

# **Florida Statewide Quality Assurance Program**

## **Annual Report 2003 -2004**

*provided through*  
**Delmarva Foundation**  
*in cooperation with*  
**Joint Commission Resources, Inc.,  
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MEDSTAT**

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## **Executive Summary**

The efforts of Delmarva Foundation and its partners in the Florida Statewide Quality Assurance Program (FSQAP) focused on new and ongoing initiatives over Year Three of the contract. A full complement of reviews, training and technical assistance were provided as ongoing processes were enhanced. A year that initially began with a focus on documentation, compliance and process, quickly evolved into a collaborative effort to enhance the entire process and shift to a focus on personal outcomes for the people being served.

Year Three marked the beginning of efforts to significantly modify the monitoring procedures and tools utilized by Delmarva in both the PCR and PPR realms, moving from a process to an outcome orientation focus and from a “reviewer” to a consultative model. The new WiSCC process was developed to blend the PPR and PCR activities, thus generating a more efficient and outcome oriented approach for analyzing the work performed by Waiver Support Coordinators. The new CORE process for providers of other Onsite Review services expands the interview with individuals receiving services and incorporates a focus on organizational systems. With the new consultative approach, all providers are encouraged to develop and implement systems that generate results for the people they serve. These new processes also provide information vital to targeting root causes for declining attainment of outcomes and supports, and forming the basis of corrective measures.

Delmarva Foundation’s Year Three Education and Training activities focused on improving and increasing the educational and training opportunities available to all stakeholders. In addition to these formal training sessions, Delmarva Foundation staff provided informal training on a number of different occasions throughout Year Three. Delmarva expanded its current public web site at [www.delmarva-florida.org](http://www.delmarva-florida.org) to include a resource center. A new category of Career Opportunities at Delmarva was added to the web page which links to the Delmarva Foundation home page. The Upcoming Training Information has been improved and includes a link for users to access the on-line training modules. The project staff worked with an experienced instructional designer to design and develop two web-based training modules that were available on the Resource Center by June 30: Protecting Individual Rights and Preventive Health Screening. Reviewers and managers periodically met with District personnel above and beyond the regular Quarterly Meetings, to address specific issues, concerns or education needs.

Delmarva Foundation maintained an active and high profile approach to ensure that Florida stakeholders had the ability to stay current with FSQAP activities, procedures, and findings. Through a multi-pronged effort of utilizing meetings, training sessions, letters, report distribution, web-based technology, and general customer service availability, Delmarva Foundation worked to establish a variety of mechanisms for information distribution. Year Three FSQAP customer service activities related to every

component of Delmarva Foundation's review activities, with close to 2,600 contacts being fielded by the Customer Service Specialist, Managers, and other support staff.

Person-Centered Reviews were completed on 2,456 randomly selected consumers of DD-HCBS Waiver services in Year Three of the contract. A subgroup of the random sample included 276 individuals who had participated in a Person-centered Review in Year One and were randomly selected to be included in a Longitudinal Study over the four years of the contract. Of these, 187 are still available for a POM interview in Year Four.

Close to 40 percent of the individuals evaluated during the current year had 13 or more outcomes Met, while 46 percent had 13 or more supports Present. This reflects a decrease of approximately 10 percentage points in both when compared to Year Two results. A comparison of the percentage of outcomes Met and supports Present by individual POM item for the first three years of the contract indicates a significant downward trend in the percentages Met or Present. Only four of the twenty-five outcomes and none of the twenty-five supports saw an overall increase. Despite the decline in the percentage of individual Outcome items Met and Supports Present, the top five POM items for which the Outcome is most frequently Met and the Support is Present remained consistent from Year One to Year Three as did the 5 POM items most frequently Not Met or Present.

Preliminary analysis was initiated to identify the causal factors and the significance of this decline. Additional analysis will be required to understand whether shifts in demographic or other classification variables from year to year can account for this pattern of results. The new review processes are intended to address the decline in Outcomes over the years by placing the focus on positive results for individuals being served in the program.

The categorization of recommendations from the PCR and use of standard pre-populated recommendations in the health, safety and behavioral category provided summary data on the types of Recommendations made for 2,449 of the Person-centered Reviews. The data indicate that over 47 percent of the recommendations were in the areas of health and safety (including behavioral). Further 13.7 percent of the recommendations were in the area of Rights, with an additional 32.9 percent in the areas of Community Involvement/Participation, Goal Achievement; Relationships/Social Roles; Satisfaction with Supports/Services; and Vocational.

There were 938 Onsite and 1,090 Desk Provider Performance Reviews completed during Year Three. The average statewide score for Onsite Provider Performance Reviews for agency providers and solo providers was 83 percent and 85 percent respectively. For Year Three, the average statewide score for Desk Reviews was 74 percent as compared to the Year Two average score of 78 percent. For the agency providers, the average score was 71 percent, and for solo providers, the average score was 74 percent.

Quality improvement initiatives continue to be a focus for the project. Over three years, the FSQAP has compiled data from over 14,000 individual review activities to support

and identify directions for quality improvement initiatives and improved strategies and approaches for supports and services. A work group was established that culminated in a new report format for quarterly distribution of data reports, based on specific district needs. Districts use these reports to target problem areas/providers and improve the quality of service delivery. Two Psychotherapeutic drug studies identified categories of people who are potentially “high risk” for negative side effects from the use of certain drug combinations. As a result, quarterly reports are now provided to each District Case Management Team for use in required medication monitoring, identifying consumers in paid residential supports who are potentially “high risk”. A follow up study to assess the effectiveness of this system is expected during Year Four of the contract. An additional Year Three quality improvement enhancement included the addition of analytic and evaluation staff capacity and the completion of three formal Quality Improvement studies: an element level analysis of Desk Review results; an analysis of the reasons POM outcomes were not met; and a study on the development of a public reporting system for APD data.

As the FSQAP moves into its fourth year, revisions and enhancements to the new quality improvement processes and protocols are anticipated. The Desk Review documentation process will continue as in Year Two. However, some focus may be applied to streamlining the process before implementation of the next four-year contract period. Other modifications and enhancements may be needed to accommodate the growing database of information that is being collected through the review processes. Six Quality Improvement studies will be conducted during Year Four that will enhance the continued emphasis of quality improvement initiatives.

## **Section One: Project Activities and Accomplishments**

In addition to conducting required Provider Performance Reviews, Person-centered Reviews, and training and education sessions, major project initiatives were undertaken in Year Three to modify and strengthen the review processes to focus on outcomes, enhance the projects technical assistance and training initiatives, and increase the use of data collected through the project and other sources to identify and target quality improvement initiatives. Project activity during Year Three is summarized under the following subsections:

- Overview of Contract Modifications;
- Increase Review Volume;
- Development of new review processes;
- Expanded Training and Specialized Technical Assistance;
- Quality Improvement Initiatives;
- Internal Organizational Operations and Quality Improvement Initiatives;
- External Communication Modalities.

### **Overview of Contract Modifications**

In June 2003, the Florida Legislature appropriated additional funding for the Developmental Disabilities Home and Community Based Services (HCBS) Quality Assurance program for projected workload increases and program improvements based upon a request developed by the Agency on Health Care Administration (AHCA) in June 2002 and the Governor's 2003-2004 Budget request to the Florida Legislature. Based upon the planning activities that occurred during the development of the budget request during June 2002, many of the program improvements identified within the budget request were implemented with current project resources during the Year Two (FY 2002 –2003) contract. Improvements included modifications to the provider performance review process that placed greater emphasis on person centered outcomes, and enhancements to follow up reviews to include a technical assistance component. Training and education sessions were expanded to target each district.

Further, as statewide data on review results became available, there was an increased interest in quality improvement initiatives, in additional evaluation capability, and in approaches to facilitating health care follow up for individuals identified as potentially at risk based on Medicaid drug claims for certain combinations of psychotherapeutic drugs. Project activities were initiated to begin to address these interests.

Based on a proposal submitted in August 2003 and continuing discussion with the Project Status Team, a contract amendment was executed on January 9<sup>th</sup>, 2004, that enabled the project team to build on the needs identified in the original LBR issue, and to support the current level of effort as well as any emerging needs. This contract amendment provided funding for an increased workload, supported the development and implementation of a new review process, expanded training and technical assistance for providers,

consumers/family members, health care professionals and other stakeholders and provided additional support to improve quality improvement initiatives. In addition to being consistent with the intent of the original legislative budget request submitted by AHCA, the expanded work was consistent with the system revisions and changes associated with the DCF Developmental Disabilities redesign activities. The major deliverables are summarized below and are described throughout Section One:

- Increased volume for Provider Performance Reviews;
- Established work group to develop new review process for Waiver Support Coordination including pilot implementation;
- Establishment of stakeholder group to recommend revisions to the process and content of Medication Reviews available through the DD HCBS Waiver;
- Establishment of stakeholder group to develop an outcome based review approach for services reviewed Onsite, other than Waiver Support Coordination;
- Development and establishment of a web-based resource center;
- Development of system for web-based interactive training modules including implementation of two modules;
- Development of district data reports through workgroup process and the distribution of reports for two quarters;
- Completion of three quality improvement studies.

### **Increase in Review Volume**

Additional workload funding was provided to accommodate increases and modifications to workload for Provider Performance Reviews. The volume of required Onsite Reviews, Desk Reviews, and Follow Up review activities was adjusted to meet actual review need. In addition, a range of the minimum and maximum number of reviews that could be provided within existing resources was provided to allow for flexibility in changing review needs, based upon current protocols.

### **Development of New Review Processes for Onsite Reviews**

Based upon the experiences of the first two years of the project, a new review process for Waiver Support Coordination was developed through funding provided through the Year Three contract amendment. This review process, originally described as the Waiver Support Coordination Review (WiSCR), was developed to blend the PPR and PCR activities, thus generating a more efficient and outcome oriented approach to review the work performed by Waiver Support Coordinators. As the procedures were developed through a stakeholder work group, a consultative approach to the review process emerged that became the Waiver Support Coordination Consultation (WiSCC) review. The Personal Outcome Measures (POM) interview and the Medical Peer Review components of the former Person-centered Review were complemented with the addition of the new WiSCC review tool containing 11 elements. Six elements are focused on outcomes or the degree to which Waiver Support Coordinators are addressing needs and supports that

produce results that are important to the individual. Five elements, identified as key process elements or Minimum Service Requirements (MSRs), measure compliance with basic waiver requirements that are process oriented.

As part of the WiSCC, a Focused Plan is developed with the Waiver Support Coordination provider and a follow up consultation is scheduled to review progress. Work began on the development of these new processes in the beginning of the third quarter of Year Three, with five pilot reviews/consultation taking place in April. The review tool, processes and procedures were completed by the end of the Year Three contract period, with implementation scheduled during Year Four.

While no additional funding was appropriated to specifically target changes to other Onsite review processes, the project implementation team felt this was important to address, giving all Onsite service reviews an outcomes-based focus. Therefore, in addition to the development of the Waiver Support Coordination Consultation review process, in cooperation with APD and AHCA as well as a stakeholder group, the project team undertook the development of a new review process for other waiver services reviewed on site: Residential Habilitation, Adult Day Training, Non Residential Support Services, Supported Employment, and Supported Living. This new review process, the Collaborative Outcome Review and Enhancement (CORE), shifted evaluation of the providers from a largely compliance-based process to one that is results oriented, based on the needs of the individuals being served. One review tool is used to review all services subject to an Onsite review. The tool contains 25 elements. The first 18 elements relate directly to outcome-oriented areas, while the additional seven are the Minimum Service Requirements (MSR) that examine critical waiver process elements similar to the WiSCC.

During Year Three, 16 CORE pilot reviews were completed. Each review resulted in revisions to the tool, with the final version ready for implementation during Year Four of the contract. Revisions are expected throughout the initial year of implementation in order to improve reliability and validity of the process and to address feedback from providers, consumers, families and reviewers. Both of these processes are designed with a consultative approach in order to create an environment conducive to learning. Providers are encouraged within this process to develop systems that generate results for the people they serve.

### **Expanded Training and Specialized Technical Assistance**

Through the additional funding provided in Year Three, training and technical assistance has expanded in three areas: increased number of training sessions; targeted support and facilitation for stakeholder groups; and the implementation of a thorough web-based resource center that provides information and materials on training as well as interactive instructional modules. While training sessions targeted at the district level were added in Year Two, the legislative appropriation provided additional training and education funds that were used in part to provide 18 units of training in Year Three. These training

activities focused on improving and increasing the educational and training opportunities available to all stakeholders.

Eighteen formal training sessions were conducted in Year Three. Ten of these were focus sessions developed and presented at the request of district staff or provider agencies. The remaining eight were specialized group sessions presented to all District Medical Case Management Teams and other district staff. These trainings were included a component of the medical stakeholder group responsible for the design and development of changes to the Medication Review Process conducted by Delmarva. Almost 600 people participated in these formal training sessions.

Delmarva also expanded its current public web site at [www.delmarva-florida.org](http://www.delmarva-florida.org) to include a resource center. A graphic link on the Welcome page was added connecting to the resource center that was designed to be informative and easy to navigate for consumers, families and providers. Because consumers, providers and other stakeholders for whom we want this new information to be available often do not have high-speed Internet connections, the design was kept basic in order to assure access from home telephone dial-up. New features include a category of Career Opportunities at Delmarva that links to the Delmarva Foundation home page. Other links to related websites were added and continue to be added as requested. Continuing features include copies of review tools (including previous tools) and approved reports.

The Upcoming Training Information was improved and includes a link for users to access the on-line training modules. A quarterly calendar listing all Delmarva training is available as well as information regarding additional conferences and seminars of interest. Directions for the user to register and complete both the community training sessions and the on-line modules have been added.

The project staff worked with an experienced instructional designer to develop two web-based training modules that were available through the Resource Center by June 30, 2004. "Protecting Individual Rights" is a one-hour course with a target audience of provider staff and families. A shorter course, "Preventive Health Screening" (30 minutes) was designed for consumers and families. These were areas most often requested by individuals served and provider staff. Both modules were reviewed by several content experts and coordinated with APD. Each course includes a test for the user to complete.

The facilitation and support of two stakeholder groups was also a component of the expanded education and training activities during Year Three. One stakeholder group addressed revisions to the onsite provider performance review process with an implementation plan consistent with implementation of the new Waiver Support Coordination Review process. The stakeholder group developed the Collaborative Outcome Review Enhancement (CORE) process described earlier and supported the development of new tools, protocols and procedures; revisions to the automated application; statewide piloting; and report format revisions.

The second stakeholder group, the Medication Review Initiative, was comprised of Consultant Pharmacists, Physicians (neurology, psychiatry and family practice), DD Medical Case Management staff, Waiver Support Coordinators and Residential Providers. This group met on a regular basis to address specific target areas for improvement in the DD HCBS Waiver Service, Medication Review. The Medication Review Stakeholder group developed the following strategies in three areas: Best Practices; Medicaid Waiver Handbook revisions; and Improvements and standardization of district medical case management process and procedures. These strategies and recommendations have been forwarded to AHCA and APD for consideration.

### **Quality Improvement Initiatives**

Over the past three years, the quality assurance activities of the FSQAP have compiled data from over 14,000 individual review activities to support and identify directions for quality improvement initiatives and improved strategies and approaches for supports and services. The capacity is emerging to utilize and share this rich warehouse of information in meaningful ways: to evaluate trends and patterns; determine statistically significant and valid correlations; as well as to propose and establish predictive measures for positive outcomes for services and supports available through Medicaid funded programs.

Through the first two years of the project, review results were reported on a provider or consumer basis and aggregated data were reported on a routine basis at the district and state level. Through funding provided in Year Three, a district workgroup, facilitated by Medstat, was formed to identify and design a format for quarterly district reports to support district Quality Improvement initiatives. Based on the work group input, a pilot report including review data through Year Two, Quarter Two was presented to the district leadership group. Based upon the Leadership group's review and input, a final report was distributed in June 2003 for Year Two data through the third quarter. District quarterly reports will be provided throughout Year Four, with an updated format to reflect data collected through the WiSCC and CORE processes.

Two studies of Medicaid Drug Claims that examined the usage of Psychotherapeutic Medications for consumers enrolled in the DD HCBS Waiver were conducted in Years One and Two of the project. As a result of these studies, a process for providing Quarterly Reports to each district was established. The reports provide information on Waiver consumers who live in paid residential settings who were prescribed drugs in certain combinations. The consumers were identified as potentially "high risk" for negative side effects. These reports are provided to each District Case Management Team for use in required medication monitoring for consumers in paid residential supports. Based on Year Three claims data, a subsequent study will be conducted to establish a baseline to determine the impact of providing this information to the districts.

An additional Year Three quality improvement enhancement included the addition of analytic and evaluation staff capacity and the completion of three formal Quality Improvement studies which have been submitted to AHCA for approval.

“Florida Statewide Quality Assurance Program Provider Performance Reviews: An Analysis of Desk Review Results”

In the Desk Review study, provider performance was analyzed at the element level, across all services. Because many elements monitored by the reviewers appear in several and sometimes all the services, the study explored how providers performed on the elements regardless of the service being provided. Performance was measured as the percent who met the criteria on each element. It was found that performance on average is high (over 90 percent) on elements relating to licensure but quite poor (below 60 percent) on elements regarding documentation of required training

“Personal Outcome Measure Study: Reasons Outcomes are Not Met”

During a PCR, reviewers have consistently recorded the reason an outcome was Not Met for individuals who receive a POM. The study completed this year was the first attempt to analyze these reasons within the broad POM areas: Identity, Autonomy, Affiliation, Attainment, Safeguards, Rights, and Health and Wellness. The reasons were grouped into broad areas of concern such as a lack of education, access/availability issues, a lack of choice, and rights violations. Findings indicated that reasons surrounding access to friends, family and different social roles are especially prominent in the areas of Health and Wellness, Affiliation and Safeguards. Another common theme across many of the POM areas was a need to approach people receiving services as adults, with adult responsibilities. Often cited as an issue were individuals not being allowed to handle money, having barriers to vote, having choices made for them and having pre-determined bed, meal and bath times.

“Delmarva Foundation Florida Statewide Quality Assurance Program: Public Reporting”

Over the three contract years that Delmarva has monitored the Developmental Disabilities Medicaid Waiver services, a wealth of data and information have been collected on providers, services and consumers. Because there has been growing interest in publicly reporting these data, Delmarva completed a research study to help determine the best format for presenting the data and also the most appropriate information to display in a public arena. In the study, basic principles and guidelines for creating a public reporting system are discussed and recommendations made as to the development of a Public Information, Systems, Supports and Reporting System for the Developmental Disabilities program.

## **Internal Organizational Operations and Quality Improvement Initiatives**

To continue to meet the on going contract requirements as well as implement the new Year Three initiatives, several personnel actions occurred over the past year. Hector Rivera was utilized as a PCR verifier/scheduler for a good portion of the year, assisting reviewers to be more efficient. Although no new additional Delmarva reviewers were hired as full time employees, two contract review staff, Christy Gentry and Carole von Rossum continued to conduct reviews throughout the year with one additional trained contract reviewer, Mary Huckaby, providing limited services at the end of the contract year. JCR Inc. hired Nilda Barreto as a PPR reviewer for the District 2 area to replace Marion Olivier-Reulas who was promoted to Regional Manger (replacing Richard Hollis who moved out of the country) and also brought on three part time employees throughout the year: Francie Young in District 7, Susan deBeaugrine in District 2 (who has remained employed on a PRN basis with Delmarva), and Claudia Kassack in District 2. Subsequently, on March 1, 2004, Ms. Claudia Kassack was moved into a manager's position through Delmarva, with primary responsibilities in the area of training and education. Delmarva also recruited Sue Kelly, PhD as a Senior Research and Evaluation Analyst, starting employment on May 1, 2004. Dr. Kelly's role is to conduct several quality improvement studies relating to the project, and provide general analytic support.

Delmarva Foundation's efforts to ensure a high standard of performance included numerous internal training and quality assurance activities. Separate conference calls have taken place for PPR and PCR QAR's throughout Year Three on a weekly or bi-weekly basis. These calls provided a forum for reviewers to ask questions, share experiences, and provide input regarding the efficiency of the process, technical challenges, and feedback gathered from consumers, providers, and other stakeholders with whom they have contact while conducting reviews. These bi-weekly conference calls ensured that reviewers received consistent information regarding procedures, interpretations, and system updates. Managers reinforce and supplement this information through telephone and face-to-face contact with reviewers. Policy clarification and interpretation supplements the information provided during the conference calls, when appropriate.

A four-day training was conducted in January of 2004 that incorporated joint and separate curriculums for the PCR and PPR reviewers. The training began with internal quality improvement discussions led by Maulik Joshi (Delmarva CEO) and Tim Jones (Delmarva CFO), particularly focusing on the Six Sigma process. Bob Foley presented on the new initiatives being pursued by Delmarva, specifically what evolved into the CORE and WiSCC processes. Guest speakers spoke on topics such as: HIPAA, Health Issues, Behavioral Training, Self Advocacy, The Family Care Council, Guardianship, and POM's. Additional discussions covered inter-rater reliability and WiSCC development.

Reliability for PCR QAR's was maintained through The Council in Year Three. This occurred formally through the annual reliability process and through on site monitoring of five percent of the reviews throughout the year. Annual reliability was conducted in the use of the POM for Adults and in the use of the POM for Children and Youth. All

PCR reviewers maintained their reliability throughout Year Three. Formal inter-rater reliability functions were conducted during Year Three for PPR QAR's through the efforts of the PPR Quality Assurance Coordinator (QAC). The QAC observed the monitoring activities for each reviewer throughout the State, evaluating compliance with established monitoring protocols, professionalism, and the level of consistency in each reviewer's interpretation of specific monitoring tool elements.

Delmarva Foundation managers continued to review and approve 100% of all PCR and PPR reports prior to their distribution. Direct feedback was provided to individual QAR's as questions or concerns were identified, and more general concerns were addressed on the bi-weekly conference calls. Additional computer system checks have also been put in place to ensure complete and adequate entry of review information.

### **External Communication Modalities**

Delmarva Foundation took a very active and high profile approach to ensure that Florida stakeholders had the ability to stay current with FSQAP activities, procedures, and findings. Through a multi-pronged effort of utilizing meetings, training sessions, letters, report distribution, web-based technology, and general customer service availability, Delmarva Foundation has established a variety of mechanisms for information distribution.

Quarterly meetings with the Interagency Quality Council (IQC) were held in a variety of locations throughout Florida in Year Three, and Delmarva Foundation was an active participant and presenter at each of these meetings. While sharing of quarterly data provided a cornerstone for these meetings, the IQC also served as a key forum for sharing and developing future FSQAP initiatives. For example, during the June 2004 meeting, Medstat representatives presented a template of a new report that was developed for the Districts. Feedback from the group was accepted and incorporated into the reports.

Project staff held regular Project Status Meetings with AHCA and APD representatives. These meetings evolved from bi-weekly Implementation Meetings held during Year One to a forum for updates, discussion, and decision making that continued through Year Three, all relating to the comprehensive and ever-fluid implementation of the FSQAP process. Other small group meetings also occur regularly to address specific project areas or implementation issues.

Regional Managers met quarterly with each Agency for People with Disabilities' District/Region to discuss monitoring results, FSQAP impacts to the system, District/Region initiatives to utilize Delmarva Foundation's results, training and education opportunities, and any other topic that might impact service quality and the PPR or PCR processes. In addition to the Regional Manager, a PCR reviewer and a PPR reviewer often attended these meetings to discuss specific review results or findings. APD participants included the liaison with Delmarva Foundation, staff involved in the QI process, and on occasion, the DD Program Administrator or other representatives.

Delmarva Foundation's outreach efforts went beyond the above information sharing and the eighteen formal Education and Training sessions. Presentations were made to many groups ranging from statewide conferences such as ARC/FL and the Florida Association of Support Coordinators to DD Headquarters and District Leadership staff. Formal and informal discussions were held with many of the major statewide associations and provider groups, as well as with numerous advocacy organizations. Delmarva Foundation representatives attended WSC and provider meetings, and participated in Medical Case Management conference calls and meetings.

At the national level, a project update was presented by Marcia Hill, Vice President, at the Annual NASDDDS Reinventing Quality conference in Minneapolis, and Tim Jones participated in a panel discussion at the Quarterly NASDDDS meeting on the role of Quality Improvement Organizations (QIO's) (formerly Peer Review Organizations, or PRO's) in State Medicaid programs. Additionally, Linda Tupper, DDN, RN presented a project update at the Southeastern AAMR meeting.

The Department of Children & Families Developmental Disabilities (APD) web site accessed through My Florida.com included a special announcement in May directing individuals to the Delmarva resource center. At the suggestion of a family member, magnets with the web-site address were designed and distributed at the Family Café in Orlando in May 2004.

An active Customer Service component is an integral part of the FSQAP. During Year Three, a team including the Customer Service Specialist, Managers, and other support staff handled almost 2,600 contacts. Questions or issues that cannot be addressed by the Customer Service Representative are referred to other experienced team members, as appropriate. This teamwork approach helps ensure the correct person responds to the request, helps reduce the number of incorrect or incomplete addresses in the Delmarva data system, and ensures that providers who have not received or have lost important correspondence from Delmarva receive another copy with the correct address in a timely fashion.

One tool used extensively in the overall customer service process was the Delmarva Foundation website. Providers were referred to the website to access the monitoring checklists and protocols, PPR procedures, reconsideration information, and general information about Delmarva Foundation. Individuals and families were referred for these reasons as well, and also to access the Consumer Road Map. Additionally, individuals, families, providers, and even districts were referred to the Delmarva Foundation website to access the Annual and Quarterly reports containing the general activities and findings associated with the FSQAP process.

The following table summarizes Customer Service inquiries from July 1, 2003, through June 30, 2004. The Customer Service Contact Log and correspondence files available in the Tampa office provide additional documentation and information.

### **Inquiries to Customer Service**

Nature of contacts	Number
Provider Performance Reviews – Onsite reviews	347
Provider Performance Reviews – Desk reviews	1,926
Person-Centered Reviews	226
General consumer and provider information and updates	58
Interpreting Services	33
<b>Total</b>	<b>2,590</b>

#### *Desk Reviews*

The majority of the telephone calls and other forms of communication from the provider community continue to relate to desk reviews. Most common issues that generate questions are related to timeframes, training, level 2 background screening, recoupments, and explanations of provider performance scores. Close to 400 contacts were logged during the fourth quarter of the contract year, for a total of 1,926 for the entire year. This is up from 1,286 in Year Two.

#### *Provider Performance Onsite Reviews and Quality Improvement Plans*

The second most frequently received number of calls related to Onsite reviews. During the final quarter of the contract year, 96 contacts were made concerning some aspect of the Onsite review process, with a total of 347 for Year Three, approximately the same number as in Year Two. Assistance is provided on how to submit or resubmit a QIP; accessing copies of the monitoring tool through the web page or mail; or providing information related to the reconsideration process.

#### *Person-centered Reviews*

During the fourth quarter there were 56 contacts made with customer service regarding the Person-centered Reviews, a total of 226 for Year Three. Calls are from consumers, parents, guardians, WSC's, residential programs, and training centers and most frequently involve process updates, review cancellations or concerns related to the PCR reports, Quality Assurance Reviewers (QAR) or the PCR process in general.

#### *Interpreting Services*

In addition to the typical customer service supports, the Customer Service Specialist was also involved in arranging interpreter services on a number of occasions. Bilingual assistance (English-Spanish) is available to providers, consumers, their families and to QARs as requested. This service was arranged for individuals whose primary language is Spanish and also for individuals who communicate through American Sign Language. Services were established to facilitate the effective completion of the Personal Outcome Measures interview. Follow up telephone interviews have been requested on several

occasions by the QAR to determine the level of satisfaction the consumer had with services being reviewed.

*Miscellaneous*

Various miscellaneous contacts have been made with the Delmarva customer service representative during Year Three. Some examples include: requesting information on Consumer Directed Care; full guardianship in regards to consumer consent; requests to mail reports; request for the AHCA web page address; employment opportunities; and other general information needs.

## **Section Two: Person-Centered Reviews**

### **Overview**

The concept of quality of life has emerged as an important component of many program evaluation efforts in recent years. A central issue in such efforts is to ensure that individual values and preferences are considered in the planning and evaluation process. This approach also incorporates societal values such as intrinsic human worth, dignity, and the need for positive growth as core components to supports and services. The Florida Developmental Disabilities Program has been in the forefront of these efforts and adopted the use of the Personal Outcomes Measures (POMs) developed and published by The Council on Quality and Leadership (The Council) to report Performance Indicators to the State of Florida.<sup>1</sup>

The POM is a primary component of the Person-Centered Reviews (PCR) conducted as a part of the FSQAP review functions. The focus of the review is on measures that emphasize values-based supports and services, individualized planning, and personal outcomes. Other components of the PCR include follow-up interviews and a central record review with the support coordinator, verifying the adequacy and appropriateness of the support plan and cost plan, a review of claims data and a Medical Peer Review.

### **Review Volume**

Person-Centered Reviews were completed on 2,456 randomly selected consumers of DD-HCBS Waiver services in Year Three of the contract. The random sample was stratified by district. Individuals selected for review had the option to decline to participate in the Person-Centered Review. Other consumers from the same district selected from an oversample replaced consumers who declined to participate. During Year Three 1,151 people were replaced. The following table provides a breakdown of these replacements by reason over the first three years of the contract.

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<sup>1</sup> Go to <http://www.thecouncil.org> for information on the history of the Council, their mission statement and the development of the POM tool.

### Reason Individuals Originally Selected for POM were Not Interviewed

Reason Replaced	Year 1	Year 2	Year 3
Deceased	19	79	47
Declined Participation	265	498	605
Not Medicaid Waiver Eligible	34	74	63
QAR Unable to Make Contact	270	331	415
Relocated Out of State	26	51	21
<b>Total</b>	<b>614</b>	<b>1033</b>	<b>1151</b>
Deceased	3.1%	7.6%	4.1%
Declined Participation	43.2%	48.2%	52.6%
Not Medicaid Waiver Eligible	5.5%	7.2%	5.5%
QAR Unable to Make Contact	44.0%	32.0%	36.1%
Relocated Out of State	4.2%	4.9%	1.8%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

Among the individuals who were replaced, the proportion who declined to participate has increased by almost 10 percentage points since the first year, from 43.2 percent to 52.6 percent. At the same time, the proportion the Quality Assurance Reviewer was unable to contact has dropped from 44 percent to just over 36 percent.<sup>2</sup> Beginning with the new WiSCC process, waiver support coordinators will be responsible for scheduling POM interviews with randomly selected individuals on their caseloads. This process change is expected to reduce the difficulty contacting consumers. Because the WSC will be able to explain the POM process to the individuals and their families/guardians, this is also expected to reduce the number who decline to participate during Year Four.

In addition to the Year Three random sample, 276 consumers who were also randomly selected are part of the Longitudinal Study and agreed to receive a Person-Centered interview every year for four years. Consumers participating in the Longitudinal Study were interviewed using the same review protocols. There are currently 187 consumers remaining in the longitudinal study who will complete a PCR during the fourth year of the contract. At that time the longitudinal data will be available for analysis.

Following the demographic description of the sample, the Annual Report includes results from three components of the PCR's conducted in Year Three: the Personal Outcome Measures (POM) interview; the Medical Peer Review (MPR); and the Recommendations. POM results are presented by individual POM item; by reviews that met the criterion of 13 or more Outcomes Met and Supports Present; and by Foundational Outcomes.

<sup>2</sup> Up to three attempts are made to contact the individual. If there is no response, then a replacement is chosen from the over sample of individuals.

## Demographic Distribution

Table 2 reflects the distribution of the Person-Centered Reviews conducted in Year Three by district. The largest proportion of the sample resides in District 23, followed by District 11. On average, the representation across the districts varies somewhat from the proportionate representation in Year Two, but not by more than 2.9 percentage points for any one district.

**Table 2**  
**Person-Centered Reviews by District**

District	Number	Percent
1	165	6.7%
2	226	9.2%
3	107	4.4%
4	185	7.5%
7	200	8.1%
8	119	4.8%
9	181	7.4%
10	213	8.7%
11	270	11.0%
12	73	3.0%
13	112	4.6%
14	80	3.3%
15	70	2.9%
23	455	18.5%
Total	2,456	100.0%

Gender information for the consumer sample in Year Three (Table 3) indicates that 56.8 percent of the consumers reviewed were male, while 43.2 percent were female. This distribution is consistent with demographic information for the entire DS-HCBS Waiver population.

**Table 3**  
**Person-Centered Reviews by Gender**

Gender	Number	Percent
Female	1,060	43.2%
Male	1,396	56.8%
Total	2,456	100.0%

The sample distribution by age group is shown below in Table 4.<sup>3</sup> While the proportion of children age three to 17 in the DD HCBS waiver population is 22 percent, only 12.7 percent of the sample is children representing this age group. This age group was also somewhat under-represented in Year Two (14%) and Year One (18%) of the contract.

**Table 4**  
**Person-Centered Reviews by Age**

Age Group	Number	Percent
<3	1	0.0%
3 - 17	312	12.7%
18 - 21	161	6.6%
22 - 25	220	9.0%
26 - 44	1144	46.6%
45 - 64	567	23.1%
65+	51	2.1%
Total	2,456	100.0%

Data analyzed throughout the contract years have indicated that individuals living in family homes or independent living situations appear to have better outcomes in their lives. Table 5 provides information identifying where the consumer lived at the time of the review, with the largest proportion living in a family home setting. This distribution of living arrangements for the sample appears to be consistent with the waiver population.

**Table 5**  
**Person-Centered Reviews by Living Arrangement**

Type of Living Arrangement	Number	Percent
Family home	1,170	47.6%
Independent/supported living	407	16.6%
Small group home (6 or less)	529	21.5%
Assisted Living Facility	60	2.4%
Foster home	34	1.4%
Large group home (> 6)	169	6.9%
Other	87	3.5%
Total	2,456	100.0%

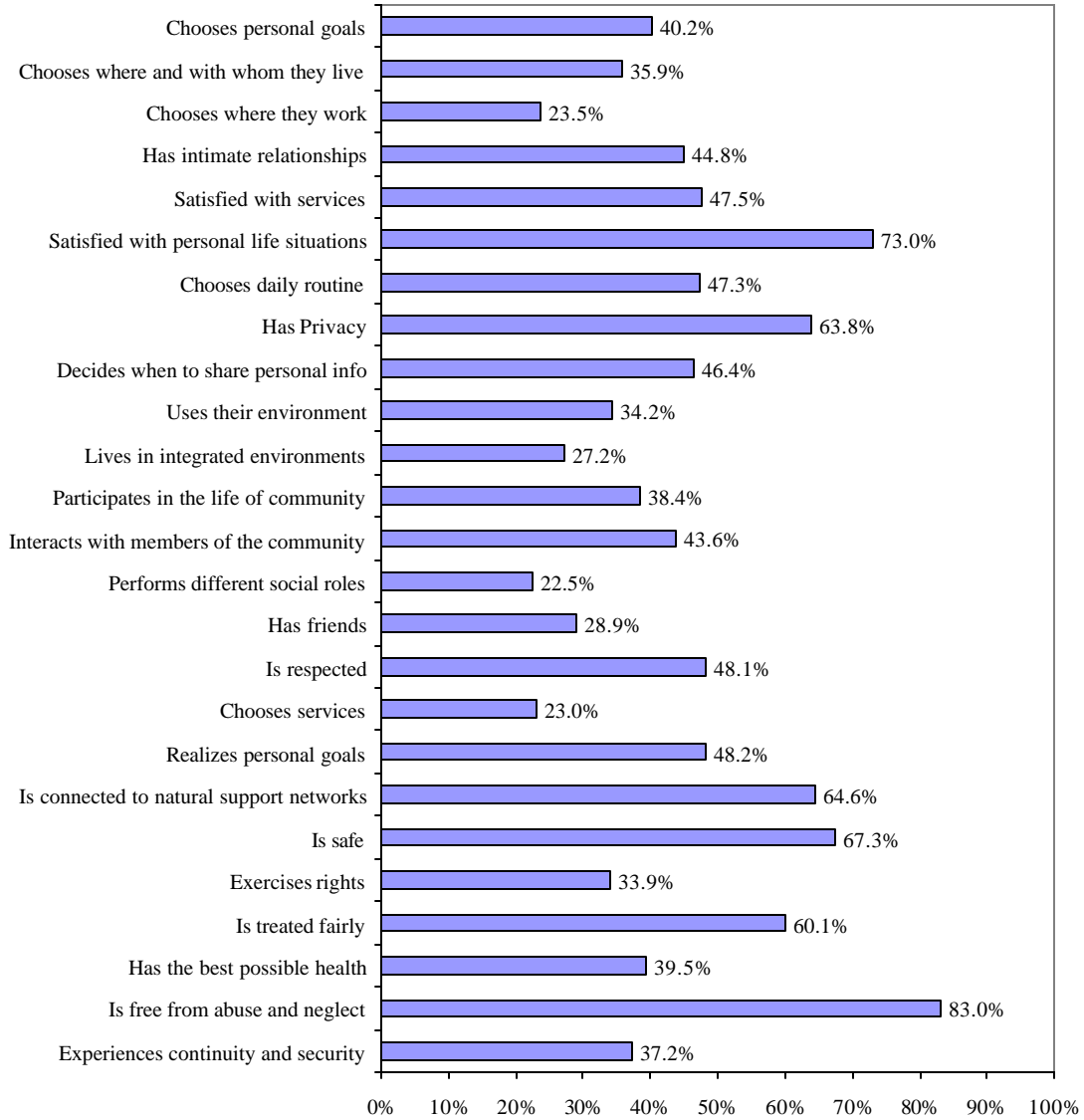
<sup>3</sup> The Waiver program does not serve children under age three. The one person listed in this category is likely a coding error.

## **POM Results by Individual Item**

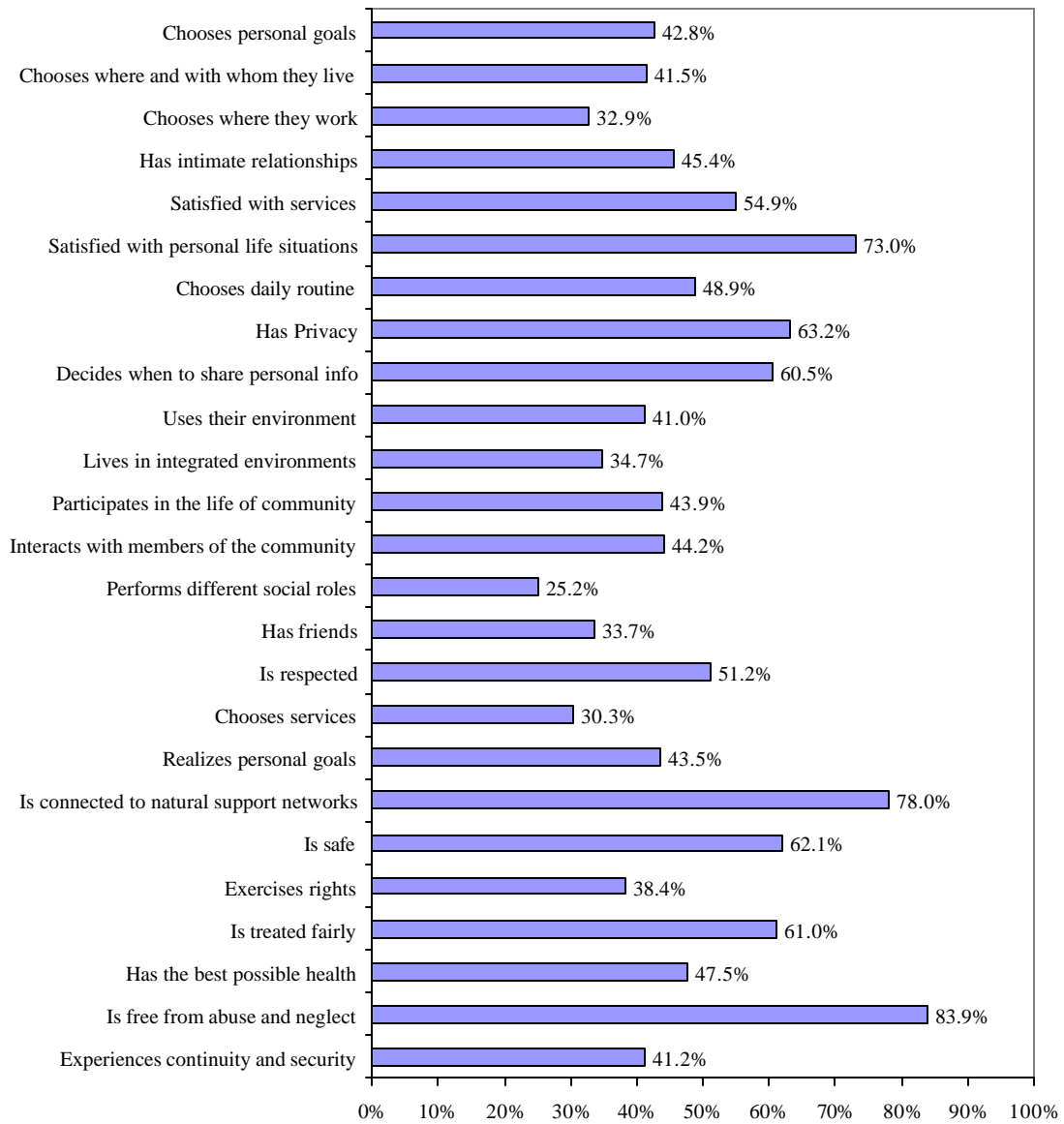
The POM interview is a 25-item assessment tool that determines if for the individual a personal outcome is Met and/or the supports are Present for each item, regardless of the service received. Figures 1 and 2 on the following pages provide the percentage of Outcomes Met and Supports Present by POM item for the sample of individuals who received a POM interview in Year Three of the contract (July 2003 – June 2004).

Theoretically, if more supports are present, outcomes for the consumer should also be better. In other words, if the supports are correlated with outcomes, the percent Met on the two measures for each item should be similar. At the aggregate level, it appears there is a continuing correlation between the provision of supports and achievement of personal outcomes. However, it is important to note here that this is an aggregate representation and should not be over-interpreted. For example, on the item *Performs different social roles* we know that 22.5 percent of consumers scored this outcome as Met and 25.2 percent of consumers scored this as Supports Present, but we do not know if these are the same consumers.

**Figure 1 - Percent of Personal Outcomes Met  
Year Three**



**Figure 2 -Percent of POM Supports Met  
Year 3**



A comparison of the percentage of Outcomes Met and Supports Present by POM item from Year Two to Year Three suggests the downward trend in percent Met or Present noted in the second annual report is continuing. Essentially none of the twenty-five outcomes showed improvement since Year Two. Fifteen of the items were five percentage points lower or more. The outcomes that have decreased most significantly include: *Experiences continuity and security*, *Has the best possible health*, and *Uses their environment*; 12.2, 11.0, and 10.9 percentage point decreases respectively.

On four of the twenty-five items, supports demonstrated an overall increase from Year Two, from a low of 0.4 percentage points for *Realizes personal goals*, to 3.2 percentage points for *Decides when to share personal information*. Scores for all of the remaining supports decreased from Year Two to Year Three, with three showing double-digit decreases—*Experiences continuity and security*, *Has the best possible health*, and *Uses their environment*, the same as for outcomes indicated above. Decreases ranged from 11.8 percentage points to 10.4 percentage points respectively.

An analysis on a case by case basis indicates the proportion of times the 25 POM items have both the outcome and the supports Met has declined steadily since the first year of the contract. The following table gives the number and percent of times POM items had both outcomes and supports Not Met and the number and percent of times the items had both outcomes and supports Met. In other words, in Year Three (July 2003 – June 2004), 2,456 individuals were interviewed on a total of 61,400 POM questions. On 28,925 questions (items), neither outcomes nor supports were Met and on 25,117 items both were Met. There has been a steady decline in the percent where both are Met, from 49.6 percent in Year One to 40.9 percent in Year Three. At the same time, there has been a steady increase in the percent where both are Not Met.<sup>4</sup>

**Table 6**  
**Outcomes and Supports per POM**

Contract Year	Number With Both		Total	Percent With Both	
	Not Met	Met		Not Met	Met
Jul 01 - Jun 02	17,775	23,663	47,675	37.3%	49.6%
Jul 02 - Jun 03	26,536	28,594	63,500	41.8%	45.0%
Jul 03 - Jun 04	28,925	25,117	61,400	47.1%	40.9%
<i>Outcome and Supports Differ</i>					
Jul 01 - Jun 02	6,237	13.1%			
Jul 02 - Jun 03	8,370	13.2%			
Jul 03 - Jun 04	7,358	12.0%			

<sup>4</sup> These changes are statistically significant at  $p < .000$ . However, with such a large number of cases in the analysis, even very small differences may show statistical significance.

Of note also is that each year a high percentage of cases (in Year Three, 88 percent) show a direct correlation between outcomes and supports—both Met or both Not Met. This is a statistically significant correlation (Year Three: Pearson's  $r = .762$ ,  $p < .000$ ). The proportion of POM items where the outcomes and supports differed has remained fairly consistent over the years, with a slight decrease of one percentage point in Year Three. For these questions either the outcome was Met and the supports were not Present, or the outcome was Not Met and the supports were Present.

Despite the decline in the percentage of individual outcome items Met and supports Present, the top five POM items for which the outcome is most frequently Met and the support is most frequently Present remained consistent from Year One through Year Three:

- Free from abuse and neglect
- Satisfied with personal life situations
- Has Privacy
- Is Safe
- Connected to natural supports

The lowest levels of both supports provided and outcomes achieved have also remained consistent over the three years of the contract and are as follows:

- Chooses work
- Performs different social roles
- Chooses services
- Lives in an integrated environment
- Exercises rights

Detailed information about the outcomes Met and the supports Present as well as the reasons outcomes and supports were Not Met or were Not Present can be found in Appendix 1 – Exhibits 1-4.<sup>5</sup>

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<sup>5</sup> For a more detailed analysis for the reasons, see also Personal Outcomes Measure Study: Reasons Outcomes are Not Met, Delmarva Foundation, Submitted to AHCA June, 2004.

## Percentage of Persons Meeting Criterion Levels of Supports and Outcomes

Based on discussion with AHCA, APD and the Interagency Quality Council, the provision of supports and outcome achievement as 13 or more Met or Present has been established for reporting purposes and has been tracked since Year One of the project. Results for this indicator are presented in Table 7.

**Table 7: 13 or More Met/Present**

Contract Year	Outcomes		Supports		Total Reviews
	Number	Percent	Number	Percent	
Jul 01 – Jun 02	1,040	54.5%	1,219	63.9%	1,907
Jul 02 – Jun 03	1,230	49.3%	1,406	56.3%	2,496
Jul 03 – Jun 04	977	39.8%	1,130	46.0%	2,456
Total	3,247	47.3%	3,755	54.7%	6,859

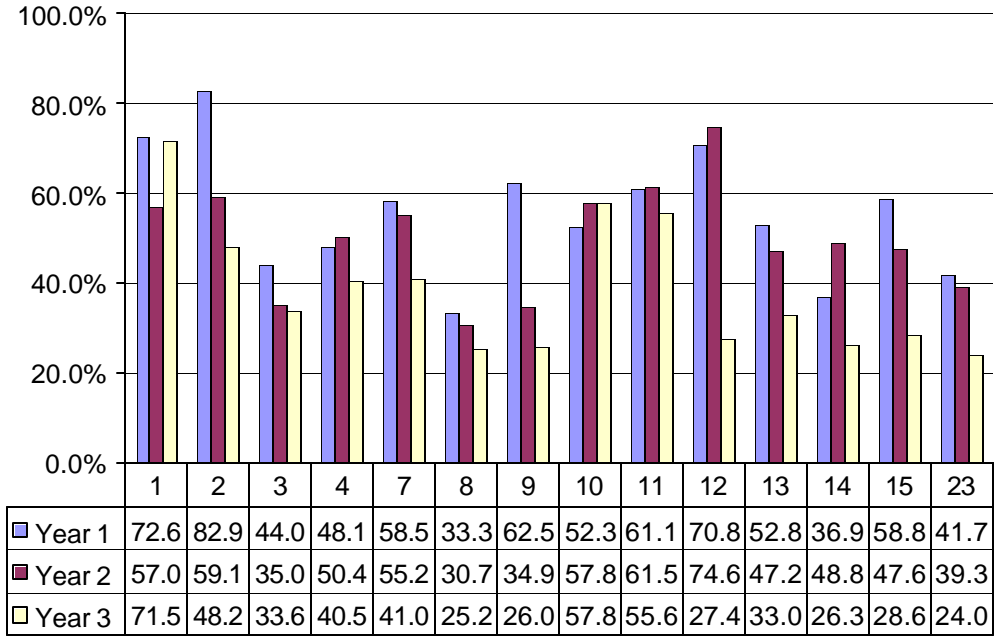
Over the three year period, on average 47.3 percent of individuals had 13 or more outcomes Met and 54.7 percent had 13 or more supports Present. However, the results reflect a significant decline since the first year of the contract in the percent of individuals meeting this standard for both outcomes Met and supports Present. The percent of individuals having 13 or more outcomes Met has declined from 54.5 percent to 39.8 percent and for those having 13 or more supports Present the decline was even greater, from 63.9 percent to 46.0 percent in Year Three. These represent statistically significant changes from Year One to Year Three ( $p < .000$ ). Because results have been presented in quarterly and annual reports, Delmarva and other Stakeholders have witnessed these declines over the years. As discussed in Section One of this report, a new review process is being implemented in Year Four. The focus of this new process is outcomes for individuals and organizational practices. Reviewers will consult with providers and consumers to determine if systems are in place to help consumers achieve outcomes and if systemic practices are in fact being implemented with a resultant achievement of outcomes for the individuals who are served. The intent of this new process is to shift the focus of providers from a process to an outcomes orientation. Processes will still be subject to documentation review, to monitor specific service requirements.

### Results by District

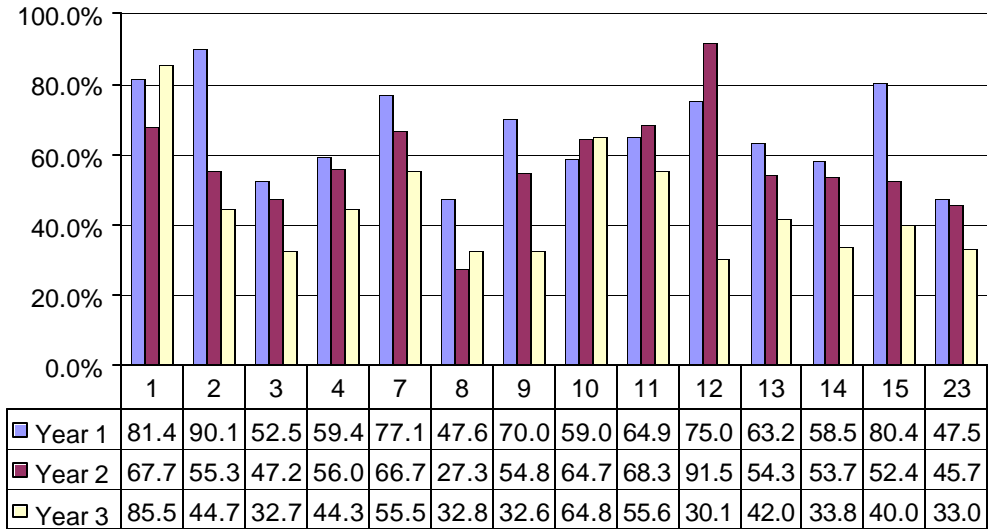
Figures 3 and 4 illustrate there are substantial differences between the districts in the extent to which people have 13 or more supports Present and 13 or more outcomes Met.<sup>6</sup> With few exceptions, each district displays the decrease in performance on these standards as discussed above. While District 1 showed a decline in both outcomes and supports Met from Year One to Year Two, it is the only district that improved in both of these areas during Year Three and has the highest Year Three average on both outcomes and supports.

<sup>6</sup> See Appendix 1, Exhibit 5-7 for details on the 13 or more criterion by district, age and home type.

**Figure 3: 13 or More Outcomes Met by District**



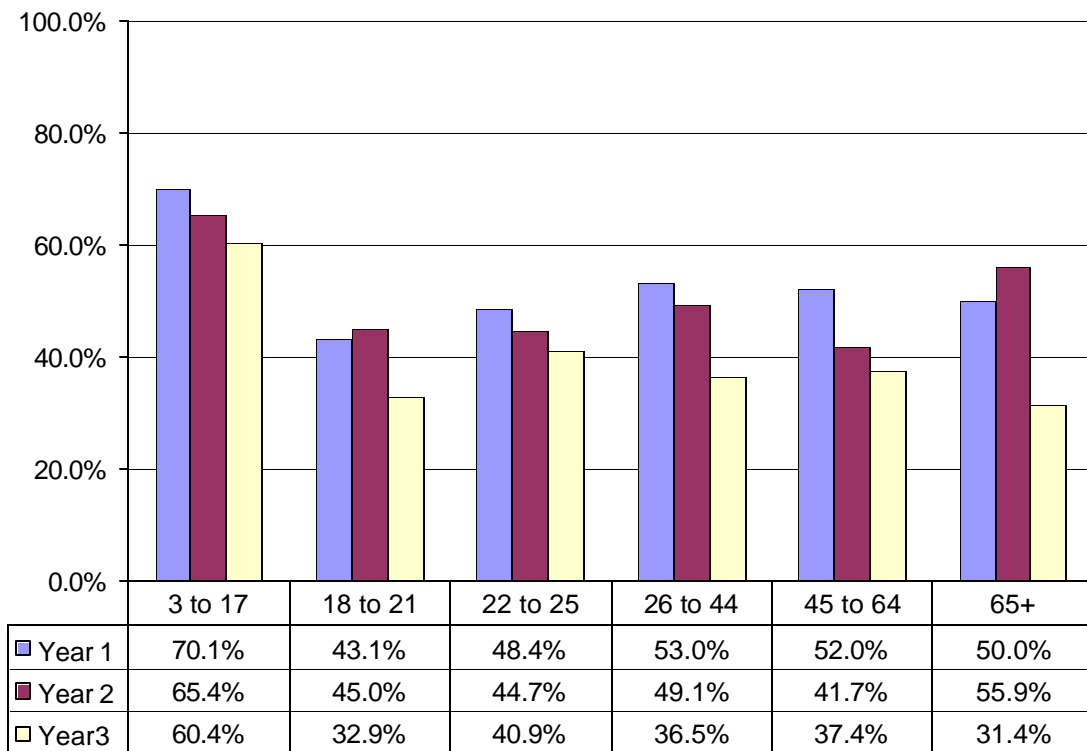
**Figure 4: 13 or More Supports Present by District**



## Results by Age Group

A small increase in the percentage of individuals meeting the outcomes criterion is seen among those classified in the 18 to 21 year age group and in those 65 years or over from Year One to Year Two, but all other Years and age groups showed a decrease. Small decreases are observed in the other age groups. Overall, the 3 to 17 year age group has the highest percentage of individuals with 13 or more outcomes Met.

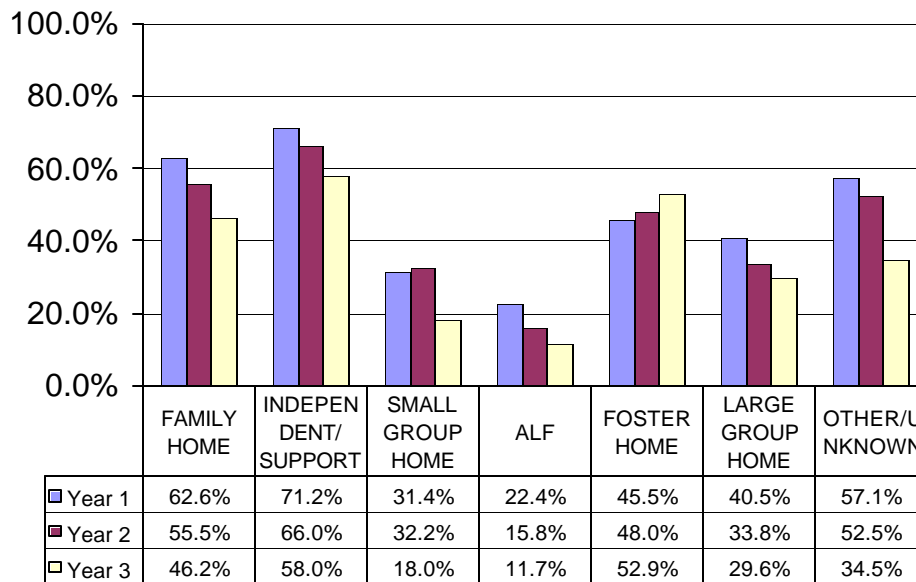
**Figure 5: 13 or More Outcomes by Age Group and Year**



Results by Living Arrangement

Figure 6 shows the pattern of outcomes as they relate to the type of living arrangement reported at the time of evaluation. These suggest there may be a tendency for a greater proportion of those in certain types of living arrangements to have 13 or more outcomes met. Individuals in Independent or Supported Living arrangements were more likely to meet this standard than people in any other type of living situation every year. People in Assisted Living Facilities are least likely to have 13 or more outcomes Met. However, the number of people in this category each year is quite small (Appendix 1, Exhibit 7). On the other hand, over 17 percent of the Waiver population lives in a Small Group Home setting (over 4,200 people) and only 18 percent of the people sampled who lived in small group homes had 13 or more outcomes Met in Year Three.<sup>7</sup> A majority of the Waiver population lives in a family home (approximately 60 percent). People living in family homes have seen a decrease on this standard every year. While people living in foster care are the only consumers who showed an improvement on this standard over the years, this must be viewed with caution as they are represented by small numbers each year, 22, 25 and 34 respectively.

**Figure 6: 13 or More Outcomes Met by Type of Living Arrangement**

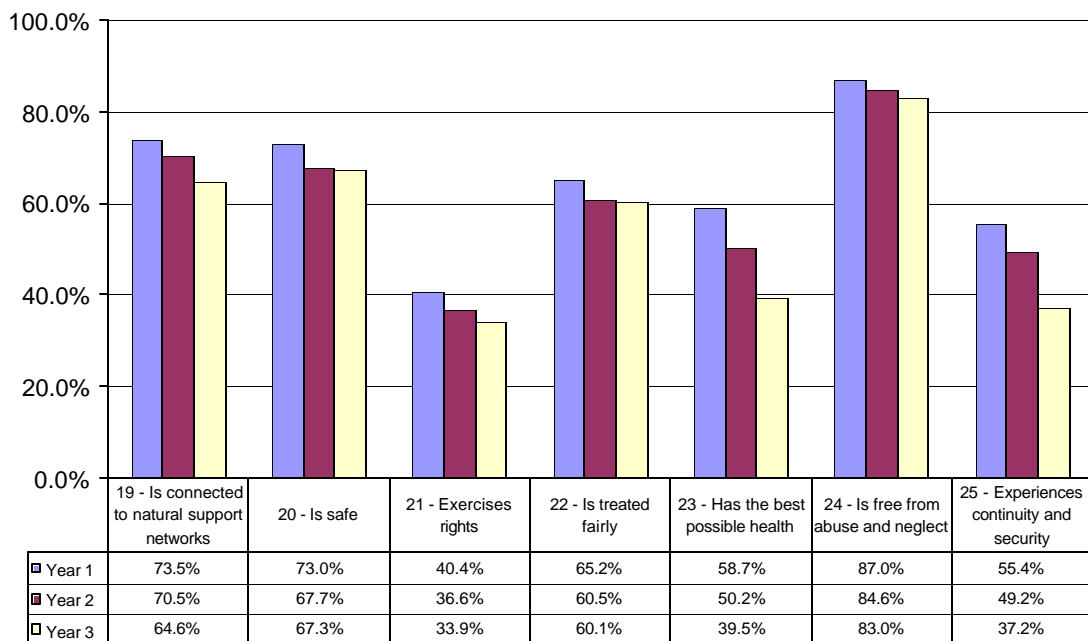


<sup>7</sup> Waiver population information taken from the Agency for People with Disabilities ABC data base.

## Foundational Outcomes

The last seven Personal Outcome Measures (Items 19-25 on Exhibit 1) include the items measuring Safeguards, Rights, and Health and Wellness. These are the Foundational Outcomes and are considered to be basic outcomes that most people with developmental disabilities would expect to have Met most of the time. The percent of reviews for which all seven Foundational Outcomes are Met has been selected as a Performance Indicator that is reported to the Governor and Florida Legislature. Figure 7 displays the percent Met for individuals within each Foundational Outcome. The outcome most likely to be Met is that individuals are perceived as free from abuse and neglect (83 percent in Year Three). Results indicate a decline for each foundational outcome since Year One. In Year Three, *Exercises rights*, *Has the best possible health*, and *Experiences continuity and security* are all under 40 percent Met.

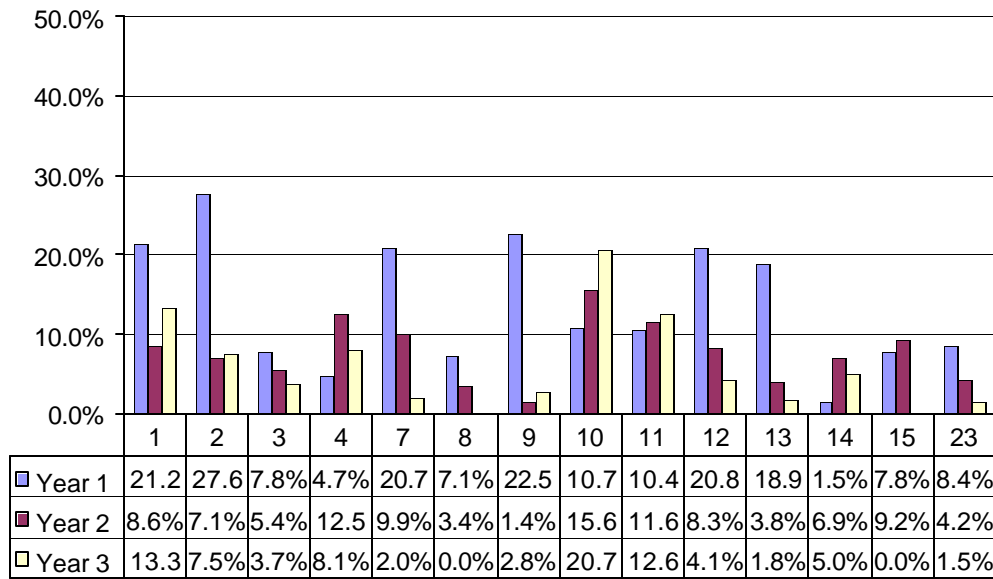
**Figure 7: Foundational Outcomes  
Percent Met**



## Results by District

Results in Figure 8 display the percent of individuals for whom a Person-centered Review was completed who Met all seven Foundational Outcomes, displayed for each district.<sup>8</sup> The statewide average for All Foundational Outcomes Met is 6.6 percent, down from 7.8 percent in Year Two and 13.4 percent in Year One. However, Districts 1 and 10 showed appreciable increases from Year Two to Year Three. Five of the districts in Year Three (1, 2, 4, 10, and 11) were above the state average on this measure, ranging from 7.5 percent in District 2 to over 20 percent in District 10. On the other hand, however, none of the 70 PCRs completed in District 15 or the 119 completed in District 8 had All Foundational Outcomes Met in Year Three.

**Figure 8: Foundational Outcomes by District  
Percent All Are Met**

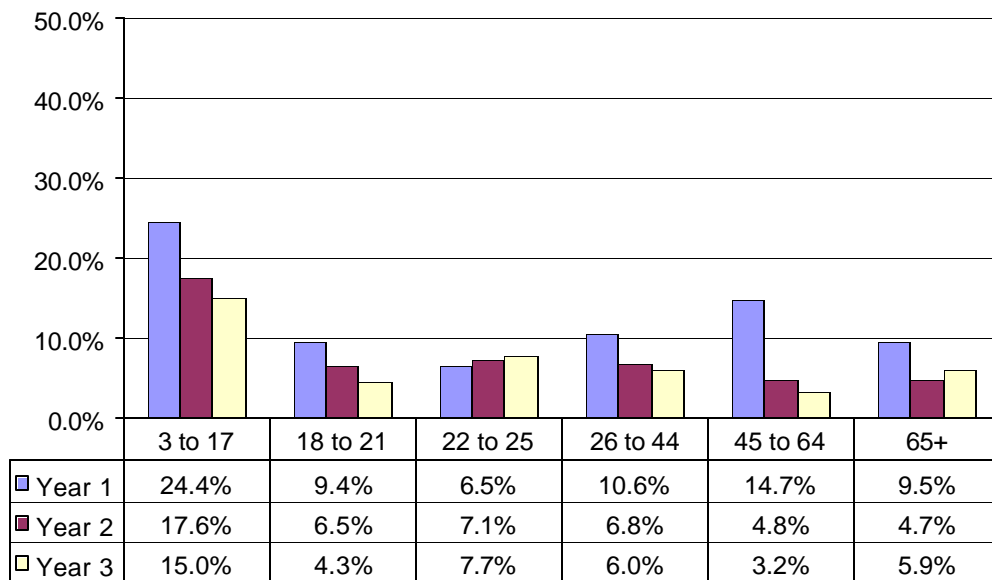


<sup>8</sup> The number of reviews in Year One for Districts 12, 14, and 15, and in Year Two in District 15 are under 70 and therefore should be viewed with caution. See Appendix 1, Exhibit 8 for additional details.

## Results by Age Group

As illustrated in Figure 9, the youngest of the Medicaid Waiver population have been most likely to have All Foundational Outcomes Met every Year of this project. However, the proportion of this group performing well on the measure has dropped from 24.4 percent in Year One to 15 percent in Year Three. A small increase in the percentage of individuals meeting the outcomes criterion from Year One to Year Three of the study is seen among those who were in the 22 to 25 year age group. Among those 65 or older, a small increase is demonstrated from Year Two to Year Three. These are “cross-sectional” results and do not necessarily reflect the pattern of individual change over time. Groups each year may be composed of different people as they age.

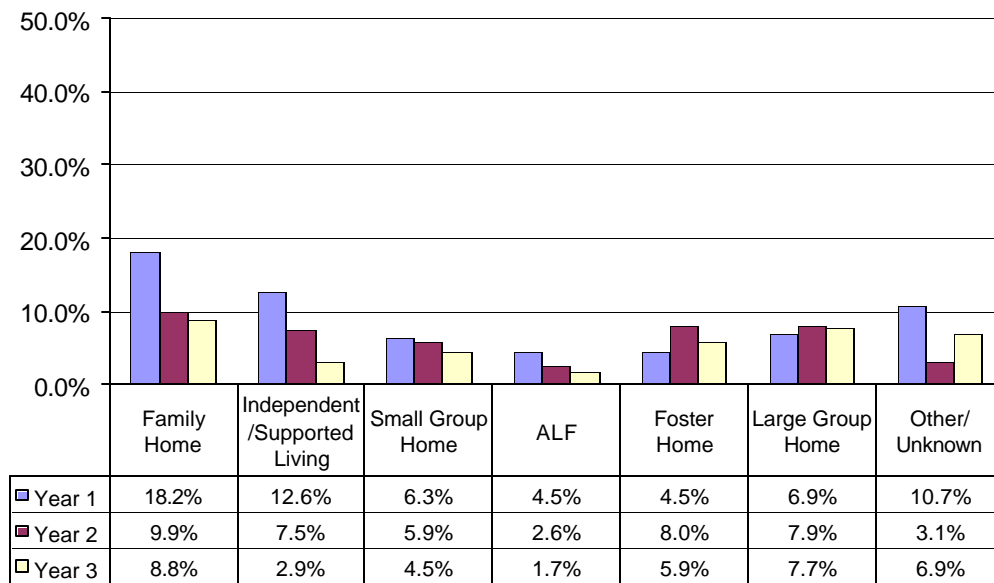
**Figure 9: Foundational Outcomes by Age Group  
Percent All are Met**



## Results by Living Arrangement

All Foundational Outcomes are least likely to be Met for people living in Assisted Living Facilities and most likely to be Met for people in a family home in the most recent year of the study. However, people in family homes and independent/supported living environments have been most likely to decline on the standard over the years.

**Figure 10: Foundational Outcomes by Living Arrangement  
Percent All are Met**



## Medical Peer Review Findings

Whenever a Person-centered Review report has a recommendation related to health, safety or behavior, the Nurse Reviewer enters a disposition code that refers concerns to the District DD Medical Case Management Team to make them aware of any health, safety or behavioral concerns of an individual in their jurisdiction. They are then available to provide assistance or intervention, if requested, to the individual, family, or waiver support coordinator in securing or arranging needed supports and services. Summary information about the dispositions from the Medical Peer Review process for the three years of the project is presented in the following table. Disposition categories for completed reviews include: 1) no evidence of problems/no concerns; 2) concerns to be forwarded to the Medical Case Management Team; 3) concerns yes/claims no; and 4) ancillary claims only. Over the years, fewer reviews with no evidence of problems or concerns have been noted, down to 9.6 percent from 37.3 percent in the first year of the contract. The number of reviews with concerns forwarded to the Medical Case Management Team has more than doubled since Year One, the percent increasing from 49.8 percent to almost 90 percent.

**Table 8**  
**Summary of Medical Peer Review Dispositions**

Medical Peer Review Dispositions	Number of Reviews			
	Year 1	Year 2	Year 3	Total
No evidence of problems/No concerns	712	343	235	1,290
Concerns to MCM	949	2,113	2,193	5,255
Concern yes/no claims	200	79	26	305
Ancillary claims only	46	5	2	53
<b>Total</b>	<b>1,907</b>	<b>2,540</b>	<b>2,456</b>	<b>6,903</b>

Medical Peer Review Dispositions	Percent of Reviews			
	Year 1	Year 2	Year 3	Total
No evidence of problems/No concerns	37.3%	13.5%	9.6%	18.69%
Concerns to MCM	49.8%	83.2%	89.3%	76.13%
Concern yes/no claims	10.5%	3.1%	1.1%	4.42%
Ancillary claims only	2.4%	0.2%	0.1%	0.77%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100%</b>

Additional information about the recommendations and a summary of the frequency and types of specific health or behavioral health recommendations is provided in Table 9 in the next section on results related to recommendations.

## **Recommendations from the Person-Centered Review**

A key component of the Person-centered Review is the recommendations made by the reviewer based on the results of the Personal Outcome Measures interview, the central record review, the medical peer review which includes a claims review and other information gathered during the review process. The reviewer includes recommendations in the PCR report that have been identified by the consumer as important to helping maintain or achieve the personal outcomes they consider important. Waiver Support Coordinators (WSC's) are responsible for reviewing recommendations and taking appropriate follow up action. Draft procedures from the State Developmental Disabilities office provide directions to districts on tracking follow-up activity on these recommendations. While follow-up action may not be indicated for every recommendation, the WSC is expected to document review of each recommendation and take action or provide appropriate supports when necessary. Provider Performance Reviews of WSC's and other providers include a review of the Person-centered Review reports and the follow up activity associated with the recommendations.

During Year Two, the automated PCR application was updated to include data fields (categories) so that recommendations could be aggregated for analysis purposes at two levels. The first level includes general categories into which specific recommendations that are usually written in narrative (or text) form can be assigned (or coded). These general categories include: Community involvement/participation; Goal achievement; Health and safety (including behavioral) Relationships/social roles; Residential; Rights; Satisfaction with supports/services, Vocational and Other. The second level provides standard recommendations that can be selected, and therefore, aggregated at a more detailed level. At this time standard recommendations are available only in the general health and safety (including behavioral) category.

Reviewers are encouraged to individualize recommendations based on the needs of the person being reviewed, the information available and the circumstances supporting the recommendations. Recommendations related to health and safety, however, are primarily selected by the nurse reviewer and are fairly consistent across reviews. If a reviewer makes health and safety recommendations, the nurse reviewer will confirm their appropriateness prior to the approval of the report.

Due to the use of standard pre-populated recommendations in the health, safety and behavioral category, information related to needed health, safety and behavioral services is more readily available. The percentage of reviews with recommendations by category and a summary percentage of health, safety, and behavioral recommendations are provided in Table 9 on the following page. It is important to note that each PCR Report may have multiple recommendations. Over 47 percent of the recommendations were related to Health and Safety and almost 14 percent were related to Rights.

**Table 9:**  
**Person Centered Review Recommendations**  
Year 3

Category	Specific Recommendation	Reviews With			
		Number	Percent	Number	Percent
Community Involvement/Participation		1,083	6.6%	970	39.6%
Goal Achievement		1,018	6.2%	836	34.1%
Health and Safety (including Behavioral)	Auditory evaluation is indicated	84	0.5%	84	3.4%
	Behavioral review is indicated	306	1.9%	303	12.4%
	Dental care is indicated	595	3.6%	592	24.2%
	ENT evaluation may be indicated	6	0.0%	6	0.2%
	Environmental assessment is indicated	178	1.1%	173	7.1%
	Evaluation of adaptive equipment is indicated	211	1.3%	192	7.8%
	Female preventive healthcare is indicated	270	1.6%	269	11.0%
	Gastrointestinal evaluation may be indicated	24	0.2%	24	1.0%
	Locate a PCP	24	0.2%	24	1.0%
	Locate local Medicaid dental provider	62	0.4%	62	2.5%
	Male preventive healthcare is indicated	82	0.5%	82	3.4%
	Medication administration education is indicated	120	0.7%	120	4.9%
	Medication compliance evaluation is indicated	36	0.2%	35	1.4%
	Neurological evaluation is indicated	490	3.0%	488	19.9%
	Nutritional evaluation is indicated	213	1.3%	213	8.7%
	Occupational therapy evaluation is indicated	86	0.5%	86	3.5%
	Oral motor evaluation is indicated	24	0.2%	24	1.0%
	Other:	1,972	11.9%	1,207	49.3%
	PCP visit is indicated	86	0.5%	84	3.4%
	Pharmacy review is indicated	1,590	9.6%	1,570	64.1%
	Physical therapy evaluation is indicated	129	0.8%	129	5.3%
	Psychiatric evaluation is indicated	721	4.4%	709	29.0%
	Respiratory therapy evaluation is indicated	12	0.1%	12	0.5%
	RN assessment is indicated	130	0.8%	130	5.3%
	Speech therapy evaluation is indicated	157	1.0%	157	6.4%
	Vision screening is indicated	221	1.3%	221	9.0%
Relationships/Social Roles		1,489	9.0%	1,193	48.7%
Residential		692	4.2%	634	25.9%
Rights		2,258	13.7%	1,477	60.3%
Satisfaction with Supports/Services		829	5.0%	675	27.6%
Vocational		1,010	6.1%	919	37.5%
Other		303	1.8%	223	9.1%
Totals		16,511	100%	2,449	

## Section Three: Provider Performance Reviews

### Review Volume

There were several categories of providers subject to a Provider Performance Review (PPR) in Year Three of the contract:

- New providers;
- Established providers who were not reviewed in Year Two (received a 90 percent or above with no Alerts in Year One);
- Providers reviewed in Year Two who had a review score of less than 90% or who had Alert Elements of Performance that were Not Met;
- Or, providers of Supported Living Coaching who are subject to annual review through State Rule.

The following table shows the number of reviews completed each year of the contract. During Year Three of the FSQAP project, 2,049 Provider Performance Reviews were completed, almost the same as in Year Two. Of this number, 938 reviews were Onsite reviews of providers of core services. A core service is defined as Support Coordination, Supported Living Coaching, Supported Employment, Adult Day Training, Residential Habilitation or Non Residential Support Services. For each location in which a provider provides Adult Day Training, Residential Habilitation, or Support Coordination, an individual service review is completed. In addition, 1,090 Provider Performance Reviews completed in Year Three were Desk Reviews of providers of all other DD Waiver Services with the exception of Adult Dental Services, Consumable Medical Supplies, Adaptive Equipment and Environmental Modifications.<sup>9</sup>

**Table 10**  
**Statewide Provider Performance Reviews**  
**Year One – Year Three**

Review Type	Year One	Year Two	Year Three	Total
	2001 - 2002	2002 – 2003	2003 - 2004	
Onsite	881	847	938	2,666
WiSCC/Core			21	21
Desk	1,001	1,207	1,090	3,298
Grand Total	1,882	2,054	2,049	5,985

<sup>9</sup> There were 16 CORE and 5 WiSCC reviews completed as part of the Pilot Project for the new review processes to be implemented in July 2004. These are not included in analyses for the annual report.

In addition, there were 180 Follow Up Reviews and 136 Follow Up Reviews with Technical Assistance conducted during Year Three. At the time of this report, 823 Documentation Follow up Reviews had been completed and 96 Reconsiderations.

## **Review Results**

The following summarizes Provider Performance Review (PPR) results for Year Three. Average scores by district are provided for Onsite reviews and Desk reviews. For Onsite reviews, average scores are displayed by agency and solo providers. Average scores are also provided for Core Assurances and for the six services subject to Onsite reviews. Statewide data from follow up reviews are discussed, as well as summary information for Alerts and Recoupment citations and Quality Improvement Plans. Data are also presented on the performance rates of specific Elements of Performance including the Standard on Projected Service Outcomes as well as the identification of the Elements of Performance Most Often Not Met for the Core Assurances and six core services.

Extensive revisions were made to the scoring methodology during the second year of the contract. The revised Standards and Protocols were put into place in February 2003 and used for only 144 agencies and 93 solo providers of Onsite review services. An additional scoring adjustment was necessary in June of 2003, removing “Not Applicable” responses from the score. This was found to have an effect on the Onsite review scores, particularly in the area of Behavioral Health.<sup>10</sup> Therefore, comparisons of Onsite review scores from Year Three to the previous years’ results are inappropriate. The revision and adjustments had little impact on the Year Two Desk Review results. Only 46 (3%), of the Desk Reviews in Year Two were conducted using the original review standards and protocols, and the scoring adjustments made in June 2003 did not affect Desk Review scores. Therefore, some trend analysis for Desk Reviews is possible comparing the results from Year Three to the total number of reviews from Year Two.

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<sup>10</sup> For details on the changes in the methodology see Florida Statewide Quality Assurance Program Annual Report: 2002-2003, Review Results Section, pg. 34. Also see the First Quarter, Year Three report, Executive Summary.

## Volume by District

The following table displays the number of Provider Performance Reviews for each district, whether Onsite or Desk, agency or solo. While 60 percent (564) of Onsite Reviews were agency providers, over 75 percent (823) of Desk Reviews were solo providers.

**Table 11:**  
**Number of Reviews by Review Type and Provider Type**

*July 2003 - June 2004*

District	Onsite			Desk		
	Agency	Solo	Total	Agency	Solo	Total
1	27	11	38	13	18	31
2	24	50	74	13	99	112
3	43	17	60	8	54	62
4	31	38	69	15	75	90
7	25	51	76	32	72	104
8	18	12	30	19	17	36
9	30	11	41	12	40	52
10	45	14	59	24	32	56
11	87	27	114	47	57	104
12	32	29	61	7	52	59
13	42	17	59	7	47	54
14	23	4	27	8	23	31
15	38	38	76	8	42	50
23	99	55	154	54	195	249
Total Reviews	564	374	938	267	823	1,090

When analyzing PPRs, it is important to note that some districts had only a few reviews completed when broken down by review type (Onsite v Desk) and provider type (agency v solo). For example, there were only four Onsite Reviews for solo providers in District 14 and fewer than 10 Desk Reviews for agencies in Districts 3, 12, 13, 14 and 15.

## Average Onsite Scores for Agency and Solo Providers by District

The average statewide scores for Onsite Provider Performance Reviews completed in Year Three for agency and solo providers are 83 percent and 85 percent respectively. Although agency providers, on average, scored slightly higher, this appears to be a fairly insignificant difference.

**Figure 11**  
Average Onsite Provider Performance Review Scores  
Year 3

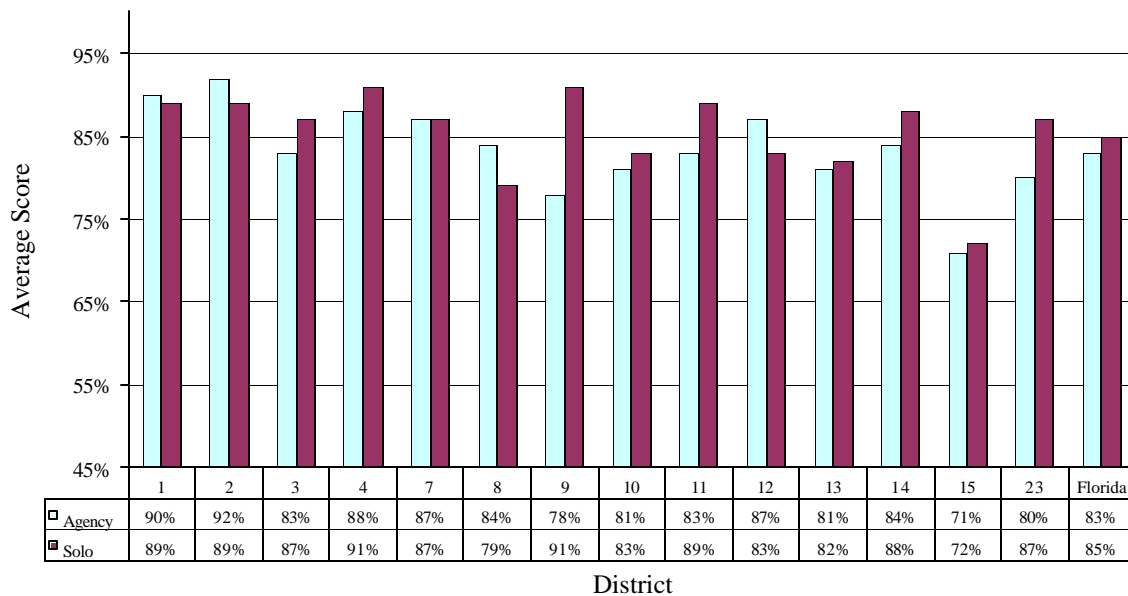


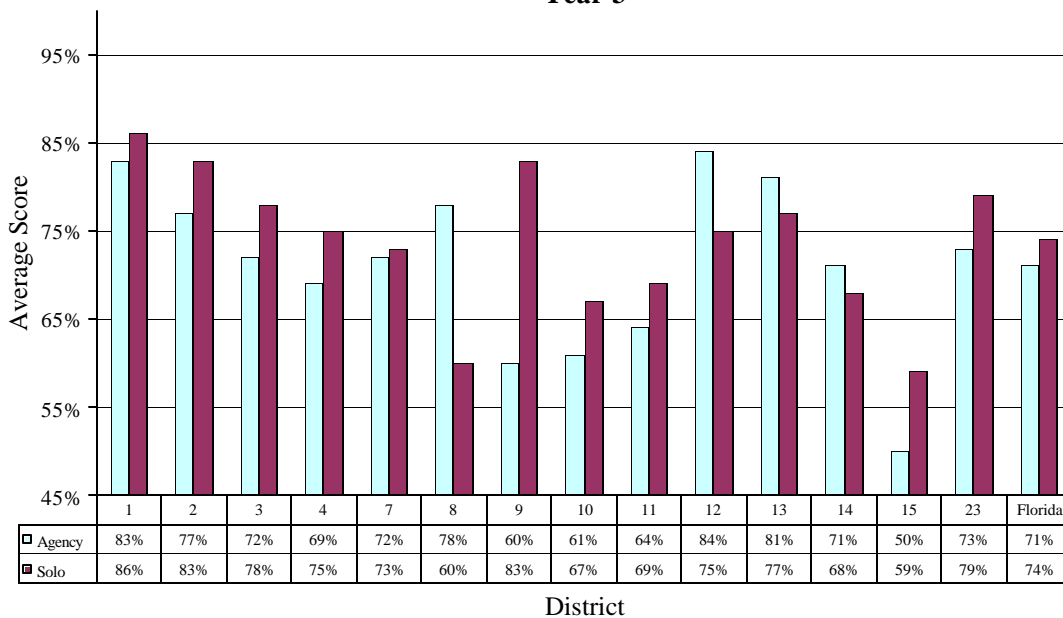
Figure 11 provides district average Onsite scores for agency and solo providers for reviews conducted from July 2003 through June 2004. Almost all average scores for agencies and solo providers are 80 percent or higher. Agency review scores vary from a low of 71 percent in District 15 to a high of 92 percent in District 2. Performance scores for Solo providers range from a low of 71 percent in District 15 to a high of 91 percent in District 9. The largest gap between the two provider types is in District 9, where solo providers' performance scores were almost 17 percent higher than agency scores. District 15 had the lowest scores for both provider types.<sup>11</sup>

<sup>11</sup> Appendix 1, Exhibits 11 and 12, provide additional detail for Onsite and Desk Reviews, including the number of alerts and recoupments by district.

## Average Desk Reviews Scores by Provider Type

All DD HCBS Medicaid Waiver Providers are required to meet the provisions of the Core Assurances for the Waiver services, as well as the Service Specific Requirements for any service for which they are an enrolled provider. Although the Review Tools and Protocols used in Onsite and Desk Review processes are the same, only selected Elements of Performance are scored in the Desk Review due to the off site nature of the review. The Desk Review includes a review of those Elements of Performance that can be assessed through review of documentation, verification of provider enrollment information, provider qualifications and training, billing authorizations, invoices, service documentations, and follow up telephone contact with consumers/family members served by the provider. Consequently, there are considerably fewer Elements of Performance reviewed during a Desk Review and Elements of Performance that are Not Met can impact the review score more negatively than for an Onsite Review.

**Figure 12**  
Average Provider Performance Reviews Desk Review Scores  
Year 3



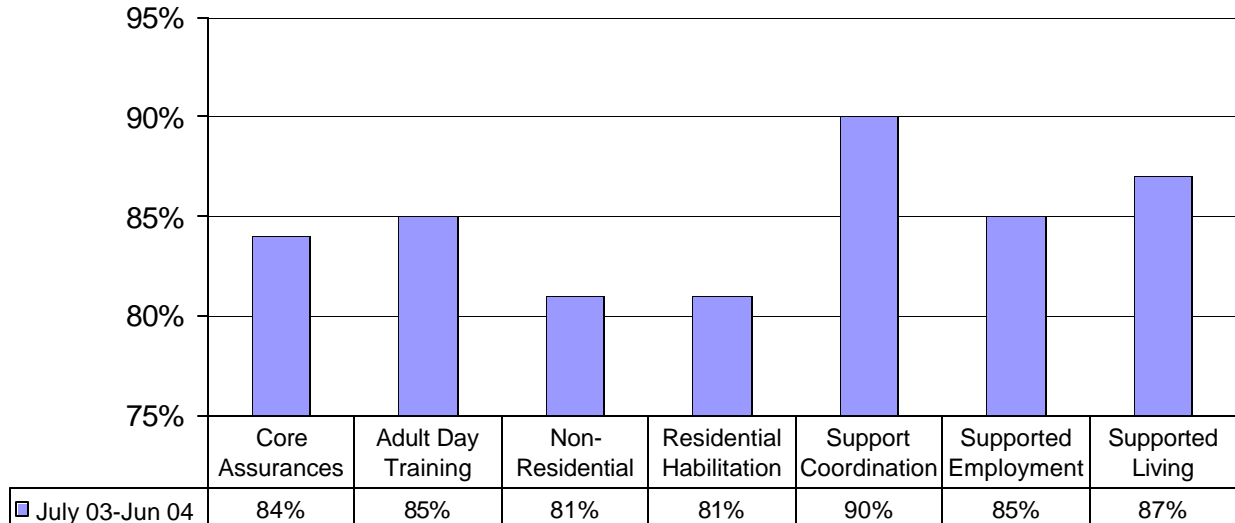
In Year Three, there were 1,090 Desk Reviews completed for DD HCBS Medicaid Waiver Providers who provided only services subject to a Desk Review and did not provide one of the six core services. Recall from Table 11 that several districts are represented by only a few PPRs, especially for agencies. In fact, only four districts have more than 20 agency desk reviews. This should be taken into consideration when interpreting the variation of scores across districts.

The average statewide score for Desk Reviews was 74 percent, 10 percentage points lower than for Onsite Reviews. For the 267 agency providers who received a Desk Review, the average score was 71 percent, down from 74 percent in Year Two. The 823 solo providers who received a Desk Review received an average score of 74 percent. This represents a decrease from 78 percent in Year Two.<sup>12</sup>

### Average Scores by Service Component

Figure 13 displays the average scores of individual service components, including the Core Assurances. This provides an assessment of how well providers of these individual services are meeting the requirements of the Developmental Services Waiver Services Medicaid Coverage & Limitations handbook. The graph provides average statewide scores for Core Assurances and each of the six core services for Year Three. Analysis and comparison of these data must be viewed with caution, as there is considerable variability in the volume of reviews within each service component.

**Figure 13: Average Provider Performance Score by Core Service**



The average Year Three review scores are all over 80 percent. Waiver Support Coordinators received the highest score, 90 percent, and Non-Residential Support Services and Residential Habilitation received the lowest, each with 81 percent.

<sup>12</sup>Additional detail is available in Appendix 1, Exhibit 12

## Alert Items

Data on Alert items Not Met are provided for all Year Three Provider Performance Reviews.<sup>13</sup> There were 306 Onsite reviews with a total of 574 Elements of Performance found as Not Met that were Alert items. Of those, 488 were Elements of Performance related to background screening and maintaining appropriate documentation for those screenings. The remaining 86 Alerts were in the following areas:

Description of Alert	District											Total
	2	3	8	9	10	11	12	13	14	15	23	
Dignity Respect	2				2	3			1	2	1	<b>11</b>
Personal Privacy		1	1	2	4	8	2			4	3	<b>25</b>
Rpt Abuse Neglect	7	2	2	1	4	2	3	1	4	7	17	<b>50</b>
<b>Total</b>	<b>9</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>10</b>	<b>13</b>	<b>5</b>	<b>1</b>	<b>5</b>	<b>13</b>	<b>21</b>	<b>86</b>

Eleven alert items from Onsite Reviews were in the area of Dignity and Respect for the individual being served, 25 related to Personal Privacy and 50 were issues revolving around Reported Abuse and Neglect. The ratio of alerts to the number of reviews is 0.61 (574/938). In other words, there is just over one Alert for every two reviews.

There were 319 Desk Reviews with 624 Elements of Performance Alert items that were Not Met. All of these Alert items were related to background screening and maintaining appropriate documentation for those screenings. This represents a ratio of approximately 0.57 of reviews with Alert items to the total number of reviews completed (624/1,090). This ratio is the same as is reflected in the Year Two report (674/1,203=0.56)—about one for every two reviews.

## Recoupments

Onsite Provider Performance Reviews were completed for 904 providers, a total of 938 reviews, during Year Three. Of these providers, 396 (43.8%) had a total of 1,267 Elements of Performance subject to recoupment that were Not Met. A provider can receive a Not Met on one or more recoupment elements per review. There were on average 1.4 recoupment citations per provider in Year Three (1,269/904).

Elements of Performance for Desk Reviews subject to Recoupment are service specific requirements related to reimbursement documentation. Results for Desk Reviews indicate that 474 reviews, 43.5 percent of the desk reviews in Year Three, had a total of 608 Elements of Performance Not Met that were subject to recoupment. This represents

<sup>13</sup> See Appendix 1: Exhibit 11. Exhibit 12 reflects alerts for desk reviews.

an increase from 37.8 percent in Year Two. There was approximately one Recoupment citation for every two reviews (ratio of .5). This is similar to Year Two, with a ratio of .56 Recoupment citations per review.

### **Quality Improvement Plans**

A Quality Improvement Plan (QIP) must be submitted when a Review Score is less than 90% or if there is an Alert item scored as Not Met. Among the 938 Onsite provider reviews in Year Three, 576 or 61.4 percent, required the submission of a QIP. A majority of these providers, 54.7 percent, scored below 90 percent with one or more elements requiring a QIP. Another 32.6 percent were cited for background screening alerts with one or more elements requiring a QIP. Of the 576 QIPs completed, 75.7 percent (436) were approved either after the first or second review. Less than 10 percent of the reviews (55) were no approved with the first submission of the QIP and only 23, or approximately four percent, were not approved after the second review cycle. The providers who had QIP's denied twice or did not submit a second QIP were targeted for a Follow Up with Technical Assistance review.

Of the 1,090 Desk Reviews conducted in Year Three, 69.5 percent (758) required the submission of additional documentation. This is the same proportion as for Year Two.<sup>14</sup> A majority of the 758, 57.9 percent, were reviews with performance scores below 90 percent. The remaining providers required submission of additional documentation based on citation of alert elements.

### **Follow Up Reviews, Follow Up with Technical Assistance Reviews, and Documentation Follow Up Reviews**

Providers who had a review score of 90 percent or below, and/or a background screening alert element(s) cited, and an approved QIP are identified for a Follow-Up review. If the provider scored below 70 percent and/or had a Core Alert, the provider receives a Follow Up with Technical Assistance review. For providers who have not yet submitted a required QIP or the QIP has been denied twice, the provider is subject to a Follow-up with Technical Assistance review. During Year Three 180 Follow up reviews were completed. Of these, 156 or 86.7 percent of the providers who received a Follow-up review had Met 50 percent or more of the Elements of Performance previously Not Met. One hundred and five follow up reviews, or 58.3 percent, Met 75 percent or more of the Elements of Performance Not Met during the Onsite review.

Follow-up with Technical Assistance reviews were completed for 136 Onsite reviews. Of these, 53.3 percent Met 50 percent or more of the elements that were Not Met on the annual review and 29.4 percent Met 75 percent or more of the Elements of Performance previously Not Met. Districts are made aware of providers with ongoing Not Met elements, and these providers are reviewed the following year.

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<sup>14</sup> This varies somewhat from the Year Two Annual Report due to changes in data fields.

Delmarva began the process of Documentation Reviews at the end of February 2003 using the PPR application. A Documentation Follow up Review allows the provider to submit documentation that was not available or submitted during the annual review. This type of review includes Onsite as well as Desk Review providers. Providers who receive Onsite reviews and have only documentation type elements scored as Not Met are only required to submit the missing documents rather than complete a QIP. Desk Reviewed providers who score less than 90 percent and/or have an Alert Item cited will be subject to a Documentation Review. In Year Three, 823 Documentation Reviews were completed, and nearly 76 percent were for Desk Reviews. The majority of providers who sent in information for the Documentation Review, 52.1 percent, met 50 percent or more of the Elements of Performance that were previously Not Met. In addition, over 34 percent Met 75 percent and almost 20 percent Met 100 percent of the elements that were Not Met on the annual review.

**Reconsiderations**

For Year Three, 95 reconsiderations were processed (one additional is pending). Of these, 41 were approved. It is important to note that the number of reconsiderations accepted is based upon multiple sites and reconsiderations are considered approved if even one element is accepted. The chart below displays the number of reconsiderations completed for Desk Reviews and Onsite Reviews and the number approved or denied.

Review Type	Status	Count
Desk	Accepted	21
Onsite	Accepted	20
Desk	Denied	20
Onsite	Denied	34

**Projected Service Outcomes**

The revisions to the service specific requirements for the six core services – adult day training, non-residential support services, residential habilitation, supported employment, supported living coaching, and support coordination – included the addition of a new Standard with several elements on Projected Service Outcomes. Projected Service Outcomes are program outcomes identified in the Developmental Services Waiver Services Medicaid Coverage and Limitations handbook that the provider must meet for each individual who receives one of these services. The Standard related to Projected Service Outcomes has from five to eight Elements of Performance, depending on the service. The Elements of Performance must be met at 100% in order to be scored as Met. During Year Three, a total of 2,017 individual core service locations were reviewed (Adult Day Training – 271; NRSS – 409; Residential Habilitation – 669; Supported

Living Coaching – 332; Supported Employment – 163; and Support Coordination – 227). The average percentage Met for the Standard ranged from 70.6 percent for Supported Employment to 59.5 percent for Support Coordination. Other services had average scores of 65.7 percent for Residential Habilitation, 62.4 percent for Non-Residential Support Services; 70.4 for Adult Day Training; and 69.9 percent for Supported Living Coaching.

The first two Elements of Performance for each Projected Service Outcome Standard relate to having a systematic method for collecting outcome data as well as a process to periodically review outcome data and take appropriate corrective measures if the data indicate the program goal is not being achieved. Although these Elements of Performance are not new requirements, the percentage being Met was much lower than the other Elements of Performance included in the Projected Service Outcome Standard. The Element of Performance related to a systematic method of data collection was Met at rates ranging from a low of 23.6 percent (NRSS) to a high of only 46.5 percent (ADT). The percent of individuals for which the Element of Performance related to reviewing data and taking corrective action was Met ranges from a low of 19.4 percent (NRSS) to a high of 46.5 percent (ADT).<sup>15</sup> Reviewers identify whether each individual (consumer) reviewed for the service is meeting each specific projected service outcome and scores the element accordingly. Therefore, if the provider does not have systems in place to demonstrate they are systematically collecting data and reviewing the data reflective of the projected service outcomes for each individual receiving the service, these Elements of Performance are scored as Not Met. On average only 32.5 percent of providers reviewed scored these elements as Met.

The remaining projected service outcome Elements of Performance for each service measure common areas including satisfaction, choice, and the effective use of supports to assist individuals in making progress toward goals and increasing their abilities. There are also unique projected service outcomes for each of the services as well. The average scores for these remaining Elements of Performance ranged from 66.5 percent to 92.8 percent. On average, 79.9 percent of providers reviewed were scored on these elements as Met.<sup>16</sup>

### **Elements of Performance Most Frequently Not Met**

Specific Elements of Performance that are most often Not Met for Core Assurances and the six “core” services have been regularly displayed in the Quarterly Reports since Year One. The data presented in Appendix 1, Exhibit 15 reflect the five Elements of Performance that were most often Not Met for each service and for the Core Assurances for Year Three. The table identifies the actual Element of Performance and the number and percent of times it was scored as Not Met.

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<sup>15</sup> These are discussed further in the following section, Elements of Performance Most Often Not Met.

<sup>16</sup> See Appendix 1, Exhibit 14 for details.

A review of the Elements of Performance in the second annual report reflected a shift in the type of elements being scored as Not Met most often with the implementation of the Revised Tools and Protocols. For the core services, the Elements of Performance cited most often under the original tools and protocols were associated with the presence of policies and procedures or required training. The Revised Tools and Protocols placed a stronger emphasis on program outcomes and person-centered approaches. Comparing Year Three to the Year Two (revised) results for Core Assurances and core services, the elements have remained fairly consistent.

For Core Assurances in Year Three, we find the Elements of Performance most often Not Met most likely refer to the provider's self assessment: *the assessment does not examine the provider's compliance with requirements in the Medicaid Waiver Agreement and Assurances*; and *the self-assessment is not effective in determining the need for improvement*. In 28.5 percent of reviews, there is no evidence that providers are informing individuals and families about suspected abuse and neglect.

Comparing the six core services, two Elements of Performance appear in all six services on the "top five" list of elements most often Not Met. Many providers are not establishing a systematic method of data collection for projected service outcome data. This element is the first or second most often Not Met in five of the core services.

The second element appearing in all six core services on the "top five" list also pertains to Projected Service Outcome data: *there is evidence that the data are reviewed periodically and that corrective measures are put in place if the data indicate the goal is not being achieved*. However, if providers are having difficulty establishing systematic data collection methods it would follow that they are not able to periodically review data to determine if goals are being met. Providers of NRSS are most likely to show poor performance on this element, with over 80 percent of reviews showing this as Not Met.

Two elements concerning the goals and progress of individuals are often scored as Not Met. For ADT, Residential Habilitation, Supported Employment and Supported Living Coaching, providers are not adequately tracking and acting on an individual's progress or lack of progress. In addition, many providers are not periodically reviewing the Implementation Plan (IP) to determine if progress is being made and if the IP is updated to reflect new interests, goals, needs, or strategies to promote meaningful progress.

## **Section 4: Discussion of Findings and Recommendations**

Through June 30, 2004, the Florida Statewide Quality Assurance Program (FSQAP) has conducted 6,859 Person centered reviews with individuals who receive services and supports through the Developmental Disabilities Home and Community Based Services (DD HCBS) Waiver. Almost 6,000 Provider Performance Reviews have been completed through Onsite (2,666) or Desk Reviews (3,294) of almost 4,000 providers of DD HCBS Waiver services. Review results from both types of reviews have been reported on a regular basis through quarterly reports and presentations at state and local meetings.

As project staff have shared review results and worked with the State and districts to improve the quality assurance process and provide training and technical assistance, emerging trends and patterns have been noted and are being used to direct improvements in supports and services. Concurrently, preliminary analysis of review results has been initiated to further examine results, identify significant findings and suggest structured approaches for on going evaluation of data to document empirically noted trends and patterns. This section provides a discussion of some of the trends and patterns as well as recommendations.

### **Discussions of Findings**

The Person-centered Review results provided in this report are displayed by project year. The results reported over the past three years have reflected a decline in the number of Outcomes Met and Supports Present as measured by the POM. A comparison of Year Three to Year One results reflects a decrease of almost 27 percent in 13 or more outcomes Met (54.5 to 39.8 percent) and 28 percent in 13 or more Supports Present (63.9 to 46.0 percent). There were similar changes in the data presented on All Foundational Outcomes Met, with a 50 percent decrease since Year One (13.4 to 6.6 percent Met). The percent of individuals with Outcomes Met and Supports Present by individual POM item has also declined each year.

One factor that is possibly depressing the outcomes measures each year is the increasingly smaller proportion of children age 3 to 17 represented in the sample. This group has been underrepresented each year, with a decrease from over 18 percent in Year One to just over 12 percent in the most recent year. A similar decline in representation is apparent for people living in independent or supported living environments. Because children and people living independently have better outcomes results, the decreasing representation among these groups may serve to suppress the outcomes measures. However, it is also apparent from the Year Three results that outcomes *within* these groups have decreased each year.

The Year Two annual report presents results from some preliminary analyses suggesting age, living arrangement, and district size were all significant predictors of provision of supports and outcomes achieved. Results indicated that consumers in the youngest age group (3-17 years) and consumers living in residential settings were more likely to have

supports Present and outcomes Met. Findings in the Year Two report also indicated the size of the district, measured as the number of consumers served, had an impact on outcomes achieved and supports provided. A Quality Improvement study will be conducted to further explore these relationships, utilizing three years of data. If strong predictors of positive outcomes can be identified and verified, efforts can be made to help direct resources to improve the life experiences of people with disabilities in Florida.

As noted in several sections of this report, Delmarva, AHCA and APD, in cooperation with the Joint Commission and The Council, have worked collaboratively to design and implement a new Onsite review system to help ensure better outcomes and supports for the individuals in this program. These new review processes have been implemented. Anecdotal evidence suggests that reviewers and providers alike are aware of a different focus in the procedures, from process/documentation to a person-centered approach. Analysis of data collected in the next several years should reflect a positive impact from these changes. It is important to note that this represents a fundamental change in the criteria for a provider's "score". It is not only essential to have systems in place to help individuals achieve outcomes but that those systems are being utilized, and positive results for individuals being served are apparent. Therefore, Onsite provider performance "scores" are expected to vary greatly from Year Three to Year Four and direct comparisons will only be possible at the element level (Minimum Service Requirements).

In the area of Provider Performance Reviews, changes, revisions and additions to the review process during the first two years of the project, as noted in this report, have limited the ability to report and compare "performance scores" across the first three years of the project, particularly for Onsite reviews. General trends and patterns have been discerned at the district level, at the services level and on a statewide basis for Desk Reviews. Some of the more noteworthy findings are noted below.

Average Desk Review performance scores dropped by four percentage points for both Solo and Agency providers, with an overall decrease from 78 percent to 74 percent. Agency providers scored nine points higher than Solo providers in Year One, using the original Tools and Protocols, 79 percent and 70 percent respectively. However, with the implementation of the revised methodology, Agency providers have scored four points *lower* than Solo providers in both Year Two and Year Three. With the revised standards, Solo providers have shown improvement while Agency providers have not. The reasons for this are not clear, however some scenarios are possible. Many solo providers of services subject to a desk review had never been monitored and were generally unaware of core assurance and service specific requirements. Agency providers, because they often work with many different human service programs and funding sources, were more familiar with requirements and procedures. Solo providers, on the other hand, appeared to have limited knowledge about the requirements. In some districts where solo provider scores were notably lower, targeted training and technical assistance sessions were provided that may have helped improve scores. Because solo providers generally had less experience, it is possible the *original* tool was less effective for them and that use of the *revised* tool has helped them increase compliance. Improvements made to the written procedures and guidelines for providers subject to a desk review resulted in large part

from customer service calls from providers confused about the process and required documentation. Therefore the improved process may have had more of an impact on solo providers than on agencies.<sup>17</sup>

The Elements of Performance reported as Most Often Not Met for Core assurances and “core” services in Year Three have remained fairly consistent with those reported in Year Two—revised Review Tools. Two elements remain problematic that address Projected Service Outcome data system issues: creating a data system and reviewing the data to determine if corrective measures need to be put into place when goals identified by the individuals are not being achieved. Tracking an individual’s progress and periodic review of the Implementation Plan (IP) to determine if the IP is up to date with current goals and needs of the individual, and if progress is being made toward those goals are two other important areas that continue to be most often Not Met for consumers. Systems for measuring individual progress toward goals and the ability of providers to make program adjustments to better address individual goals are important components of a person-centered approach to service delivery. Data in this report indicate that providers have improved performance in terms of tracking the consumer’s progress and reviewing the IP.

Follow up data available in an automated format reflect progress being made by providers who require a follow up visit. Over 58 percent of the providers receiving follow up visits have corrected over 75 percent of the Elements of Performance that were found to be Not Met; while 29.4 percent of the providers receiving a follow up with technical assistance have 75 percent or more of the Elements Not Met corrected. For follow up reviews, 86.7 percent of the providers had corrected 50 percent or more of the Elements of Performance that were previously found to be Not Met. Over 53 percent achieved this mark for Follow Up with Technical Assistance reviews. These findings are encouraging and support the continued development of a strong on site follow up and technical assistance program. Providers who continue to receive a Not Met on elements are monitored the following year and referred to the district if needed.

## **Recommendations**

Trends and findings observed by project staff as well as those supported through preliminary data analysis form the basis for the following recommendations.

1. The new review/consultation processes for waiver support coordinators (WiSCC) and providers of other services subject to Onsite review (CORE) need to be monitored closely during this first year of implementation. Regional managers and other relevant experts should carefully examine any feedback from consultants, consumers and providers, making modifications when appropriate. Reliability and validity tests should continue, with scenarios (real or fabricated) examined by all consultants and discussed at the bi-weekly conference calls.

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<sup>17</sup> Florida Statewide Provider Performance Reviews: An Analysis of Desk Review Results. Delmarva Foundation. Submitted to the Agency for Healthcare Administration June 2004.

2. Through coordination with APD in the implementation of the recently awarded Federal Real Choice Systems Change Grant for Quality Assurance, support and involvement should: continue in the area of training and technical assistance at the district and provider level to improve individual personal outcomes that are most important for consumers; promote person-centered approaches in program and services design to support those outcomes.
3. There must be an elevated emphasis at the State level to address providers who are non-compliant in participating in or completing required review processes. Continuing efforts to delineate the authority and specific action(s) to be taken for providers who are non-compliant need to incorporate appropriate requirements related to Standard Rates.
4. An increased level of evaluation and analysis is needed to appropriately identify root causes and develop intervention strategies that are appropriate and based on evidence. Structured analysis and evaluation should examine the impact of various factors (living situation, district size, type of disability, etc.) on the outcomes achieved and supports provided to the Waiver population. Quality Improvement studies should explore the factors that most likely predict good outcomes for individuals, the reasons outcomes and supports are most often Not Met, and utilize this to effect systemic improvements.
5. Based upon the Public Reporting study completed this year, it is recommended that a work group be formed to explore the development and implementation of a public reporting system for the information now collected on the Waiver population. This group should consist of representatives from Delmarva, APD, AHCA, providers and consumers.
6. An important component of the new review processes is to identify barriers to service delivery that impact consumers. A reporting system on a district as well as statewide level should be developed to disseminate and act upon the identified barriers, thereby improving the overall service delivery system.