal 90%)



a. We revised Policies 1506 (Transitions of Care—Hospital) and 1508 (Transitions of Care—Nursing Facility) in January and September 2025, respectively, to clearly delineate expectations regarding acknowleding orders.

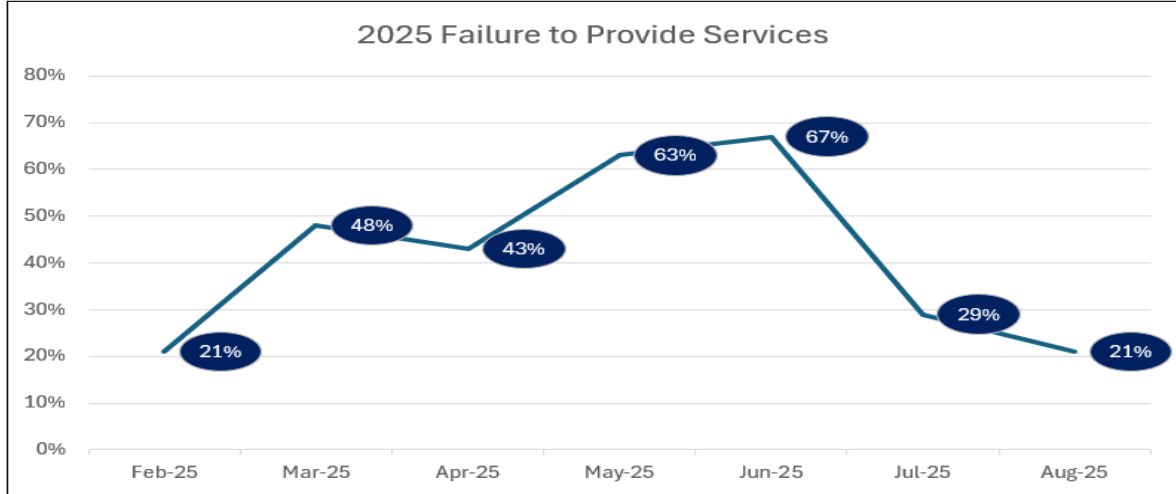
b. A new note template was added to the electronic medical record in 2025 to addres the regulatory requirments of acknowledging orders.
   i. In order to decrease Provider documentation burden, we have created a second note (November 2025) template targeted to routine, low-order consultants (i.e., podiatry, audiology, dental, optometry).
   ii. This note will decrease the documentation burden on Providers, making it more likely they acknowledge all orders on other notes.

c. We will develop a process of single-point accountability for review of SNF documentation. In our current process, SNF documents are scanned to the EMR without a designated person to review.

d. We will implement a new process wherein all orders from participants discharged from the hospital or emergency department are reviewed by the Nurse Case Managaer (RNCM) and Provider Monday through Friday at 9am and 3pm. This standardized organizational process will mitigate the risk of missing orders.

Quality Aim 4b. Delivering all documented services.

Figure 7. Composite Score of Audit Findings (Goal ≥ 95%)

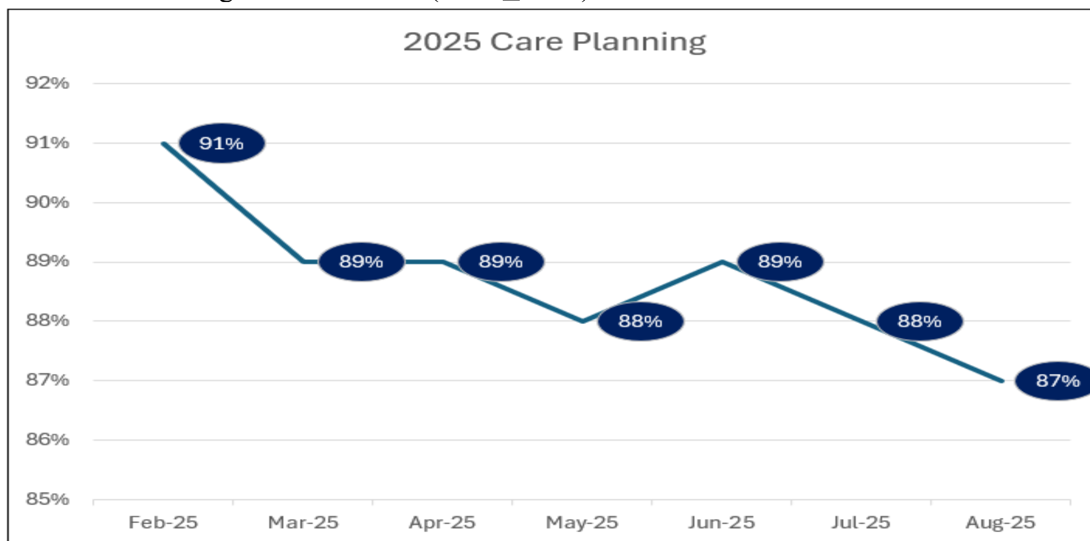


An internal audit in August 2025 demonstrated that we may not be adhering to our current process of sending weekly missing chart findings to the Nurse Managers and Center Administrators with followup by the Director of Operations /Regional Director and Director of Nursing

i. We have reimplemented (November 2025) our best practice weekly IDT chart review when Team members have a designated time to review charts for missing findings.

Quality Aim 4c. Care planning.

Figure 8: Care Planning Documentation (Goal ≥ 90%)



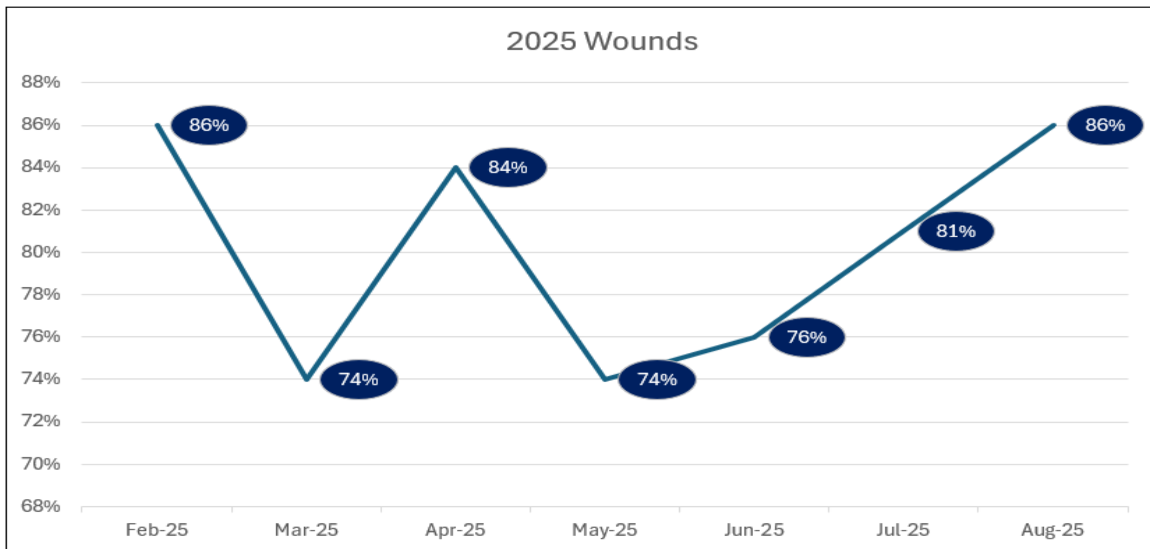
e. We revised Policies 1502 (Assessment and Reassessment of Participants) and 1505 (Care Planning) in March 2025.

f. We have created a Care Plan Committee that meets monthly to review care plan audit outcomes. The leads include a Quality Coach and Center Administrator. The goal of the committee is to identify and address any barriers to care planning.

g. A care planning checklist was created in November 2025 to help address deficiencies.

Quality Aim 4d. Wound Care

Figure 9: Wound Care Documentation (Goal ≥ 90%)



h. We will terminate our contract with The Wound Company because we did not see improvement in our wound care or wound care documentation in 2025.

i. We will continue weekly wound rounds.
   i. A wound rounds workflow was created in October 2025 to help address deficiencies.
   ii. In order to address any deficiencies, the Nurse Manager will now conduct weekly audits of wound documentation to identify and address any deficiencies.